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Translating theory into clinical practice: a qualitative study of clinician perspectives implementing whole person care

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ABSTRACT

Whole Person Care (WPC) is an emerging framework that emphasises the clinician's role in empowering patient healing. However, reliably translating a framework's theory into practice is a recognised challenge for clinicians. Observational studies have revealed discrepancies between a clinician's stated values in theory and how these may be implemented in practice. The aim of this qualitative study is to bridge the gap between the theory of WPC and its practical implementation by clinicians. We interviewed a diverse group of 34 clinicians attending the 2017 International Whole Person Care Congress to explore (1) their conceptions of WPC in theory as well as (2) how they monitor their practice in real time. Data were analysed using Grounded Theory Methodology. Preliminary results were presented in the form of a workshop at the 2019 International Whole Person Care Congress to validate our findings with relevant stakeholders. The results revealed a vision of WPC that highlighted themes of the clinician's way of being, seeing the person beyond the disease, and the clinician–patient relationship. Our results demonstrate that clinicians use a range of strategies to monitor their practice in real time. Mindfulness and self-awareness were frequently cited as being crucial to this ability of self-regulating their practice. This study helps establish a unifying framework of WPC based on a diverse range of clinician-reported experiences. More importantly, it sheds light on the range of strategies employed by clinicians who monitor their practice in real time. These collected insights will be of interest to any clinician interested in translating their stated values into their clinical practice more reliably.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Observational studies have revealed discrepancies between clinicians' stated values and their actual clinical practice, revealing the challenge faced by clinicians in successfully implementing therapeutic frameworks into their practice.
⇒ Whole Person Care (WPC) is one emerging therapeutic framework that distinguishes between healing and curing. However, it is not clear whether its community of practitioners share a common definition.
⇒ It is not clear whether clinicians practicing WPC employ strategies for monitoring their practice of WPC in real time.

WHAT THIS STUDY ADDS

⇒ This study demonstrates that WPC is a well-defined framework with a shared understanding held by a diverse set of clinicians practicing in various international jurisdictions.
⇒ Clinicians employ a range of cues to monitor their clinical practice in real time, which is broadly facilitated by the clinicians' self-awareness and mindfulness.
⇒ Our study identifies a variety of strategies used by individual clinicians to assess whether they are successfully translating their values into their moment-to-moment clinical practice.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ The emphasis on self-awareness and mindfulness in this study supports the increasing attention toward mindfulness training as part of undergraduate medical education.
⇒ It will be important to explore what forms of support are necessary to sustain these practices beyond the scope of a dedicated research project.

INTRODUCTION

Decades ago, patient-centred care (PCC) instigated a paradigm shift away from a strictly biomedical model of medicine by affirming that 'each patient must be understood as a unique human being'.[1] PCC has since been identified as an essential foundation to healthcare quality and patient safety.[2] Yet, translating this framework into everyday practice has remained challenging. Despite numerous conceptions of PCC, there is a recognised gap between conceptual frameworks and practical implementation,[3] and little evidence demonstrating the sustainability of PCC initiatives.[4] Ironically, healthcare quality improvement has disproportionately relied on formal metrics rather than qualitative perspectives, which only further highlights the gap between theory and practice.[5]

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There is a concern that clinicians have lost the ability to connect with the personhood of patients.[6] In a study of 500 patients and 401 healthcare professionals, patients rated their care as being less patient-centred than healthcare professionals.[7] A qualitative study exploring patient perceptions of PCC showed they valued human connection above the more formal aspects of care such as goal setting and care planning.[8] Similarly, listening and paying attention were by far the most frequently cited physician behaviours that patients experienced as compassionate.[9] Interestingly, physicians' self-assessment of providing compassionate care identified listening and empathy as areas needing improvement.[10]

