Arbejdet med trivsel – forudsætningen for den høje kliniske kvalitet

Lægelig direktør, Anna-Marie Bloch Münster, MD, ph.d

Region Syddanmark
Esbjerg Sygehus
Grindsted Sygehus

8. Trivsel

Fokus på kerneopgaven er en forudsætning for trivsel

Hvor skal vi være i 2025?

- Vi har en høj medarbejdertilfredshed
- Vi har et stabilt og højt fremmøde på over 96%
- Vi arbejder proaktivt med arbejdsmiljø og er arbejdsmiljøcertificeret
- Vi har et lavt antal arbejdsskader og arbejdsulykker
- Vi vil være et Compassionate hospital og være et videnscenter for compassion

Indsatser

- Fælles sæt leveregler for alle ansatte
- Struktureret og god onboarding
- Standardwork for arbejdsmiljøarbejdet herunder systematisk brug af risikovurdering
- Vi følger fokuseret op på områder med højere sygefravær og trivselsproblemer
- Vi har indført undervisning og træning i compassion
- Udvikle det strategiske samarbejde i FMU og LMU'er

Compassion

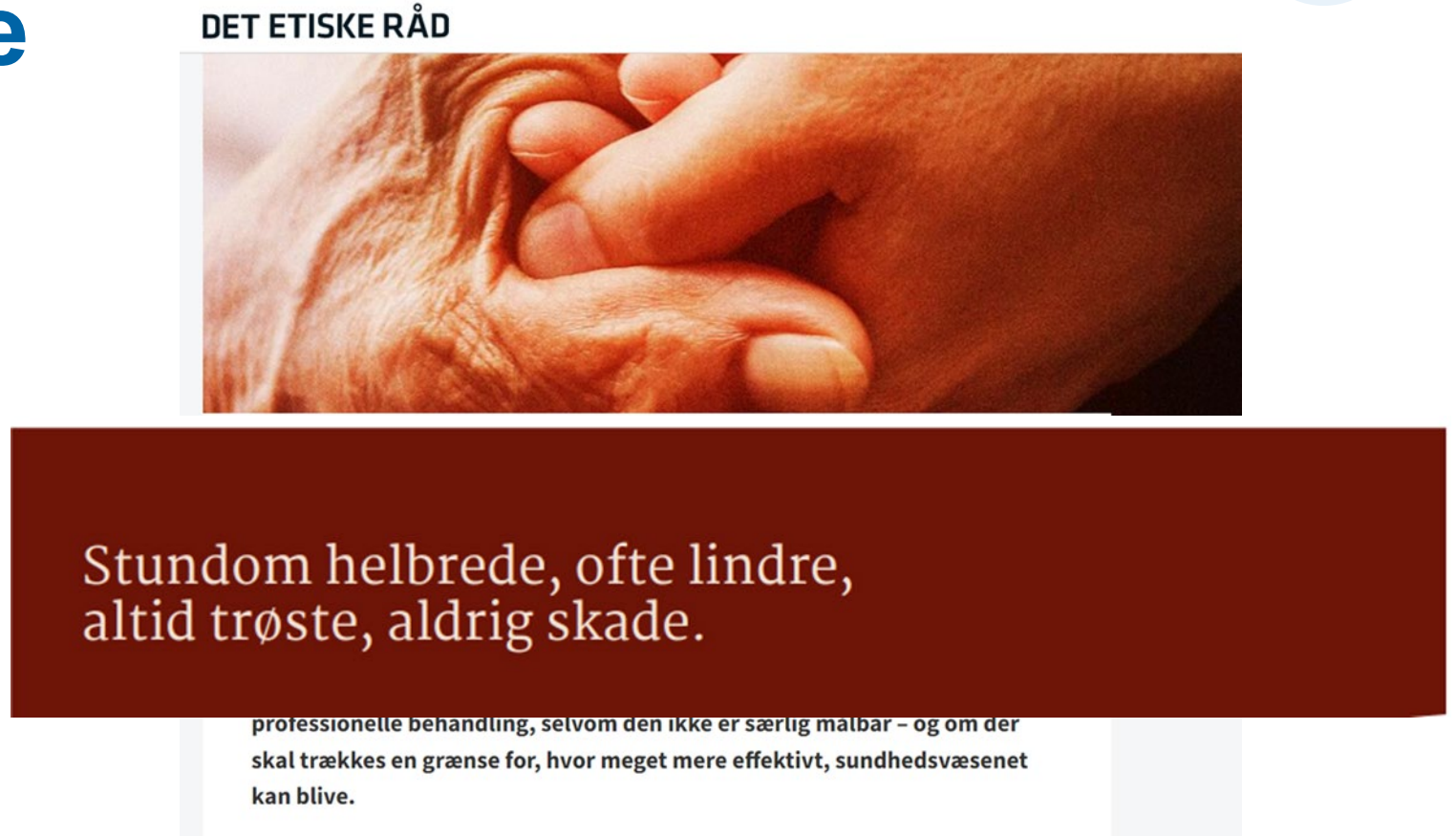
Anna-Marie Bloch Münster, MD, ph.d.

Esbjerg Sygehus
Grindsted Sygehus
Syddansk Universitetshospital

Videnssygehus for Compassion

Sundhedsfagprofessionelle: Stærkt purpose

- Meningsskabende
- Gøre en forskel
- Skabe værdi



Hvad er compassion?

- Compassion er defineret som den emotionelle respons til andres smerte eller lidelse – der involvere et ægte ønske om at hjælpe og handle
- Empati er forskellig fra compassion
- Empati er følelse og forståelses begrebet
- Compassion involvere også **at** *tage handling*
- Følelsen af empati er en nødvendig motivator eller forløber for at handle med compassion

Hvorfor overhovedet tale om compassion?

