What Does Leading with Mindfulness and Compassion Look Like?

BY AMANDA PATTON, MA

Or how not to blame the cucumber for becoming a pickle

Since 2012 Leah Weiss, PhD, has taught a perennially wait-listed course, "Leading with Mindfulness and Compassion," at Stanford University's Graduate School of Business. She is the co-founder of Skylyte (skylyte.com), which offers online training and coaching on managing team health, resilience, and well-being. Dr. Weiss previously taught compassion courses at the Stanford School of Medicine, the U.S. Department of Veterans Affairs (for people with post-traumatic stress disorder), the Boston Center for Refugee Health and Human Rights, and the Alzheimer's Association. She traces her professional interest in compassion and its connection with resilience to growing up in a family of healthcare clinicians and her own experience "seeing such highly driven people with so much intelligence, so focused on health and the health of people around them, giving so much of themselves, trying to work in environments that were really inhospitable in many ways for their own health." In 2020, during the early days of the SARS-CoV2 pandemic, she lost a physician cousin and a close family friend, also a physician, to COVID-19.

In an interview with *Oncology Issues*, Dr. Weiss shares why she believes this work is important in all levels of healthcare—from the clinic to the boardroom.

Leah Weiss, PhD

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OI. Can you say more about how leading with mindfulness and compassion intersects with healthcare and quality care delivery?

Dr. Weiss. The distinction between empathy and compassion and why that matters for burnout is not traditionally part of medical education, but it's increasingly something that folks are learning and trying to build into education [and training]. I spent a lot of time doing individual approaches to resilience earlier in my career. For the last five years I have been trying to prioritize team and organizational components of resilience, because I think it's an unfair ask—particularly in healthcare—to tell people they need to solve this themselves when it's a systems-based challenge that they are reacting to. The metaphor I always use in my talks on this point is from Dr. Christina Maslach.* It's like asking cucumbers in the pickle barrel not to become pickles, but they're sitting there in the vinegar. So, what do we do to acknowledge the vinegar and not blame the cucumber for what's happening? Part of the answer comes back to the individual, but—and the research is really showing this now—organizations that take the pathway of providing more meditation, more yoga, and more benefits focused just on the individual alone—that approach doesn't work. It doesn't help individual outcomes or organizational outcomes.

OI. What does it look like to be a mindful, compassionate leader?

Dr. Weiss. I define compassionate leadership as respecting the dignity of others, acknowledging the full context of their lives, and recognizing that people who are valued create value. This means we also must understand that there is a business case for compassionate leadership. It is not saying you should be compassionate as a detriment to your bottom line. It is acknowledging a myriad of research that shows that you have more profitability, more engagement, more patient satisfaction, and less safety errors when an organization is higher in compassion and the leaders are prioritizing it [compassion].

If you want to have a compassionate organization you have to think in terms of the individual, the team, and the culture. On an individual level, much of the work I do at the Stanford Graduate School of Business involves thinking about compassionate management from the time you are defining a position and hiring so that you are understanding the emotional intelligence components of that role. You are building compassion into what you are looking for in performance reviews and incentivizing it [compassion].

An organization can say, "We care about compassion." But it is much more than hanging a banner or making a statement. What steps is the organization taking to put these words into action? How is compassion embedded in the culture? This can even trickle down into the small details of how meetings are run.

Are you creating a sense of belonging? Are you sanctioning repeated microaggressions? Are you keeping an awareness of "in-group" bias? Are you thinking about the role of moral injury—a big topic in healthcare right now? Thinking back to the acute phase of the COVID-19 pandemic, for example. Times when, due to societal-level challenges, clinicians may have been faced with insurmountable barriers to providing the quality of care they would have liked to provide.

Even the language an organization uses can reflect compassion. My sister, orthopedic surgeon Jennifer Weiss, MD, is a physician leader who has come out strongly against the use of the word "provider."[1] She, along with many others, has argued that substituting the non-specific umbrella term provider commodifies physicians, fails to distinguish care team member roles, is confusing for patients, and is a potential barrier in physician-patient communication.