Insights from research on empathy, self-awareness and mindfulness have helped to address some of these challenges. A narrative review of 20 articles on the role of mindfulness and compassion in physician–patient communication concluded that mindfulness fosters the development of self-awareness and empathy, and therefore enhances PCC.[11] A cross-sectional study on the relationship between self-awareness, empathy and PCC among nursing students concluded that self-awareness is associated with higher empathy, and that empathy is associated with higher PCC.[12] A review of 58 articles from the dentistry literature concluded that empathy facilitates communication and has been positively associated with patient satisfaction.[13] Finally, a scoping review of 31 studies on the effects of mindfulness and physician burnout concluded that routine mindfulness practice increases compassion and restores empathy.[14]

Many of these new insights are being incorporated into novel frameworks that are building on the foundation of PCC.[15–17] Whole Person Care (WPC) is the first framework that articulates a difference between the clinician's role of curing disease versus facilitating healing.[18] Unlike curing disease, which is a physician-led process that uses biomedical science, healing is a patient-led process of overcoming suffering and coping with the disease. The clinician's role is to empower the patient by facilitating their openness to change and personal growth.[18] Its delineation between healing and curing makes WPC a promising framework for guiding clinicians in their pursuit of alleviating patient suffering. Given its emphasis on mindfulness and self-compassion,[19 20] WPC has become particularly relevant in the context of the COVID-19 global pandemic, which has resulted in increasing rates of stress and burnout among healthcare providers.[21–23]

The literature on frameworks such as patient-centred and person-centred care offers two important insights that inform the implementation of WPC. First, establishing a shared definition remains challenging but necessary. Patient-centred care literature has highlighted diverse themes including shared decision-making, holistic care, interdisciplinary care and population health management.[24–31] A broad range of stakeholders including patient advocates, regulatory institutions, trainees and professionals have understandably identified this multiplicity of interpretations as a barrier to its implementation.[30 32] Second, assessing the translation of theory into practice remains nebulous. Observational studies have revealed discrepancies between clinicians' espoused values and their delivery of care, demonstrating that theory alone does not guarantee changes in clinical practice.[33 34] Efforts to measure these frameworks in practice such as patient-directed and clinician-directed surveys and observational scales have been limited by varying validity and reliability, narrow applicability and poor triangulation with the experience of care or outcomes.[35 36] Qualitative methodology is one tool that may disentangle such contradictions between theory and practice by bringing to light the implicit knowledge and personal strategies of individual clinicians.[33]

Context and aim

As medical students (PL, VC, CF) at the time of project conception, it was clear that learning the art of medicine was an entirely independent process from learning biomedical sciences. We were interested in clinician perspectives to help shed light on how we could monitor our own progress in learning the art of medicine. With an upcoming Whole Person Care International Congress attended by clinicians from around the world, we saw an opportunity to learn how clinicians conceptualise and assess the implementation of WPC.

In our study, clinicians attending the Whole Person Care 2017 International Congress were interviewed in order to explore (1) their conceptions of WPC and (2) how they assess their implementation of WPC. Results were shared with stakeholders at the 2019 WPC International Congress where feedback was solicited to ensure validity. The findings of this study help construct a broadly applicable framework that describes how clinicians understand WPC and how they assess whether they are delivering WPC in practice. More broadly, the collective insights from clinicians monitoring their practice in real time will be of interest to any clinician seeking to translate their stated values into their clinical practice more reliably.

METHODS

Study sample and recruitment

Interview respondents were purposefully recruited at the 2017 Whole Person Care Conference held in Montréal, Canada to recruit a diverse pool of clinicians from many specialties and healthcare professions with some interest in, and/or experience with, the practice of WPC. Inclusion criteria were kept broad to allow for maximum variation and included participants at the conference who self-identified as a clinician involved in patient care and were over the age of 18. Awareness of the research study was raised by conference organisers. Recruitment occurred during conference lectures, with a poster at the conference, and by researchers who actively recruited participants between plenary sessions. Patients and the public were not involved in this study.