- Udbrændthed i sundhedsvæsenet
  - Internationalt problem
  - Epidemi af udbrændthed blandt sundhedsprofessionelle
- Forskning har identificeret tre kendetegn ved udbrændthed
  - Emotionel udmattelse
  - Manglende personlig udvikling
  - De-personalisering (ude af stand til at skabe en personlig relation med patienten – andre), og tænker på patienten som en samling af symptomer og ikke som et menneske

Patientsikkerhed og trivsel

Table 2. Quality of Life, Burnout, Symptoms of Depression, and Empathy Measures for Residents Reporting No Perceived Errors vs Reporting Perceived Errors*

Variable	Metric (Scale)	Group Baseline, Mean (SD) (N = 184)	No Reported Errors (n = 122)	Reported Errors (n = 62)	Difference (95% Confidence Interval)	P Value
QOL	LASA overall QOL (0-10), mean	6.60 (1.88) (n = 160)	6.54	6.01	−0.52 (−1.00 to −0.05)	.03†
Burnout‡						
Depersonalization	MBI-DP (0-30), mean	7.10 (5.94) (n = 145)	6.62	9.85	3.23 (1.35 to 5.12)	<.001†
Emotional exhaustion	MBI-EE (0-54), mean	21.51 (9.91) (n = 142)	19.21	26.06	6.85 (3.88 to 9.82)	<.001†
Personal accomplishment	MBI-PA (0-48), mean	39.01 (5.25) (n = 142)	39.26	36.27	−2.99 (−4.77 to −1.22)	.001†
Depression	Any positive 2-item depression screen, %	32.21 (46.99) (n = 149)	33.02	63.33	3.50 (1.71 to 7.20)§	<.001‖
Empathy						
Emotive	IRI-EC (0-28), mean	22.47 (4.26) (n = 159)	22.25	21.36	−0.89 (−2.11 to 0.32)	.15†
Cognitive	IRI-PT (0-28), mean	20.25 (4.48) (n = 158)	20.60	19.95	−0.65 (−1.91 to 0.60)	.31†

Abbreviations: IRI-EC, Interpersonal Reactivity Index–Empathic Concern Subscale; IRI-PT, Interpersonal Reactivity Index–Perspective Taking Subscale; LASA, linear analog scale assessment; MBI-DP, Maslach Burnout Inventory–Depersonalization; MBI-EE, Maslach Burnout Inventory–Emotional Exhaustion; MBI-PA, Maslach Burnout Inventory–Personal Accomplishment; QOL, quality of life.
*Summary statistics averaged over all survey points providing data.
†Wilcoxon-Mann-Whitney test.
‡Higher depersonalization or emotional exhaustion scores and lower personal accomplishment scores are indicative of greater burnout. Thresholds to categorize physicians as having low, average, or high burnout are based on normative scales[10] (depersonalization: low burnout, 0 to 5; average burnout, 6 to 9; high burnout, ≥10; emotional exhaustion: low burnout, 0 to 18; average burnout, 19 to 26; high burnout, ≥27; personal accomplishment: low burnout, ≥40; average burnout, 34 to 39; high burnout, 0 to 33).
§Odds ratio for a positive depression screen for the errors group relative to the no-errors group.
‖Fisher exact test.

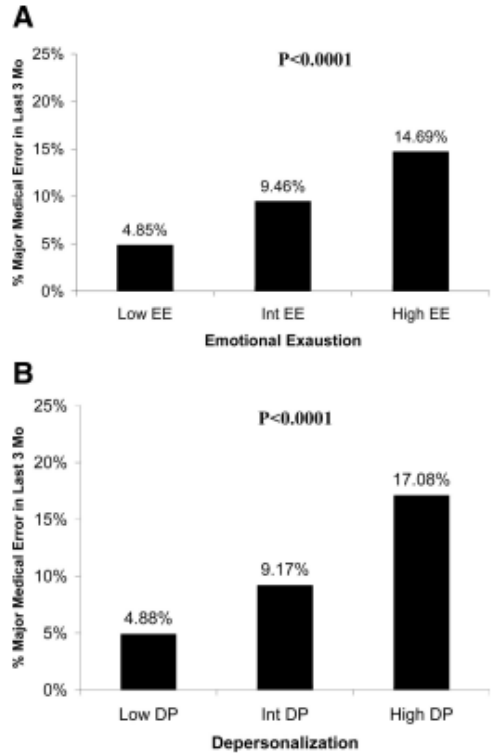


FIGURE 1. Report of making a recent medical error by degree of burnout. A, Report of making a recent medical error by degree of emotional exhaustion. According to standardized scoring system for health care professionals, surgeons with Emotional Exhaustion scores ≤18, 19 to 26, and ≥27 are considered to have low, intermediate (Int), and high degrees of burnout, respectively. B, Report of making a recent medical error by degree of depersonalization. According to standardized scoring system for health care professionals, surgeons with depersonalization scores ≤5, 6 to 9, and ≥10 are considered to have low, intermediate (Int), and high degrees of burnout, respectively.

West et al JAMA 2009; 302:1294-1300,
Shanafelt et al; Ann Surg 2010; 251:995-1000

Region Syddanmark
Sydvestjysk Sygehus

Hvorfor compassion som værktøj

- Does treating patients with more compassion really matter?
- Does caring make a difference?
- Does it matter in measurable ways?

Compassion træning hvordan og hvorfor?