Further, replacing the professional title of doctor with the word "provider" has disturbing historical context. In 1930s Nazi Germany, Jewish physicians were stripped of the title *arzt* (doctor) and instead referred to as *behandler*, which many experts translate as "provider." During the Third Reich it was a way to dehumanize physicians and turn them into non-human competency providers.

Today, subbing the term provider for professional titles, such as physician, nurse practitioner, physician assistant, or pharmacist, sets healthcare delivery in a transactional framework rather than in the relational framework that is important to achieving patient-centered care. The non-specific term "provider" blurs the roles and unique contributions of each healthcare team member to patient care.

Compassionate leaders ask what we are doing collectively around these topics of humanizing and bias. How are we acknowledging the impact of COVID-19 and what people are holding in the context of their lives?

One of the key things is recognizing, as Mahatma Gandhi said, "Compassion is a muscle that gets stronger with use." It's something that we need to practice, stay aware of, and work on collectively and individually.

OI. In today's healthcare environment, everyone on the cancer care team is so pressed for time. How might this work in the real world?

* Editor's note: Christina Maslach, PhD, pioneered research on the definition, predictors, and measurement of job burnout and is the creator of the Maslach Burnout Inventory. She is a Professor of Psychology (Emerita) and a core researcher at the Healthy Workplaces Center at the University of California, Berkeley.

Dr. Weiss. Part of the answer is recognizing there are constant opportunities to practice compassion or not. This doesn't mean that we must enable bad behavior in the workplace or say "yes" to unreasonable requests or poor-quality work. Often people have a whole set of misnomers in their mind about what compassion means. They may believe compassion means enabling a co-worker who is doing what they're not supposed to do. No. Absolutely not that.

Rather, think of focusing on interactions between staff, for example, and recognizing opportunities to work on creating more compassionate interactions. Consider questions such as how to disagree with compassion. How to call someone out with compassion. How do you show up to these courageous, compassionate conversations? Nobody is too busy to do that. I'm not saying stop and go to a meditation retreat. I'm saying you have to be thoughtful about how you are interacting. It doesn't take time. It does take attention.

OI. What would compassion look like when you have to give a colleague, or someone you supervise, criticism or negative feedback?

Dr. Weiss. We've developed a tool for folks to play around with. It's an exercise to help practice compassionate language interactively. [Access the tool at: skylyte.com.]

The question always comes up: You want to be a compassionate leader, but how do you fire people? Or what about these hard conversations?

A specific example of compassionate feedback I'll draw from is the CEO of a well-known tech company who visited my class at Stanford. One of the classic points he made is that nobody should be surprised when they are fired from an organization. Building off of this line of thinking, what you need to do out of compassion is have the straightforward difficult conversation in which you tell the person that their work is not what you are expecting. You show them where there is a gap. You ask them: What is the block? What do you need? Training? Resources? Is there something happening in your life? Start by having the conversation. Set a clear expectation of what is going to happen to close the gap between what they are doing and what you need. And then continue having the courage to show up and tell the person: Look we're still not there. Let's revisit this plan. You are letting them know so that they are not surprised when you've reached the point where it is not a good fit anymore. They are not getting the call out of the blue.

This is having the courage and willingness to have the difficult conversation and not outsource that to the human resources department. You have to be clear and direct. They may not like hearing that there is a gap in their work. But they will prefer to have an opportunity to work on it, and they can't work on it if they don't know what it is.

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OI. Thinking about the current environment, we have not really entered the post-COVID-19 stage yet. Our healthcare workforce has done an amazing job over the past year. Most—if not all—cancer programs and practices had to completely re-consider their workflows and processes. Many are simply exhausted. Now we are asking that they make time to reflect on their behavior and compassion. How does a healthcare organization or a cancer program go about this without making everyone feel as though you've added another burden when they're already feeling overtaxed?