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Data collection

Twenty-nine participants were interviewed between 17 October 2017 and 20 October 2017. Participants gave verbal consent to be interviewed and recorded. Four second-year medical students with training in qualitative research conducted in-depth interviews using an open-ended interview guide. Interviews lasted between 25 and 45 min and took place at the conference venue. At the end of each day, researchers met to share preliminary findings, discuss emerging themes and assess saturation. By the last day of the conference, many interviews had redundant information, and researchers deemed that saturation and data richness had been achieved.

Interview questions were designed to be open-ended in the context of semistructured interviews, while capturing the two major research questions: (1) how do clinicians define WPC and (2) how do clinicians monitor their own implementation of WPC. They were developed in an iterative process and first piloted prior to the conference with five experts in WPC for comprehension and clarity. No changes were made to the interview questions after the pilot interviews. A list of interview questions and potential follow-up questions can be found in online supplemental file 1.

Data analysis

All 34 interviews (five pilot interviews and 29 conference interviews) were transcribed, reviewed and de-identified before entry into Dedoose qualitative software.[37] Three researchers jointly conducted line-by-line focused coding of the first four interviews based on Corbin and Strauss's (1990) Grounded Theory Methodology.[38] A codebook was subsequently co-developed through an iterative process of independently coding transcripts and reconciling differences through discussions. Axial codes were developed to explore potential organisational structures for emerging themes. Once all transcripts were coded, researchers reread each transcript to ensure appropriate coding and for further analysis and theory building. Codes were analysed using Dedoose software for frequency of use, and the most frequent and salient codes were then read back with their quotes to ensure the most thorough and representative data. Outlying concepts were also underlined through this process. Preliminary results and a preliminary logic model (see online supplemental figure 1) were presented in a workshop during the 2019 Whole Person Care Conference held in Montréal, Canada. Workshop participants (n~40) were invited to comment on study findings and to agree or disagree with study results. This process ensured findings were both disseminated and validated with stakeholders before final publication. Workshop findings were documented in memos written by presenting authors. Feedback from stakeholders was used to contextualise results and included in the results section. For the purposes of clarity, quotes provided in this article have been edited to omit linguistic filler words. The final figures presented below incorporate the feedback from the 2019 Whole Person Care Conference on the preliminary findings and preliminary logic model.

RESULTS

All 34 participants have been involved in patient care in some form. There were two medical school applicants who were considered non-clinicians given their limited clinical exposure, although both had volunteered in ICUs. The demographic information of the 34 participants is summarised in table 1. Individual concepts were extracted from each interview resulting in a total of 180 codes, with the most common codes summarised in online supplemental file 1. Emerging themes from these codes were then organised into three main processes: conceptions of WPC in theory, conceptions of WPC in practice and how clinicians monitor their practice in real time. Each of these processes is presented here and summarised in two logic models outlining WPC in theory (figure 1) and WPC in practice (figure 2).

Clinician conceptions of WPC in theory

Three interrelated themes emerged from respondents' definitions of WPC: (1) the clinician's way of being, (2) the person beyond the disease and (3) clinician–patient relationship (figure 1). The clinician's way of being describes a personal philosophy rooted in a practice of mindfulness, self-awareness and presence, all of which extend beyond the clinical encounter. Embedded in this philosophy is the intention to see the patient as a person beyond their disease with a recognition and appreciation of the experiences and values they bring to their care. Emerging from the first two themes is the clinician–patient relationship that promotes healing and is grounded in a bidirectional, mutually felt connection.

Clinician's way of being

Rather than serving as a clinical method or tool that can be used selectively, many respondents described WPC as a personal set of values or philosophy that served as an anchor, intention or lens informing the clinical encounter. One respondent described:

> It's a way of being with people. It's an 'every conversation' thing…Once you're convinced that it's a way of having every conversation, there is no such thing as not having time (for WPC). (R4, Nurse Practitioner and WPC programme coordinator)

Other respondents described it as a quality of presence embodied in both clinical encounters and the clinician's personal life. Presence was generally referenced as a focused attention to the current moment that can be oriented toward oneself and to the other, with a notable emphasis on listening.