Compassion KAN trænes (mental træning)

Temaer i Compassion træning

CCT:

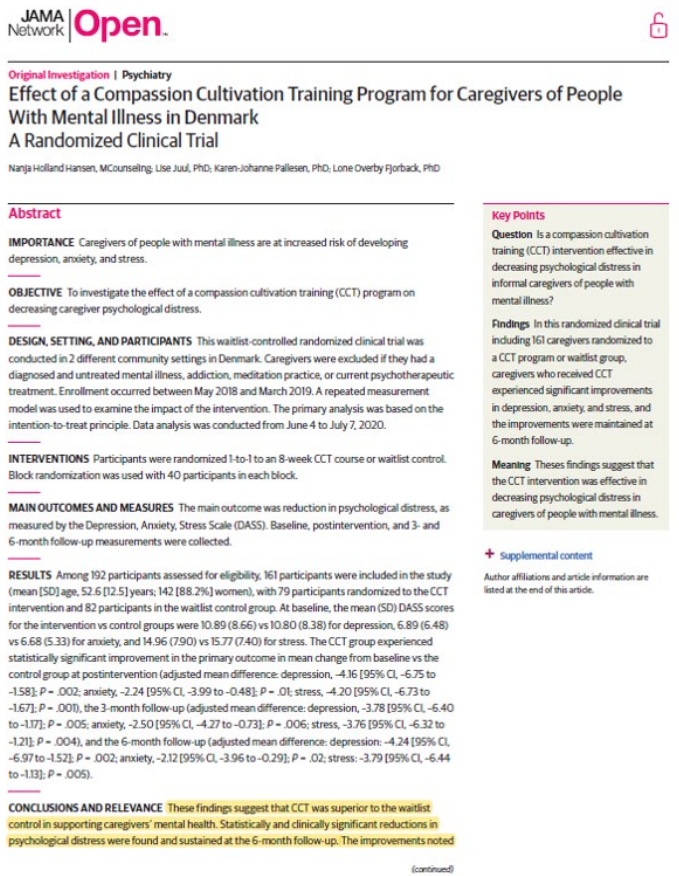
- Fokusering og Mental stabilisering
- Compassion for en person, man holder af
- Compassion over for én selv
- Kærlig -venlighed over for én selv
- Fælles menneskelighed
- Compassion for andre
- Aktiv Compassion
- Integration af Compassion i dagligdagen

- Der er efter undervisningen hjemmearbejde, der består formelle (mental træning via lydfil af 10-30 min varighed daglig) og uformelle øvelser (hvor ugens tema afprøves i dagligdagen.) Der udleveres materiale og adgang til lydfiler til alle deltager.

SCSP:

- Intro & Hvad er Selv-Compassion?
- Selv–Compassion og stabilitet
- At motivere os selv med Compassion modsat Selv-Kritik
- Selv-Compassion & styrkelse af indre Resilience
- Selv-Compassion og Compassion for patienter
- Hvordan vægter vi Selv-Compassion i hverdagen?

- Der er hjemmearbejde *via lydfiler og actions Cards efter hver session*



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Original Investigation | Psychiatry

Effect of a Compassion Cultivation Training Program for Caregivers of People With Mental Illness in Denmark
A Randomized Clinical Trial

Nanja Holland Hansen, MCounseling; Lise Juul, PhD; Karen-Johanne Pallesen, PhD; Lone Overby Fjorback, PhD

Abstract

IMPORTANCE Caregivers of people with mental illness are at increased risk of developing depression, anxiety, and stress.

OBJECTIVE To investigate the effect of a compassion cultivation training (CCT) program on decreasing caregiver psychological distress.

DESIGN, SETTING, AND PARTICIPANTS This waitlist-controlled randomized clinical trial was conducted in 2 different community settings in Denmark. Caregivers were excluded if they had a diagnosed and untreated mental illness, addiction, meditation practice, or current psychotherapeutic treatment. Enrollment occurred between May 2018 and March 2019. A repeated measurement model was used to examine the impact of the intervention. The primary analysis was based on the intention-to-treat principle. Data analysis was conducted from June 4 to July 7, 2020.

INTERVENTIONS Participants were randomized 1-to-1 to an 8-week CCT course or waitlist control. Block randomization was used with 40 participants in each block.

MAIN OUTCOMES AND MEASURES The main outcome was reduction in psychological distress, as measured by the Depression, Anxiety, Stress Scale (DASS). Baseline, postintervention, and 3- and 6-month follow-up measurements were collected.

RESULTS Among 192 participants assessed for eligibility, 161 participants were included in the study (mean [SD] age, 52.6 [12.5] years; 142 [88.2%] women), with 79 participants randomized to the CCT intervention and 82 participants in the waitlist control group. At baseline, the mean (SD) DASS scores for the intervention vs control groups were 10.89 (8.66) vs 10.80 (8.38) for depression, 6.89 (6.48) vs 6.68 (5.33) for anxiety, and 14.96 (7.90) vs 15.77 (7.40) for stress. The CCT group experienced statistically significant improvement in the primary outcome in mean change from baseline vs the control group at postintervention (adjusted mean difference: depression, −4.16 [95% CI, −6.75 to −1.58]; $P = .002$; anxiety, −2.24 [95% CI, −3.99 to −0.48]; $P = .01$; stress, −4.20 [95% CI, −6.73 to −1.67]; $P = .001$), the 3-month follow-up (adjusted mean difference: depression, −3.78 [95% CI, −6.40 to −1.17]; $P = .005$; anxiety, −2.50 [95% CI, −4.27 to −0.73]; $P = .006$; stress, −3.76 [95% CI, −6.32 to −1.21]; $P = .004$), and the 6-month follow-up (adjusted mean difference: depression: −4.24 [95% CI, −6.97 to −1.52]; $P = .002$; anxiety, −2.12 [95% CI, −3.96 to −0.29]; $P = .02$; stress: −3.79 [95% CI, −6.44 to −1.13]; $P = .005$).

