

Vulnerability, Compassion, Interdisciplinary reflective practice- From Theory to Practical strategies



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Disclosures

- No real or potential conflicts
- Employed in CHI as a clinician, academic time at UCD, clinical lead across 3 centres
- Current Chair Academic Faculty, College of Psychiatrists of Ireland, previous Vice Chair of Liaison Faculty
- Current IHCA National council and consultant psychiatry group
- UCD Health Ethics and Narrative Ireland, MindReading projects
- Accredited Balint lead, Schwartz Round lead at CHI



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Outline

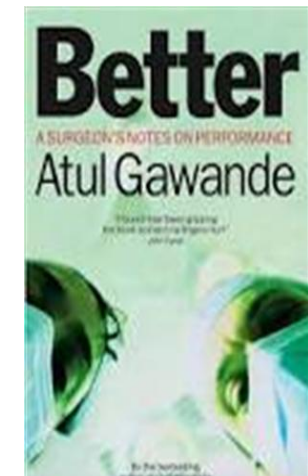
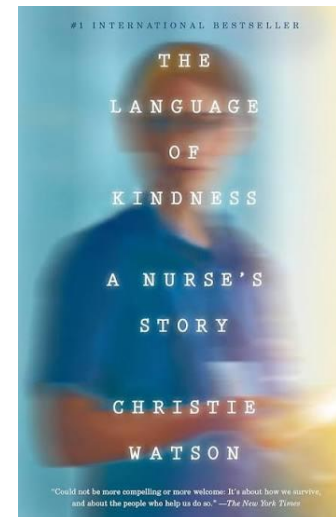
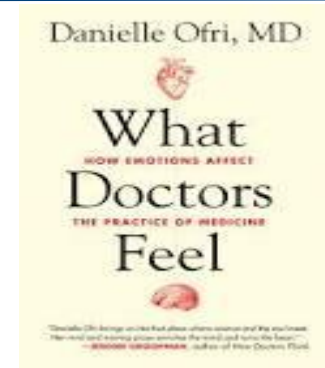
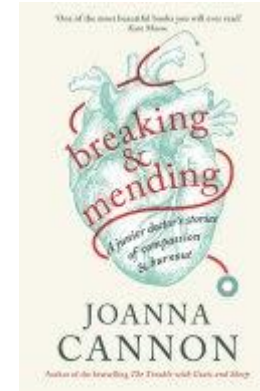
1. **What do we expect of our staff?** The Modern Clinical Paradox & Vulnerability
Exploring the tension between professional metrics and human vulnerability.
2. **Systemic Strain & The Moral Injury Crisis-** Quantifying burnout / moral injury within modern Irish and global healthcare contexts.
3. **Practical strategies!** Container 1 – The Balint Group Framework- Frameworks for clinician-patient relationships.
4. **Practical Strategies!** Container 2 – Schwartz Rounds- Systemic, multidisciplinary storytelling to mitigate emotional and moral distress.
5. The evidence for **Compassionate Leadership & Economics** The structural mandate and quantitative financial return ('Compassionomics') of supportive workplaces.

The Clinician's Paradox: Standard vs. Persona

The Traditional Blueprint: Expectations of absolute certainty, objective detachment, emotional neutrality, and algorithmic speed.

The Core Human Co-Demand: Concurrent societal expectations for profound empathy, warmth, presence, and genuine compassion.

Modern Friction Points: Declining structural trust and expanding social distance between institutions and communities. Severe daily time restrictions and operational budget boundaries dictating available care pathways.





Defining Vulnerability in Modern Healthcare

What does Vulnerability mean?

- Derived from the Latin 'vulnus' (to wound)—representing an open state susceptible to harm. To be capable of being wounded

The Patient's Forced Reality:

- Illness strips away standard autonomy; vulnerability becomes a mandatory gateway to accessing treatment.
- Requires opening oneself up to extreme physical, emotional, and existential risks.

The Shared Space:

- Bi Directional experience- “the clinician- patient relationship”
- Requires clinicians to acknowledge this exposure rather than hiding behind professional armor.

Vulnerability as Strength: Clinical Evidence

GP Focus Group Insights (Malterud et al.):

- Evaluated professional and personal boundaries among seasoned frontline general practitioners.
- 'A certain level of experience is needed to dare to admit to any crack in the smooth surface.'

The Power of Containing Uncertainty:

- Signaling clinical uncertainty is positive, *provided* the patient feels emotionally contained, secure, and cared for.
- Intuition alongside hard data improves diagnostic safety and patient trust.



Trust and vulnerability

An essential component for
therapeutic encounters-

Linked with behaviours and
attitudes e.g. to seek care, to
reveal sensitive information,
to submit to procedures which
may be uncomfortable and
breach normal boundaries,

To comply with therapy
(whether physical or
psychological), for onward
referral.

Staff experience of Trust and Vulnerability?

- Pathologising normal stress? Distress?
- Clinician exposure to illness, death, disability, work pressures
- System and authority- Attachment? (role, team, institution- where authority lies?)
- Containment?
- Making meaning?
- Commitment, control, challenge
- Patient anxiety- Where is the anxiety?