Person beyond the disease

Respondents described viewing the patient as more than their disease to be a critical aspect of WPC. Patients were viewed as complex beings who bring with them a

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Table 1 Participant characteristics

Characteristics	Number of participants (n=34)
Female	20 (59%)
Male	14 (41%)
Age (years)	
<30	4 (12%)
31–50	12 (35%)
51–70	16 (47%)
>70	2 (6%)
Current occupation*	
Physician	19 (59%)
Palliative care	5 (15%)
Family medicine	4 (12%)
Paediatrics	5 (15%)
Internal medicine	2 (5%)
Cardiology, urgent care, oncology, pathology, gastroenterology	1 (3%)
Medical student or applicant	4 (12%)
Spiritual care provider	3 (9%)
Nurse	1 (3%)
Physiotherapy	1 (3%)
Occupational therapy	1 (3%)
Social work	1 (3%)
Dentistry	1 (3%)
Acupuncture	1 (3%)
Musical therapist	1 (3%)
Homecare support	1 (3%)
Therapist	1 (3%)
Clinical psychologist	1 (3%)
Educational background (highest attained)	
Bachelor's degree	4 (1%)
Master's degree	8 (24%)
PhD	2 (6%)
MD (or MD equivalent for example, MDCM, MBChB, Dentistry)	20 (59%)
Country of practice*	
Canada	25 (74%)
USA	7 (21%)
Australia	1 (3%)
Dominican Republic	1 (3%)
France	1 (3%)
Japan	1 (3%)
Years of practice	
Mean (range) in years	18.4 (1–40) (53%)

*Some participants listed more than one category.

rich background of diverse life experiences, cultures and values, all of which inform their perspective on their disease and their priorities for care. Respondents emphasised the importance of identifying, respecting and meeting the unique needs of their patients. One respondent said:

> Whole Person Care means appreciating some of the people who come in a system, in their own lives, really trying to experience with them the complexities of their life outside of their presenting symptoms. (R15, Family physician)

Clinician–patient relationship

Finally, respondents emphasised the unique quality of the clinician–patient relationship to be an important aspect of WPC.

> And (patients) need reassurance, they need someone to talk to, and they really put their trust in us. I think it's a key of Whole Person Care because you need to create that link between the health care professional and the person—a confidence thing. That's the most important thing. (R22, Spiritual care provider)

A commonly cited feature of this relationship was its ability to empower patient healing. Furthermore, many respondents discussed the bidirectional aspect of healing in a clinical encounter. Rather than a unidirectional healing for the patient, clinicians who practice WPC benefit and derive meaning from these relationships.

> We as clinicians are wounded as well as our patient, and we both are capable of healing, and that if we think of our relationship as dyadic and bidirectional, then healing can happen in both directions… If we look at it more as a relationship where we're walking side by side, that, I think, is a much more constructive, more compassionate, more healing kind of relationship. (R27, Palliative Care physician)

Healing was described in terms of growth in response to disease, which was contrasted with curing. As one respondent said:

> Healing doesn't necessarily mean getting better… You can have a transcendent or transformative experience even though the disease is still present. (R29, Social worker)

In summary, clinicians' theoretical conceptions of WPC were described as a philosophical anchor that informs a way of being with people. Grounded in mindfulness and presence, clinicians foster a relationship with the patient who is seen as a whole person. This relationship is characterised by a bidirectionality where both patient and clinician can find meaning and healing. These foundations are also key facilitators in the process of implementing and assessing the practice of WPC.