CONCLUSIONS AND RELEVANCE These findings suggest that CCT was superior to the waitlist control in supporting caregivers' mental health. Statistically and clinically significant reductions in psychological distress were found and sustained at the 6-month follow-up. The improvements noted

(continued)

Key Points

Question Is a compassion cultivation training (CCT) intervention effective in decreasing psychological distress in informal caregivers of people with mental illness?

Findings In this randomized clinical trial including 161 caregivers randomized to a CCT program or waitlist group, caregivers who received CCT experienced significant improvements in depression, anxiety, and stress, and the improvements were maintained at 6-month follow-up.

Meaning Theses findings suggest that the CCT intervention was effective in decreasing psychological distress in caregivers of people with mental illness.

+ Supplemental content

Author affiliations and article information are listed at the end of this article.

Trzeciak S et al Compassionomics 2019, Trzeciak S et al Wonder Drug 2022
Neff K et al J Clin Psychol 2020
Hansen NH JAMA 2021

Does caring for patients make a difference – in a measurable way?(1)

Can 40 Seconds of Compassion Reduce Patient Anxiety?

By Linda A. Fogarty, Barbara A. Curbow, John R. Wingard, Karen McDonnell, and Mark R. Somerfield

Purpose: To use a standardized videotape stimulus to assess the effect of physician compassion on viewers' anxiety, information recall, treatment decisions, and assessment of physician characteristics.

Participants and Methods: One hundred twenty-three healthy female breast cancer survivors and 87 women without cancer were recruited for this study. A randomized pretest/posttest control group design with a standardized videotape intervention was used. Participants completed the State-Trait Anxiety Inventory (STAI), an information recall test, a compassion rating, and physician attribute rating scales.

Results: Women who saw an "enhanced compassion" videotape rated the physician as warmer and more caring, sensitive, and compassionate than did women who watched the "standard" videotape. Women who saw the enhanced compassion videotape were significantly less anxious after watching it than the women in the other group. Nevertheless, information recall was relatively low for both groups, and enhanced compassion did not influence patient decisions. Those who saw the enhanced compassion videotape rated the doctor significantly higher on other positive attributes, such as wanting what was best for the patient and encouraging the patient's questions and involvement in decisions.

Conclusion: The enhanced compassion segment was short, simple, and effective in decreasing viewers' anxiety. Further research is needed to translate these findings to the clinical setting, where reducing patient anxiety is a therapeutic goal.

J Clin Oncol 17:371-379.

... and as I left his office, he said, "you know, you have a very bad disease, but we are going to take care of you." The doctor-patient relationship was incredibly therapeutic and reassuring. I had no qualms, no doubts with putting my life in his hands. I had full confidence in his expertise, his concern and emotional support.

Breast cancer survivor

However, substantial evidence suggests that provision of information may play a role. For example, in a review of 34 intervention studies to increase patients' psychosocial and informational preparedness, benefits of increased preparedness (for example, reductions in pain and use of analgesics, and an average 2-day reduction in hospital stay) were found

THE LANCET

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A randomised trial of compassionate care for the homeless in an emergency department

D.A. Redelmeier MD [a], J-P. Molin BA [b], R.J. Tibshirani PhD [c]

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https://doi.org/10.1016/S0140-6736(95)90975-3

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Abstract

Homeless adults often visit emergency departments and often leave dissatisfied. We tested whether compassionate care, by improving patient satisfaction, can alter subsequent use of emergency services. We identified 133 consecutive homeless adults visiting one inner-city emergency department who were not acutely psychotic, extremely intoxicated, unable to speak English, or medically unstable. Half were randomly assigned to receive compassionate contact from trained volunteers. All patients otherwise had usual care and were followed for repeat visits to emergency departments. We found that rates of use were high, with patients making an average of seven visits a year (0·60 per month). More than a third of all patients made two or more visits within two days of each other. The average number of visits per month after intervention was significantly lower for patients who received compassionate care (0·43 vs 0·65, p=0·018). Analyses adjusting for each patient's previous rate of use confirmed that compassionate care led to a one third reduction in the number of return visits within one month (95% CI 14 to 40%). Compassionate management of selected homeless adults decreases repeat visits to the emergency department. One explanation is that patients tend to return frequently until they are satisifed with their treatment.

Does caring make a diffences? (2)

Table 2

Association Between High, Moderate, and Low Jefferson Scale of Empathy Scores of Physician Participants (n = 242), 2010, and Disease Complications in Their Diabetic Patients (n = 20,961), 2009, Parma, Italy

Patient characteristics	Physician empathy level*		
	High scorers	Moderate scorers	Low scorers
No. with diabetes mellitus	7,224	7,303	6,434
Acute metabolic complications			
No. of patients†	29	52	42
Rate (no. per 1,000 patients)	4.0	7.1	6.5

*Comparing high- and moderate-scoring physicians on the rates of occurrence of acute metabolic complications in their patients with diabetes mellitus: $z = -2.51$, $P < .01$. Comparing high- and low-scoring physicians on the rates of occurrence of acute metabolic complications in patients with diabetes mellitus: $z = 2.04$, $P < .05$.

† One hundred twenty-three patients were hospitalized with acute metabolic complications in 2009: 41 with a hyperosmolar state, 53 with diabetic ketoacidosis, 26 with coma, and 3 with a combination of these complications.