Understanding Stress: Eustress vs. Distress

Feature	Good Stress (Eustress)	Bad Stress (Distress)
Duration	Short-term / temporary	Long-term / chronic
Impact on Energy	Energizing and motivating	Draining and overwhelming
Mental Focus	Sharpens concentration	Creates anxiety and brain fog
Physical Effect	Brief physical peak, then returns to calm	Keeps body in constant 'fight-or-flight'
Typical Triggers	Promotion, workout, learning a skill	Toxic job, financial worry, burnout
Ultimate Outcome	Resilience and personal growth	Physical and mental fatigue

The Crisis on the Ground: Irish Healthcare Realities

- Frontline Stress Metrics: 67% of nurses/midwives report staffing levels fail to meet daily patient demands safely (INMO Survey). 39% report work severely impacts their long-term psychological wellbeing.
 - 24% have required formal GP/clinical visits solely for work-related psychological stress.
- Retention Danger Zones:
 - 75% of health and social care workers regularly contemplate leaving their current posts (TASC/Fórsa).
- Mass Exodus Trends: Over 7,000 healthcare professionals migrated to Australia in recent cycles, citing toxic working hours and rigid training structures (Humphries data).

Opinion- We must do more to retain our healthcare staff-Dr Suzanne Crowe - 20th Apr 2026

- 7,000 healthcare staff moved to Australia in 2025
- Dr Niamh Humphries --RCSI --Graduates are **deeply dissatisfied with work/life balance in Ireland and the incompatibility of training with family life.**
- 2024, the NCHD taskforce published recommendations to improve conditions. Junior staff still report **used bed linen in cold bedrooms and no access to hot food overnight.** Emergency tax errors, incorrect salary scales, delayed overtime payments, and lack of protected administrative or training time.
- *Companies such as Google understand this well.*
- Culture--listening to concerns- requires meaningful **engagement with patients, families, and staff, and a willingness to address problems promptly.** Above all, a positive culture attributes value – not blame – to individuals..

Trainee Vulnerabilities by Career Stage

The Rotating Rotation System: Frequent institutional moves disrupt clinical team cohesion and sever personal support networks.

Punishing Physical Demands: Extended working hours and uncompensated shifts leave zero margins for fundamental physical self-care.

Administrative & Financial Friction: Emergency taxation traps, delayed overtime processing, and unstable contract tracking.

The Stigma Dynamic: 64% of training hospital doctors would not want peers to know they are experiencing psychological struggles due to fear of institutional penalty.



What is burnout? BMJ editorial 2017

Burnout is a work related hazard that is prevalent among those working in people oriented professions such as healthcare.

Care providers commonly develop intense interpersonal relationships with those they care for, **often prioritising others' needs over their own.**

While helping and caring for others can be extremely fulfilling, it can also drain your emotional reserves.

Over time, this may result in burnout, which is indicated by feelings of **overwhelming exhaustion, depersonalisation or cynicism** towards people and work, and a sense of **professional inefficacy.**

Global nurse burnout

- Umbrella review methodology was selected to integrate evidence from multiple systematic reviews and meta-analyses
- Nurse burnout is prevalent worldwide, often marked by a sense of low personal accomplishment.
- Several factors contribute- role conflict, negative emotions, family problems, moral distress, stress, commuting distance, predictability of work tasks, and workplace advancement.

Getie A, Ayenew T, Amlak BT, Gedfew M, Edmealem A, Kebede WM. Global prevalence and contributing factors of nurse burnout: an umbrella review of systematic review and meta-analysis. BMC Nurs. 2025 May 26;24(1):596. doi: 10.1186/s12912-025-03266-8. PMID: 40420259; PMCID: PMC12108038.

Local and International Burnout Landscape

- International trainee burnout study- working hours, exams, choice, location near or away from friends and family- moderators
- Impact of the pandemic
- Irish Psychiatry Trainees (McLoughlin et al.): 65% met full global diagnostic criteria for burnout (up from 36.2% pre-pandemic). 48% scored below standard functional thresholds for clinical depression markers.
- Senior Consultants (Doherty et al.)- 77% screened positive for high burnout on the Maslach Burnout Inventory.
- Critical Care Units (PICU/NICU Meta-Analyses): Extreme burnout driven by relentless environmental severity and lack of protected decompression space

The Paradigm Shift: Burnout vs. Moral Injury

Labeling systemic dysfunction as individual 'burnout' implies a deficiency in personal resilience. In contrast, 'Moral Injury' explicitly identifies the profound psychological distress that results when healthcare workers are structurally prevented from delivering ethical, high-quality care

The Burnout Concept (Individual Centric)

Core Definition: A psychological syndrome characterized by emotional exhaustion, depersonalization, and reduced personal accomplishment.

Internal Narrative: "I have run out of gas. I am depleted and lack the personal capacity to manage this workload anymore."

Structural Flaw: Frames systemic failures as individual coping challenges, subtly shifting the burden of recovery entirely onto the healthcare professional.

Intervention Focus: Historically skewed toward self-care, mindfulness, individual psychological tracking, and yoga classes.

The Moral Injury Concept (System Centric)

Core Definition: Deep psychological and existential distress resulting from violating or witnessing violations of deeply held moral beliefs and clinical standards.

Internal Narrative: "I am being forced to participate in or deliver sub-standard care due to systemic barriers. The environment makes me complicit."

Structural Flaw: Accurately identifies institutional double-binds (e.g., maximizing throughput or minimizing bed stays over optimal patient outcomes).