Dr. Weiss. I think it's a false binary to think you have a choice here because people, especially in healthcare, are so exhausted. If you can't create an organizational environment that works for them, you're going to lose your people to another organization that can, or to burnout, or worse. There is nothing more expensive or costly to time than turnover. If you allow for burnout and the impact of burnout to proliferate, that is going to cost you a lot in terms of safety, patient satisfaction, and the human cost on your clinicians.

I tell the CEOs [that I work with], including those of many healthcare organizations: Ignore it at your own peril. Making compassion and resilience a priority is not just because it's the right thing to do; you must do it if you want to succeed in this environment. I'm not saying it's easy, but I don't think you have a choice. Compare and contrast a year from now the organizations that are investing in resilience [and compassion] and those that are not. Let's see who is in better fiscal shape.

OI. Clearly, this is not a one-time, quick fix. It's an ongoing process. Can you share an example of a healthcare organization that is doing this well?

Dr. Weiss. One I've been working with for years is Stanford Children's Hospital. There is a lot of attention on resilience—not just having a talk once in a while but building it in pervasively in performance plans and leadership trainings and community practice circles. I've helped them design and implement all of the above. I think a metaphor that your readers can relate to is that

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just like infection control, clinician resilience is something you always have to keep an eye on. Resilience for your workforce is similar. It's ongoing. If you drop the ball, the end results are catastrophic. There is a lot of research in this area related to patient safety and patient outcomes. It's not a matter of do it because you're nice. It's an imperative.

OI. How does a focus on mindful and compassionate leadership dovetail with the critical need in healthcare, and in cancer care specifically, to advance health equity?

Dr. Weiss. One piece that comes to mind is that compassionate management and compassionate leadership start all the way at the beginning with whom you hire. Representation is one of the most critical things that can happen in terms of equity and disparities. Thinking of clinical trials, some of this comes back to what are you doing as a compassionate leader to mitigate unconscious bias in the hiring processes both for clinicians and the allied staff involved in conducting these studies. If you don't have representation, then how are you trying to solve for making pathways to inclusion in studies and listening to people? Bias, stereotypes, and prejudice are a part of how human beings are wired. But we can work on that.

I do think the bottom line—the best action we can take—is to make sure we are focused not just on representation but also on belonging. Are we listening to people who are from the communities we are trying to include in studies? Are we listening to them in terms of what the blocks to improving quality of care are? That might mean that sometimes we're upstanders and followers and leading from behind in seeking out different perspectives.

Sometimes the answers are complex, but sometimes they [answers] are really straightforward. My sister's advocacy within her organization, and the resolution passed in 2006 by the Southern California Permanente Medical Group Board of Directors that prohibits use of "provider" to describe physicians in its medical group, is a great example of compassionate leadership.

OI. Any final thoughts you'd like to share with ACCC members?

Dr. Weiss. To healthcare practitioners, I want to say that if you are experiencing moral injury from the pandemic or from challenges in the system that you are a part of, find ways to voice those and process those. Otherwise, over time, these types of moral injury can lead to pain and burnout.

I think the distinction between empathy and compassion has a lot of practical importance. Empathy and empathic response to someone else's pain light up the pain region in our brain. We can't sustain that. Compassion lights up the reward regions, bringing connection, meaning, and purpose. If we don't have access to compassion as an alternate option, then we will be at much higher risk for burnout.

For the cancer care team, I think it's also important to understand the difference between empathy and compassion and then really look at how to build that into your care team and create opportunities to practice. I remember in my clinical training one of the environments I worked in had great staff, but there was very much a kind of negative tone in talking about the patients, and it had a huge impact. We can work on that; we can work on some of these habits that we can blindly fall into. We're human. We're busy. We don't realize it. These [habits] don't just matter for the patients; they matter for the sense you have of your own work, your own dignity, and your own connection that brought you into the purpose of this incredibly noble work in the first place. OI

Amanda Patton, MA, is a freelance healthcare writer. She worked as a senior writer and editor for the Association of Community Cancer Centers for more than 15 years.

Reference

1. Weiss J. "Physician" not "provider" is better for doctor and patient. Available online at: permanente.org/physician-not-provider-is-better-for-doctor-and-patient/. Last accessed April 27, 2021.