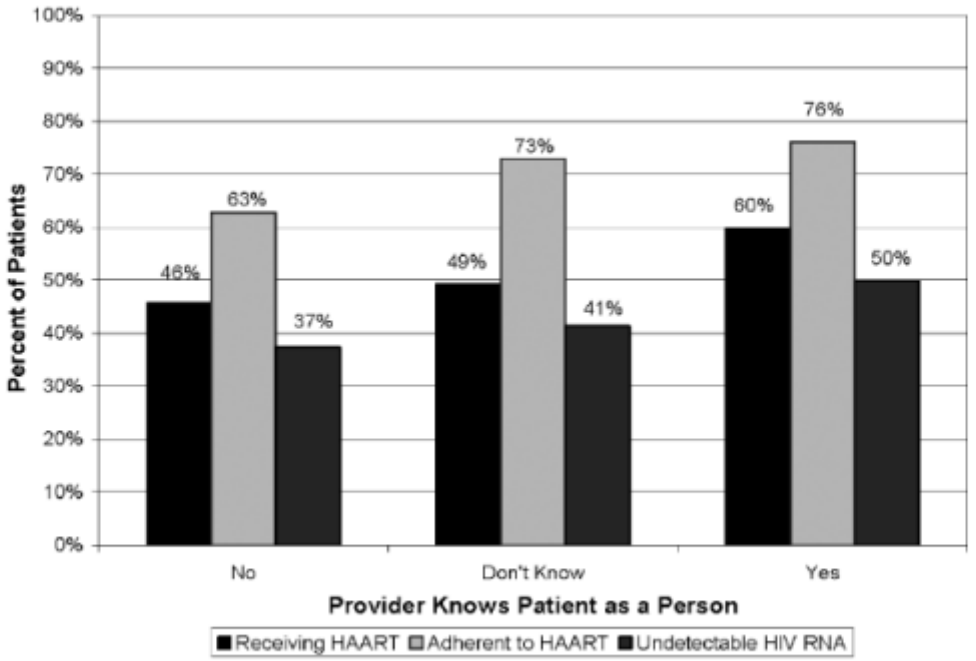


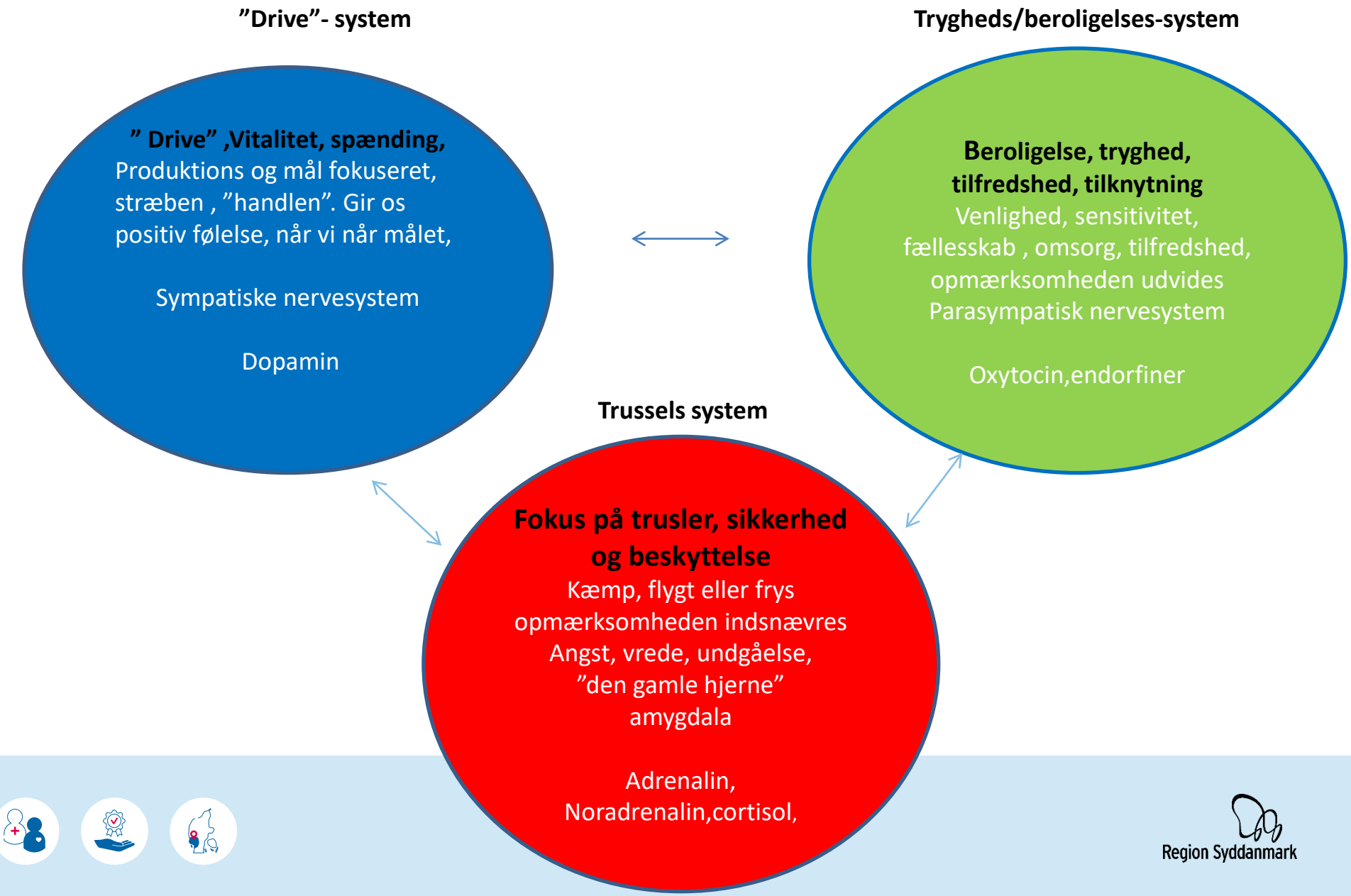
FIGURE 1. Associations between patient reports that provider knows them ''As a Person'' and patient outcomes.