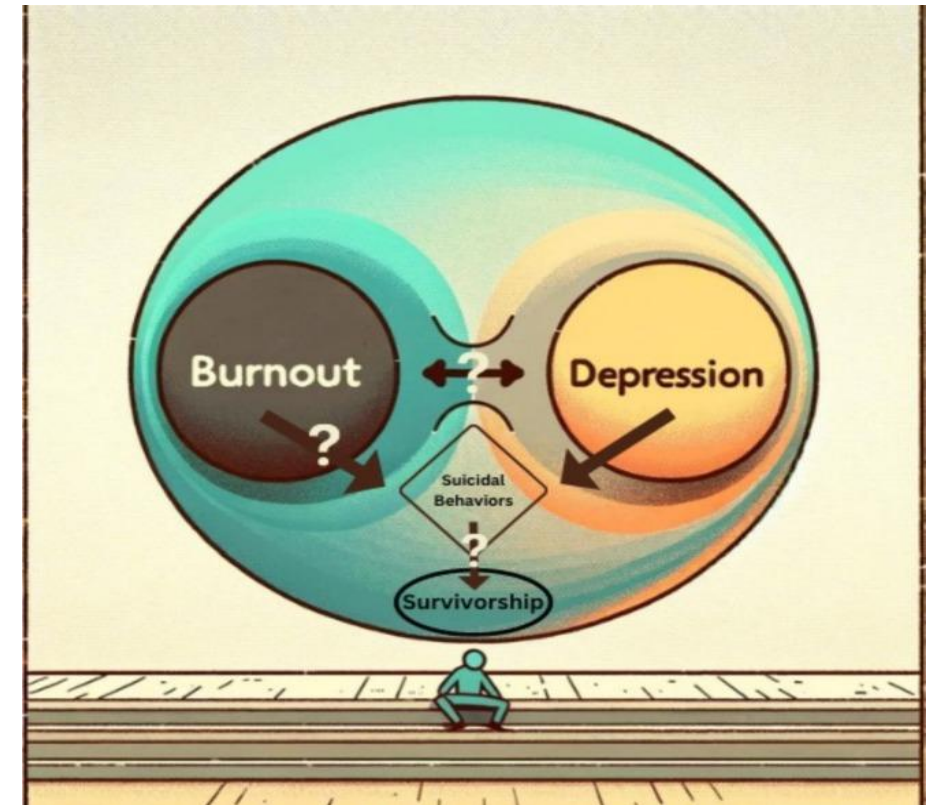
Intervention Focus: Absolute demands for systemic overhaul, transparent regulatory protections, and realigning administrative policies with clinical ethics.

Theoretical Frameworks for Workforce Strain

Theorist / Framework	Core Conceptual Dimension	Implication for Healthcare
Christina Maslach (MBI)	Triad: Emotional Exhaustion, Depersonalization, Reduced Accomplishment.	Continuous systemic crises trigger clinical cynicism and erode proactive empathy.
Leiter & Maslach	6 Mismatches: Workload, Control, Reward, Community, Fairness, Values.	Chronic staffing deficits create deep value conflicts between speed and thoroughness.
Job Demands-Resources	High job demands paired with chronically low structural resources.	Escalating patient complexity without matching structural support drives systemic collapse.

A continuum...

Where does one end and the other begin?



<https://pmc.ncbi.nlm.nih.gov/articles/PMC12075674/>



PERSPECTIVE



Kathryn

Published March 23, 2017 | N Engl J Med 2017;376:1101-1103 | DOI: 10.1056/NEJMp1615141 | VOL. 376 NO. 12
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On Wednesday, August 17, 2016, at about 5:15 in the morning, Kathryn, one of our fourth-year medical students, ended her life by jumping out of her apartment window. She was found minutes later by a small group of surgical interns who were headed to the hospital to attend rounds for their patients. One of her classmates, on his surgery subinternship, was with them. They began an effort to resuscitate her that continued, and ultimately ended, in our emergency department (ED). The classmate who had participated in the initial resuscitation efforts called Kathryn's father as soon as she arrived in the ED to let him know that something terrible had happened. By the time her father called back, the resuscitation efforts were over and his daughter was dead.

AUDIO INTERVIEW

 [Interview with Dr. Stuart Slavin on depression and suicide among physicians and trainees and how to address stigma associated with mental illness.](#)

Interview with Dr. Stuart Slavin on depression and suicide among physicians and trainees and how to address stigma associated with mental illness.
6m 24s

 **DOWNLOAD**

Suicide is a problem- Unspeakable things

- **2023 national cohort study** led analysed **suicide risks among healthcare workers** in the United States from 2008 through 2019, utilizing a sample of roughly 1.84 million employed adults
- **Health care support workers, registered nurses, and health technicians had an 81%, 64%, and 39% higher risk, respectively.** (OLFSON et al, JAMA)
- Gibbons, R, Eight Truths about suicide, 2023
- Gibbons, R. (2025). The 'Impossibility' of working in the current NHS: sacrifice to a primitive god. *Psychoanalytic Psychotherapy*, 39(2), 84–94.
<https://doi.org/10.1080/02668734.2025.2490626>

Suicide

Jain L, Sarfraz Z, Karlapati S, Kazmi S, Nasir MJ, Atiq N, Ansari D, Shah D, Aamir U, Zaidi K, Shakil Zubair A, Jyotsana P. Suicide in Healthcare Workers: An Umbrella Review of Prevalence, Causes, and Preventive Strategies. J Prim Care Community Health. 2024 Jan-Dec;15:21501319241273242. doi: 10.1177/21501319241273242. PMID: 39228162; PMCID: PMC11375687.

- Clinicians and healthcare professionals experience **significantly higher rates of suicide compared to the general population**- especially female physicians (up to 250%)
- US- **300 to 400 doctors die by suicide** - 28 to 40 per 100,000- double the national average

- **Access to Lethal Means**
- **Low Help-Seeking Behavior:** many -personal failure or "imposter syndrome".
- **Professional Stigma & Fears around oversight:** Many clinicians actively avoid seeking therapy or reporting suicidal ideation out of fear of professional stigma, administrative penalties, or losing their license.
- **Chronic Burnout:** Long hours, pandemic-related moral injury, underlying depression and anxiety.