Del Canale S et al JAAMC 2012; 87: 1243-9; Zolnierek et al Med Care 2009; 47: 826-34; Beach et al JGIM 2006; 21: 661-5

Region Syddanmark

Sydvestjysk Sygehus

Menneskets 3 typer af følelses regulerende systemer



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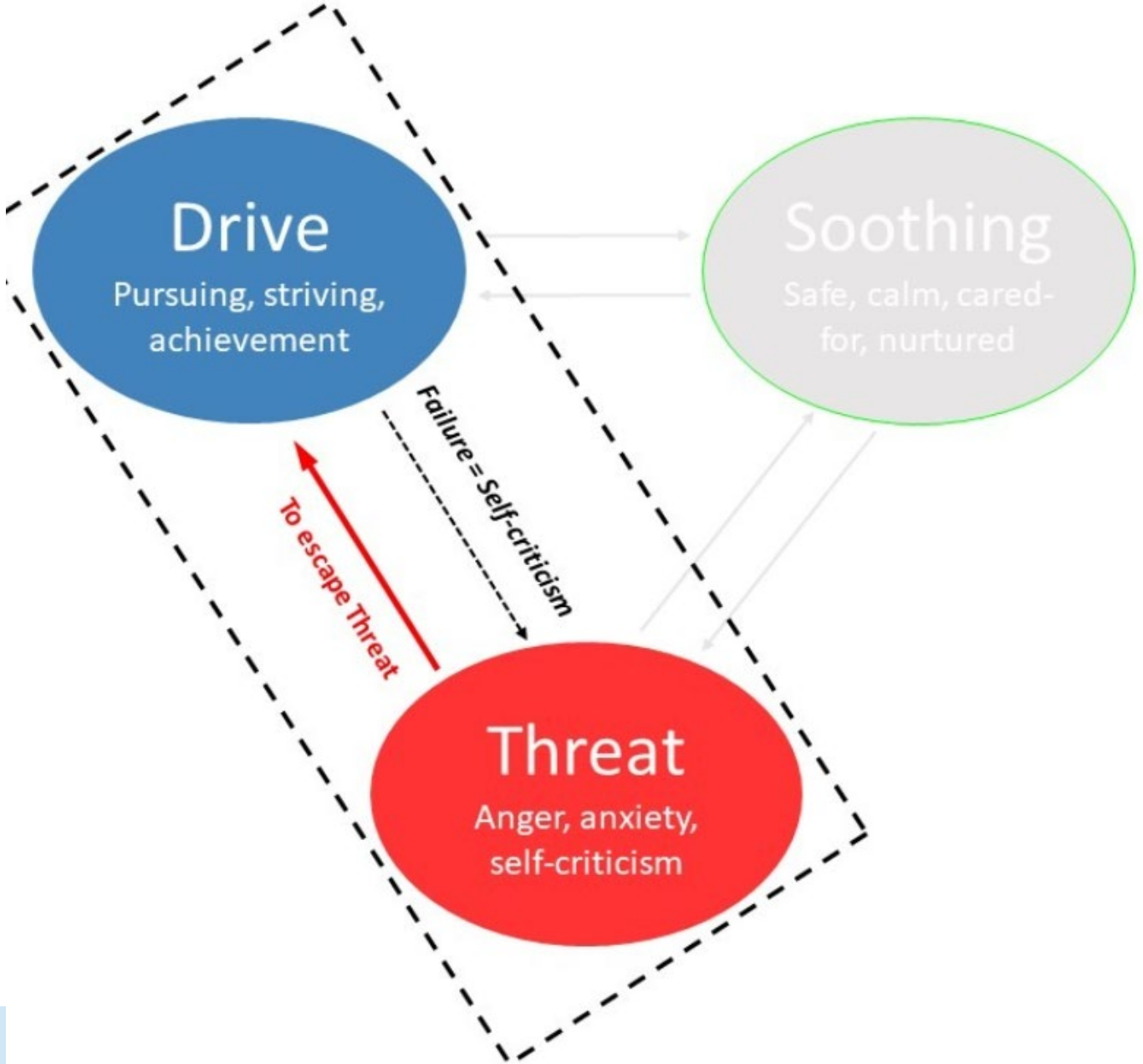

Adapted from Gilbert, P (ed) (2005). *Compassion: Conceptualisations, Research and Use in Psychotherapy.* Routledge.

frontiers in Psychology

HYPOTHESIS AND THEORY
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doi: 10.3389/fpsyg.2016.00763

Empathy Is a Protective Factor of Burnout in Physicians: New Neuro-Phenomenological Hypotheses Regarding Empathy and Sympathy in Care Relationship

Bérangère Thirioux[1], François Birault[2] and Nematollah Jaafari[1,3]*

[1] Unité de Recherche Clinique Intersectorielle en Psychiatrie à Vocation Régionale Pierre Deniker, Centre Hospitalier Henri Laborit, Poitiers, France, [2] Faculté de Médecine et de Pharmacie, Département de Médecine Générale, Université de Poitiers, Poitiers, France, [3] Institut National de la Santé et de la Recherche Médicale CIC-P 1402 du Centre Hospitalo-Universitaire de Poitiers, Institut National de la Santé et de la Recherche Médicale U 1084, Experimental and Clinical Neuroscience Laboratory, Groupement de Recherche Centre National de la Recherche Scientifique 3557, Université de Poitiers, Poitiers, France

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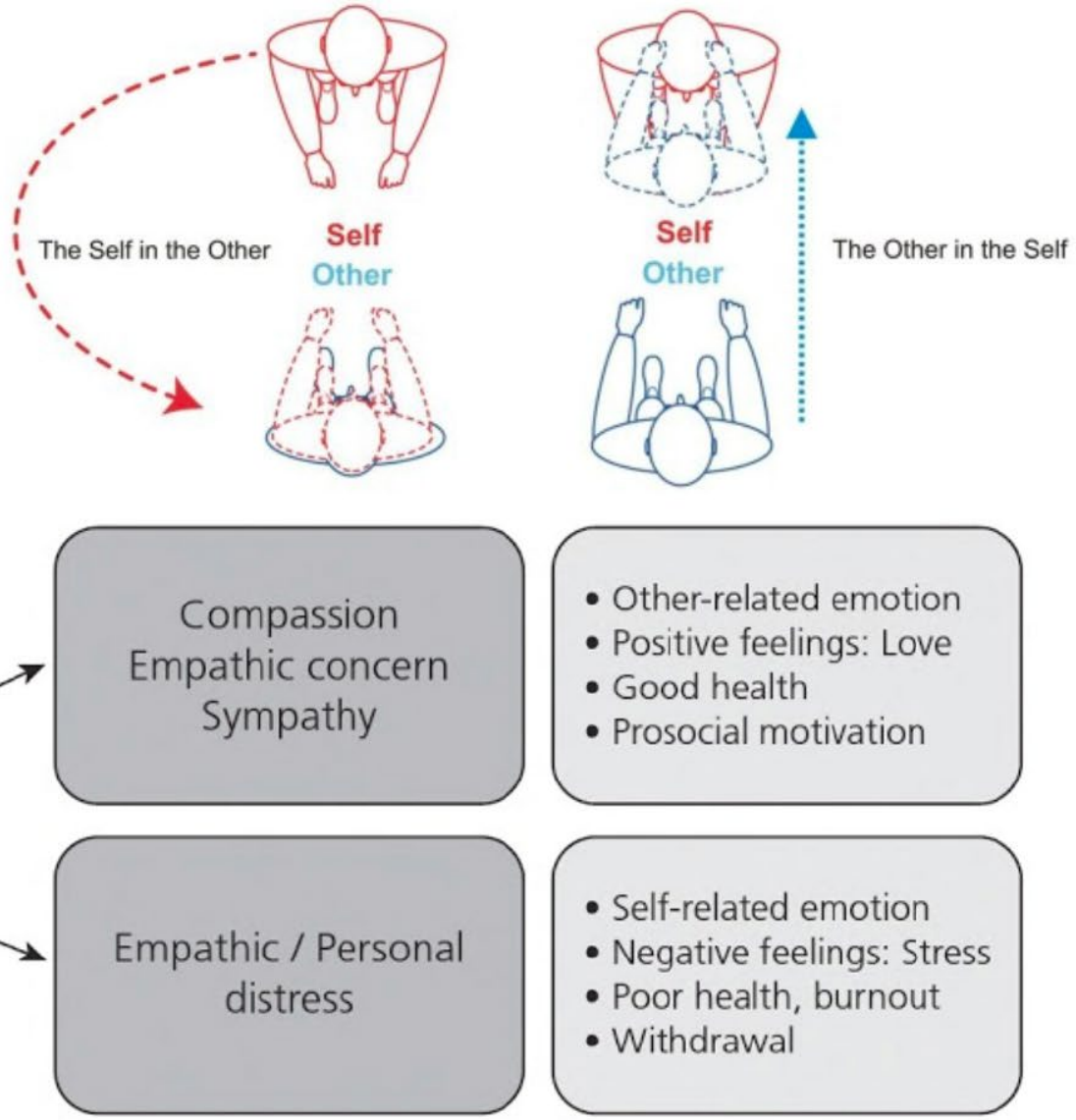
Burnout is a multidimensional work-related syndrome that is characterized by emotional exhaustion, depersonalization—or cynicism—and diminution of personal accomplishment. Burnout particularly affects physicians. In medicine as well as other professions, burnout occurrence depends on personal, developmental-psychodynamic, professional, and environmental factors. Recently, it has been proposed to specifically define burnout in physicians as "pathology of care relationship." That is, burnout would arise, among the above-mentioned factors, from the specificity of the care relationship



Top Images: Thirioux, Birault, & Jaafari 2016
Bottom Image: Klimecki & Singer 2012

doi:10.1093/scan/nst060 SCAN (2014) 9, 873–879

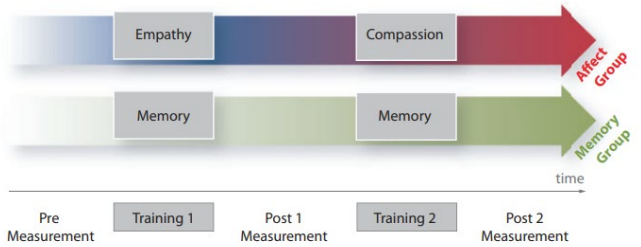
Differential pattern of functional brain plasticity after compassion and empathy training