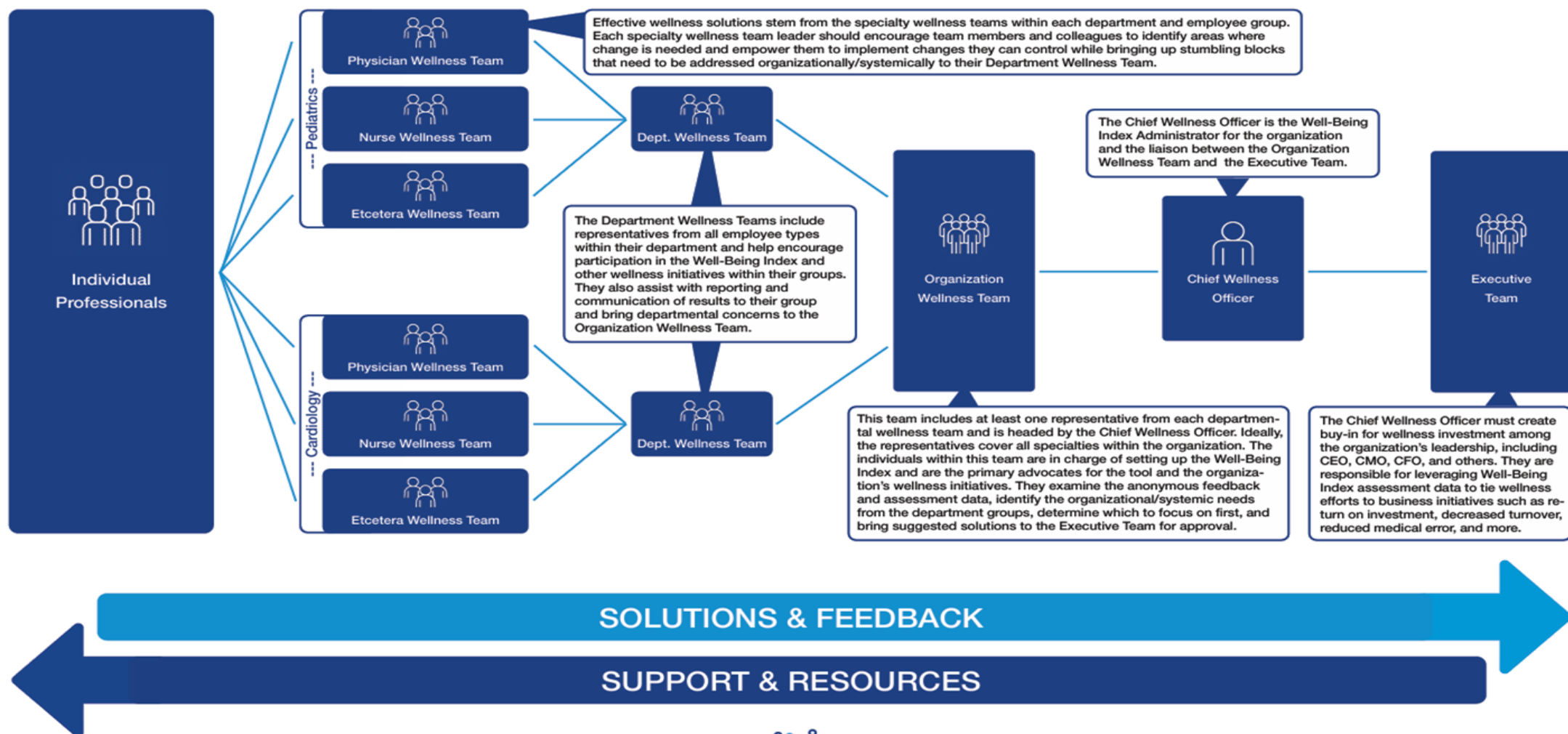
Systemic vs. Individual Remedies

- **Primary Prevention (Structural Overhauls):**
 - Codifying mandated safe patient-to-staff ratios into health system legislation.
Protecting roster recovery gaps via centralized rolling rotas to mitigate sleep deprivation.
- **Secondary Prevention (Systemic!):**
 - Embedding protected psychological containment within core paid working hours.
Fostering non-hierarchical spaces specifically designed to metabolise inevitable clinical trauma

A Visual Roadmap

This Wellness Structure is an example of how healthcare institutions can successfully organize their teams to ensure effective use of the Well-Being Index and implement strategic, seamless wellness initiatives to support staff.

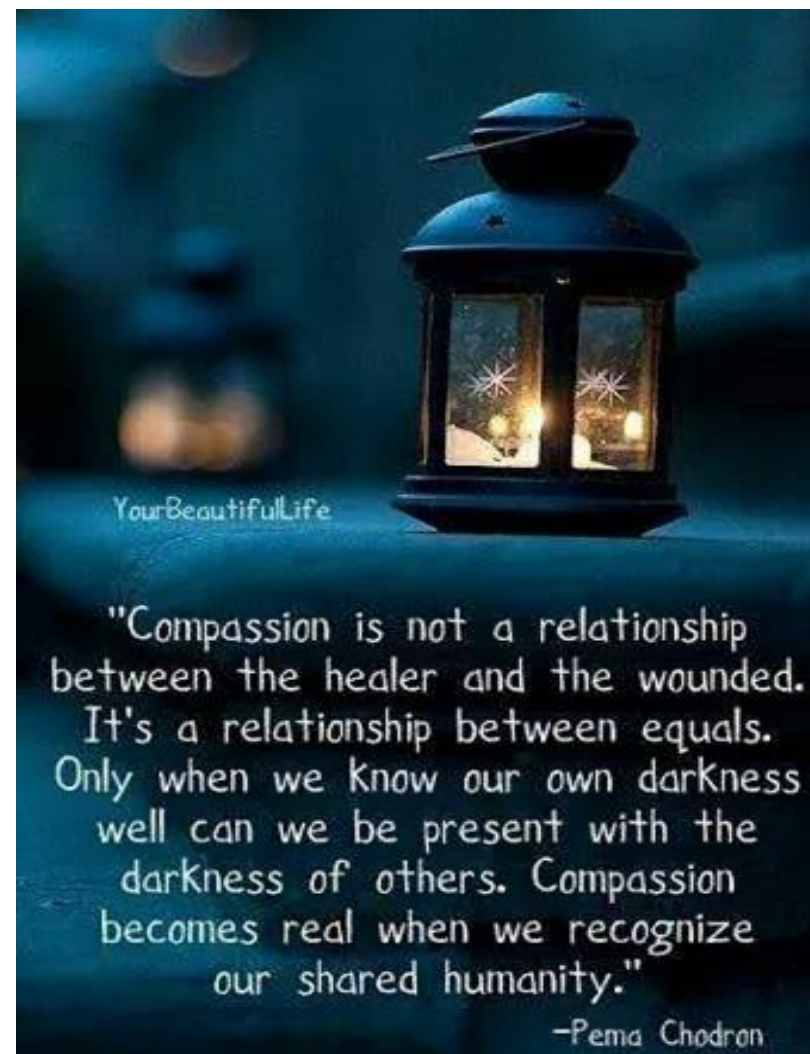
To simplify the roadmap, two example departments have been depicted. Depending on the existing makeup of your organization, this framework can be duplicated for all departments or employee groups. As indicated by the arrows below, the structure allows for an ongoing flow of information and communication between institutional leadership and professionals.



 HSE National Policy on the Prevention and Management of Work-Related Stress 2023 Policy ☒ Procedure ☐ Protocol ☐ Guideline ☐ Clinical Guideline ☐	
DOCUMENT GOVERNANCE ¹	
Document Owner name: <i>Anne Marie Hoy</i>	
Document Owner email contact: NHSF.Policyteam@hse.ie	
Document Commissioner(s): National Director of Human Resources	
Document Approver(s): National Director of Human Resources	
Lead responsibility for national implementation: Please refer to Roles and Responsibilities in Section 8.0	
Lead responsibility for national monitoring and audit: National Health and Safety Function	
Development Group Name: HSE Policy on the Prevention and Management of Work-Related Stress Policy Development Group	
Development Group Chairperson: Margo Leddy, Health and Safety Manager (Policy Team), National Health and Safety Function	
Relevant supplementary material can be found: https://healthservice.hse.ie/staff/health-and-safety/work-related-stress/	
DOCUMENT MANAGEMENT ²	
Presented to the National Joint Council:	26/09/2023
Consultation with the Trade Unions Completed:	13/10/2023

The why, now the what?

■



Balint Groups in paediatric hospital over 8 years?



Balint groups- My groups in CHI

- The typical format -trainees being asked to consider a suitable case to present.
- One trainee presents a summary of the case in 5–10 minutes.
- The group is then invited to ask a few clarifying questions of fact
- Then the presenter sits back and for 20–30 minutes takes no part in the discussion.
- The group are then encouraged to reflect on what could be going on here for the trainee and patient.
- The leader(s) probes and encourages trainees to imagine, wonder, explore, discuss.
- The presenter is then invited back into the group discussion and invited to contribute, only if they wish to, for the final few minutes.



What, where, why?

- Another perspective- clinician feelings/ pt feelings/ stuck relationships etc
- Group environment - explore with curiosity
- May untangle issues - often leaving the group members/presenter with more questions than answers.
- Solutions are actively discouraged.
- This can help the presenter approach the next consultation with the potential to see what 'else' could be present and relevant.
- Generate ideas
- Difficulties/biases
- Can pay attention to what is generated

Practical Container 1: The Balint Group Framework

- Origins & Foundation: Developed by Michael and Enid Balint- landmark 1957 work, 'The Doctor, his Patient and the Illness'.
- Core Functional Objective: Provide a safe, confidential, psychological “container” for clinicians to explore the emotional landscape of their patient interactions.
- Mechanisms of Action:
 - Recurrent small group
 - What we bring into the relationship is part of the process
 - Utilizing the emotional reactions of the clinician as a diagnostic window into the patient's internal experience.
 - Analyzing personal countertransference to minimize unconscious clinical bias.
 - Validating the emotional toll of care to restore empathy reserves.