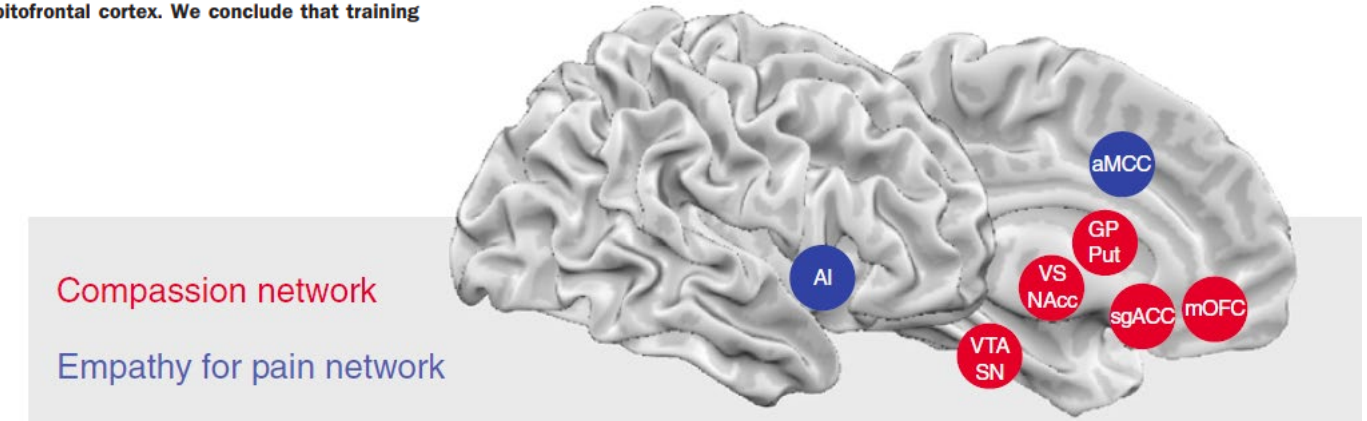
Olga M. Klimecki,[1,2] Susanne Leiberg,[3] Matthieu Ricard,[4] and Tania Singer[1,3]

[1]Department of Social Neuroscience, Max Planck Institute for Human Cognitive and Brain Sciences, 04103 Leipzig, Germany, [2]Swiss Center for Affective Sciences, University of Geneva, 1205 Geneva, Switzerland, [3]Laboratory for Social and Neural Systems Research, Department of Economics, University of Zurich, 8006 Zurich, Switzerland, and [4]Mind and Life Institute, Hadley, MA 01035, USA

Although empathy is crucial for successful social interactions, excessive sharing of others' negative emotions may be maladaptive and constitute a source of burnout. To investigate functional neural plasticity underlying the augmentation of empathy and to test the counteracting potential of compassion, one group of participants was first trained in empathic resonance and subsequently in compassion. In response to videos depicting human suffering, empathy training, but not memory training (control group), increased negative affect and brain activations in anterior insula and anterior midcingulate cortex—brain regions previously associated with empathy for pain. In contrast, subsequent compassion training could reverse the increase in negative effect and, in contrast, augment self-reports of positive affect. In addition, compassion training increased activations in a non-overlapping brain network spanning ventral striatum, pregenual anterior cingulate cortex and medial orbitofrontal cortex. We conclude that training compassion may reflect a new coping strategy to overcome empathic distress and strengthen resilience.

Keywords: fMRI; social; emotion; insula; medial orbitofrontal cortex





- fMRI-science Empathy and Compassion Research Current Biology

Compassion indsatser

Hvad har vi nået indtil nu?

PRÆ-GRADUAT:

Kandidatstuderende medicin:
Selv-compassion og CCT
Stamafdelingskoncept sygeplejestuderende (6 og 7 semester, pilot UC-Syd): Selv-compassion

POST-GRADUAT:

Eksterne lektorer: CCT, skjulte curriculum
KBU: Selv-compassion

LEDELSE:

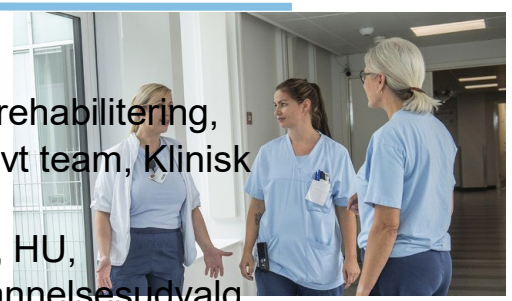
Funktionslederuddannelse: Elementer fra CCT
Koncernledelsesforum tilbudt: CCT

HELE Sygehuset:

Fælles akut modtagelse: CCT
Bedøvelse og Intensiv: CCT
Ortopædkirurgisk afdeling: Selv-compassion
Udbudt CCT-kurser som alle kan søge på tværs af sygehus og faggrupper
Prioriteret TR og AMIR samt ledelsessystemet i opstarten

OPLÆG

INTERNT: AL-kredsen, Arbejdsmedicin, Neurorehabilitering, Terapien, Syddansk Overvægts initiativ, Palliativt team, Klinisk Diagnostisk afdeling
EKSTERNT: AL-Horsens, RegionH, HR-chefer, HU, Sundhedsudvalget, KLF, Regionale videreuddannelsesudvalg, Dansk Neurologisk selskab, Sydjurs lægelaug, Lægedage, Neurovaskulær stroke konference, MS-seminar sygeplejersker, Hospitalsledelseskonference, LMU onkologi Gødstrup, Almen praktiserende læger, Klinisk Diagnostisk afdeling



QC før og efter samt longitudinelt, LUP, MTU, spot-målinger

At møde nyansatte med compassion- 1 ½ times undervisning og træning i compassion

Øvelse 1

Øvelse 2

Hvad var godt i dag og hvorfor var det godt?

Gode ting

Øvelse 3