Empirical Evidence for Balint Efficacy

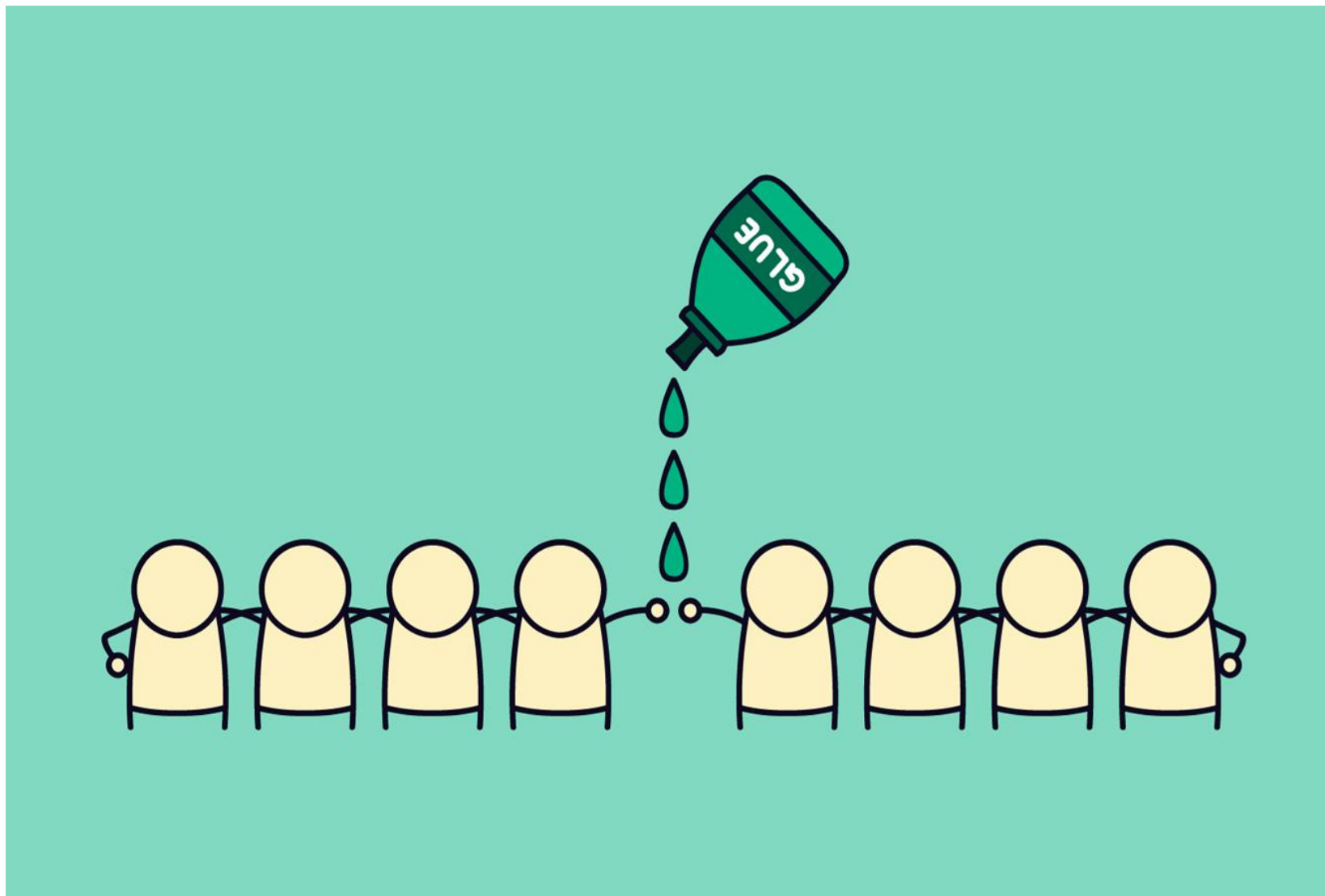
- Balint groups function as an **experiential emotional buffer**. Quantitative pre- and post-intervention studies compiled in 2025 systematic review- revealed that healthcare professionals had drastically reduced scores in emotional exhaustion (SMD = -1.62) and felt an improved sense of personal accomplishment.(Xu L et al BMC Med Educ. 2025 Nov 3;25(1):1534. doi: 10.1186/s12909-025-08072-z. PMID: 41184853; PMCID: PMC12581237)
- Professional Identity Integration (Ryding & Birr): Sustained participation (over 1.5 years) helps junior clinicians safely tolerate clinical uncertainty without panic.
- Coping Style Transformation (Popa-Velea et al.): Significantly reduces defensive coping mechanics (denial, projection, self-blame) and promotes active emotional processing.
- Mitigating Professional Isolation: Long-term evaluation data demonstrates that structured case discussion groups neutralize professional isolation and occupational distress in over 70% of cohorts (Fleurant data).

International networks

<https://americanbalintsociety.org/>



W W W . A A C A P . O R G





Practical Container 2: Schwartz Center Rounds

- The what: A highly structured, multidisciplinary, organization-wide forum exploring the human side of healthcare delivery.
- The Structural Format: 1-hour monthly session; features a panel of 3-4 diverse staff members telling personal stories on a set theme. Followed by a highly moderated interactive discussion with the entire audience, led by a trained facilitator.
- Boundaries (Point of Care Foundation): Strictly closed doors after start time to protect safety; multidisciplinary audience; catering always provided.
- Proven Global Efficacy: Regular attendance is statistically correlated with a 50% drop in significant psychological and moral distress.

Schwartz rounds- evidence

- In the United States-a positive influence on hospital culture, helping to create a working environment to support compassionate care.
- Cochrane review -interventions such as SR did appear to have benefit
- Organisations can try to improve working conditions of staff by giving them a space where they feel listened to.
- Kings Fund report showed that participants saw SR as a way to strengthen team bonds
- A follow up report on SR in the UK found that there was a correlation between attendance at SR and psychological well-being, as measured by a reduction in GHQ-12 scores.
- Economic Evaluation (Mayben)

Example- Schwartz Rounds



Committee from across disciplines



Some rules apply...



Children's University Hospital

Schwartz Rounds

No admittance after 1pm!

But please come to the next Round!

Date _____



Themes for Schwartz Rounds- a CATALYST

- Themes must deliberately unlock deep reflection over clinical metrics:
 - ❖ 'The Magic of Temple Street' — Celebrating hidden, profound system triumphs.
 - ❖ 'A Patient I Did Not Like' — Dismantling the myth of effortless clinical neutrality.
 - ❖ 'What a Patient Taught Me' — Honoring inverse learning cycles.
 - ❖ 'Behind Closed Doors' — Revealing the hidden professional toll on families.
 - ❖ 'The Impact of Loss: Holding On and Letting Go' — Exploring shared medical grief.
 - ❖ 'Making Sense of Chaos' — Processing sudden, catastrophic system events.

Quantitative Impact: Temple Street Schwartz Evaluation

Evaluation Parameter (Silke, Barrett et al., Irish Medical Journal)	Mean Score (Out of 5.0)
Would recommend Schwartz Rounds to institutional colleagues	4.90 (Highest Agreement)
Intend to reattend future Schwartz Rounds sessions	4.87
Gained a deeper understanding of colleagues' core work realities	4.77
Found the sessions directly relevant to daily frontline clinical work	4.75
Valued the interdisciplinary nature of the group discussion	4.66

Qualitative Impact: Voice of the Frontline

Dismantling Entrenched Hierarchies:

'Felt glad that the multidisciplinary team, from cleaner to consultant, was emphasized. These rounds help break down barriers.'

Reconnecting with Vocational Identity:

'Brings caring and kindness back into the workforce. Helps us remember why we chose a caring profession in the first place.'

Validation of Group Cohesion:

'Stunning. Made me very proud to work with such compassionate, sincere, and deeply expert people.'

Narrative Integration & Training Evolution

- Health Ethics and Narrative Ireland (HEANI): An interdisciplinary collective linking active clinical practice, medical ethics, and narrative models-based at UCD
- Developing educational frameworks to convert raw emotional vulnerability into sustained clinical insights.
- Formal Curricular Integration:
- The College of Psychiatrists of Ireland and the ICGP have formally mandated structured reflective practice within core specialty training portfolios.



HEANI SUMMER SCHOOL 2026
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UCD DUBLIN
UCD School of Medicine

MONDAY 22ND – WEDNESDAY 24TH JUNE 2026

UCD SCHOOL OF MEDICINE
BELFIELD CAMPUS, DUBLIN

Exploring the stories, ethics and creative perspectives that shape healthcare and human experience.

INTERDISCIPLINARY COLLABORATION
Students, academics & clinicians from medicine and the humanities learning together.

WORKSHOPS, POETRIES & PERFORMANCES
Be inspired. Be challenged.

SHARE, INTERVIEW, PAST, PRESENT & FUTURE
Connect through conversation, listening & stories.

ETHICS IN MEDICINE: PAST, PRESENT & FUTURE
Reflect on real world dilemmas.

CPD/CME APPROVED
Build your learning. Add to your professional development.

DAY 1 – MONDAY 22ND JUNE
EATING & NUTRITION ACROSS THE LIFESPAN
A TRANSDISCIPLINARY VIEW

- Eating disorders across the lifespan
- Patient voices & lived experience
- Breastfeeding, nourishment & perinatal mental health
- History, culture & the humanities

Posters, panel discussions & expert-by-experience perspectives

DAY 2 – TUESDAY 23RD JUNE
NARRATIVES IN CLINICAL PRACTICE: REPAIR & REIMAGINING

- Balint groups & reflective practice
- Creative writing for reflection
- Trust, mistrust & the therapeutic encounter
- Expert-by-experience voices
- Evening performance: *Miasma: One man's fight against the cholera pandemic*

Workshops, posters, lunch & an evening play

DAY 3 – WEDNESDAY 24TH JUNE
HUMANITIES AT THE HEART OF CARE ACROSS THE LIFESPAN

- Embodying illness & creativity
- Open communication by design
- Clinicians as patients
- The interface of arts & medicine
- Looking to the future together

Panels, poster prizes & closing reflections

FLEXIBLE ATTENDANCE
Attend one day or all three
Concession rates for 3-day attendance & early career clinicians, students & public

ENQUIRIES & CONTACT
patrick.ryan@ucd.ie

ORGANISED BY
Professor Elizabeth BARRETT is coordinating an interdisciplinary event.
• School of Philosophy – Professor Danielle Petherbridge
• School of English, Drama and Film – Professor Clare Hayes Brady
• School of Medicine – Professor Elizabeth BARRETT

THREE INSPIRING DAYS OF HEALTH, ETHICS & NARRATIVE

COME TO REFLECT. LEARN TOGETHER. SHARE STORIES. SHAPE THE FUTURE.

Finally: Compassionate Leadership Architecture

The Four Pillars of Compassionate Leadership (Prof. Michael West):

1. Attending: Listening to frontline team challenge with complete presence.
2. Understanding: Actively searching for the structural causes of their distress.
3. Empathising: Feeling and acknowledging their moral frustration without defensive dismissal.
4. Helping: Taking assertive managerial action to clear operational barriers.



Compassionate leadership= West

The ABC Psychological Blueprint:

Autonomy (voice in system design), Belonging (team cohesion), and Contribution (feeling effective).



Benevene P, Buonomo I, West M. Editorial: Compassion and compassionate leadership in the workplace. Front Psychol. 2022 Dec 9;13:1074068. doi: 10.3389/fpsyg.2022.1074068. PMID: 36571014; PMCID: PMC9784919.

Compassionate leadership is EVIDENCED

- Staff who are treated with compassion are better able to direct their support and care giving to others (Goetz et al 2010). This results in higher-quality care and higher levels of patient satisfaction (West and Dawson 2012; West et al 2011).
- Where staff generally report the absence of such leadership there are lower levels of patient satisfaction (West et al 2022), there is poorer-quality care and (in the acute sector) higher patient mortality (West and Dawson 2012; West et al 2011).

<https://www.kingsfund.org.uk/insight-and-analysis/long-reads/what-is-compassionate-leadership>

The Hard Economics of Clinical Compassion

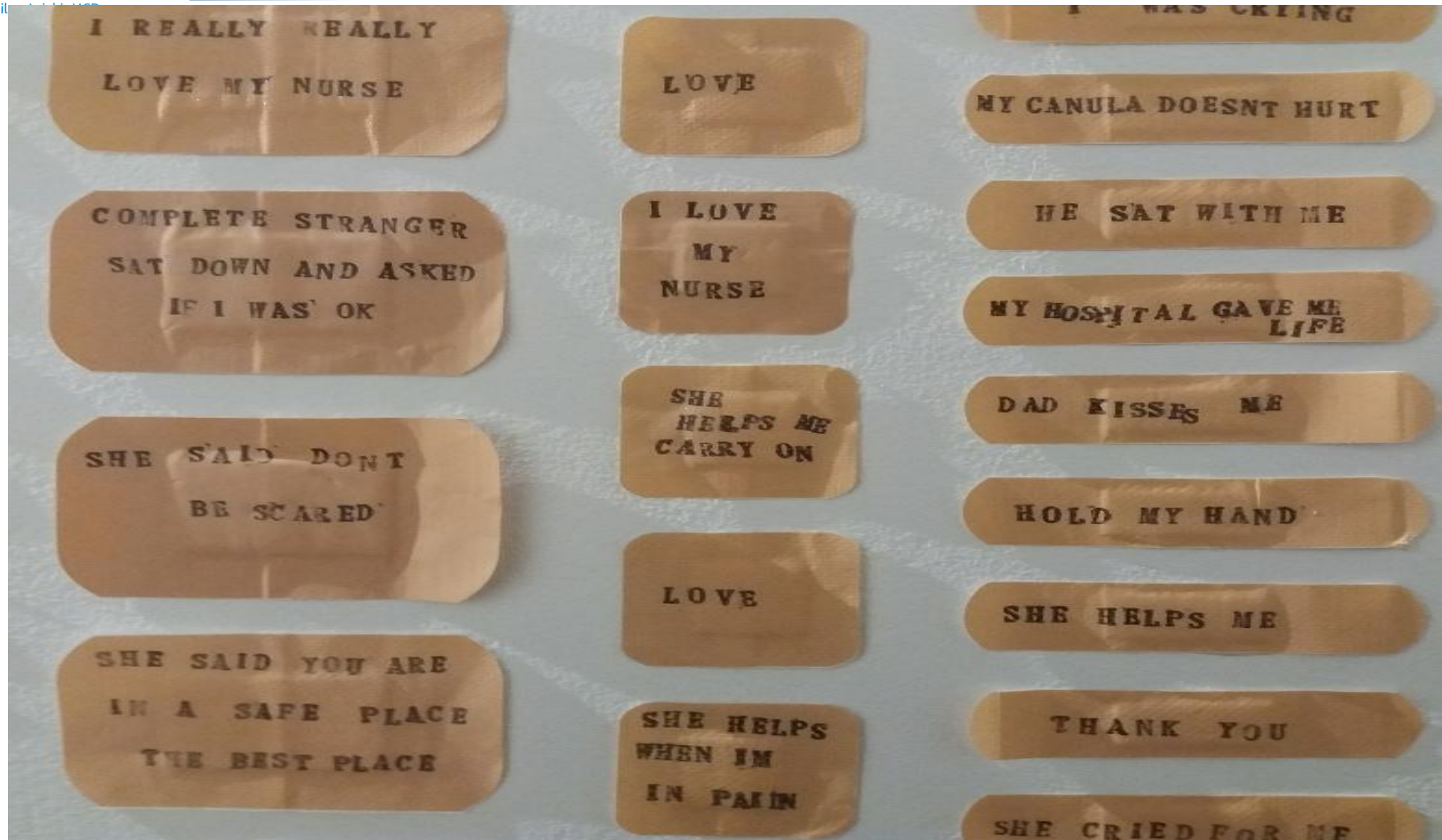
- The Framework of 'Compassionomics' (Trzeciak & Mazzairelli):
 - Demonstrates that clinical empathy is a powerful, highly cost-effective systemic intervention.
- Downstream Clinical Optimization:
 - Directly improves physiological markers in chronic conditions (e.g., blood pressure control).
 - Accelerates post-operative recovery and lowers complications.
- Systemic Financial Protections:
 - Sharply lowers expensive recruitment costs by stabilizing staff retention.
 - Decreases costly medical malpractice exposure by fostering transparency and deep patient trust.

Call to Action: Transitioning from Insight to Execution

1. The **Institutional Accountability Shift**: Organisations must abandon toxic individual blame cultures ('be more resilient') and adopt systematic containment models.
2. The **Sustainability Mandate**: Protecting regular, paid time for reflective practice is not an administrative luxury; it is a vital safeguard for patient safety.
3. Equity, Equality, **Just culture**: 'Compassion is not a relationship between the healer and the wounded. It's a relationship between equals... Compassion becomes real when we recognize our shared humanity.' — Pema Chödrön

'When we are motivated by compassion and wisdom, the results of our actions benefit everyone, not just our individual selves or some immediate convenience.'

Dalai Lama



Thank You / Questions & Answers

Contact: elizabeth.barrett@ucd.ie

Please complete your formal session evaluation forms.

Where to next?

Understand Frontline Demands:

Balancing high-stakes compassion and clinical risk with rigid regulatory frameworks.

Examine Active Cultural Fostering:

Locating where these core clinical values are actively trained and supported, rather than just demanded.

Evaluate Economic & Structural Returns:

Analyzing retention, risk mitigation, and medical outcome benefits from compassionate clinical containers.

Master Practical Implementation:

Acquiring blueprints to structure Balint Groups and Schwartz Rounds successfully within contracted work hours.

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