Clinician conceptions of WPC in practice

Respondents' rich and varied examples of implementing WPC in practice highlighted the importance of listening and connection for developing a healing relationship. Listening required clinicians to be able to take a pause, sit

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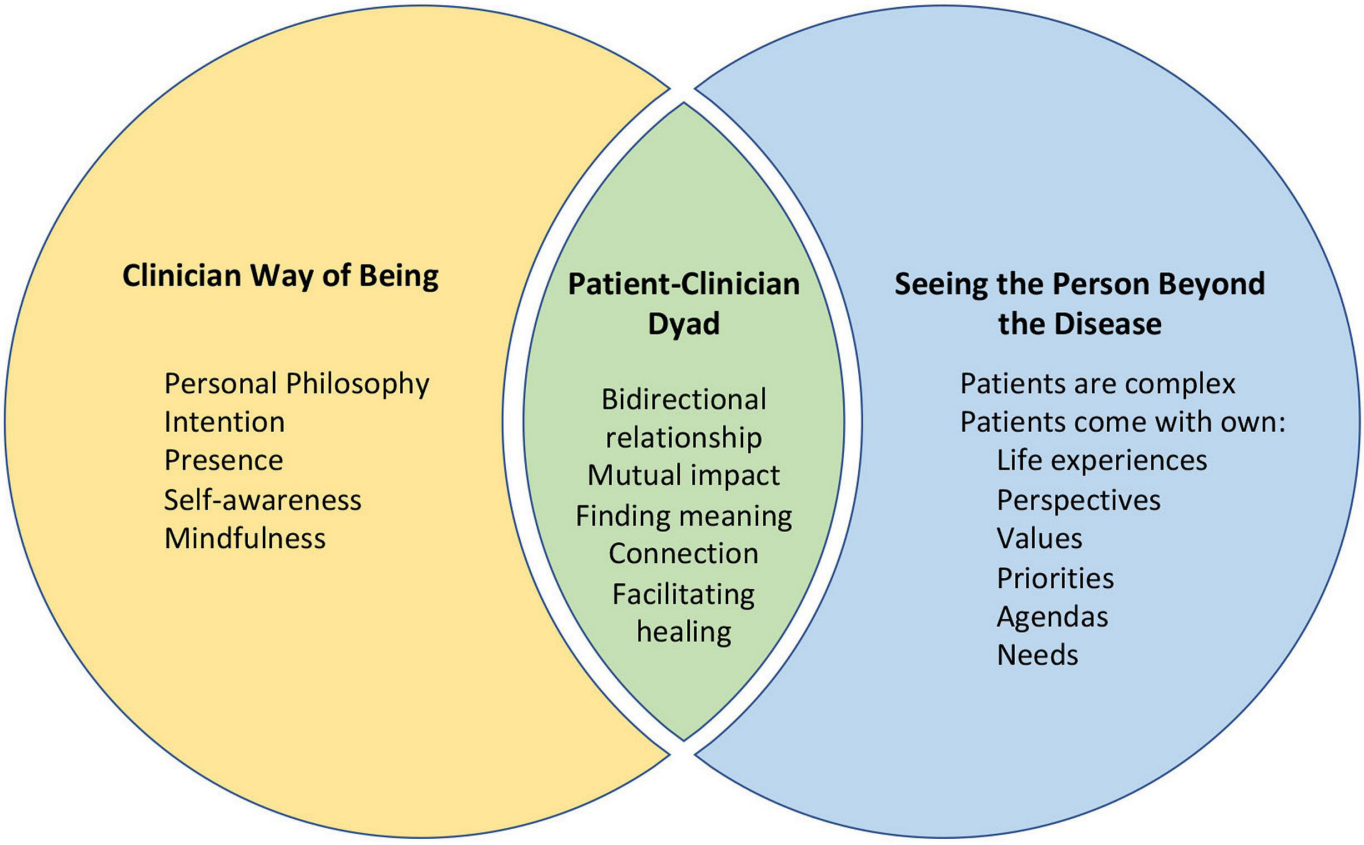

Figure 1 Clinician conceptions of WPC in theory. This diagram outlines the concepts defining WPC as perceived by clinicians. Whole Person Care stems from a clinician's way of being or their philosophy of care (left) and their approach to the patient as a person beyond their disease (right). Together, these elements enable a bidirectional relationship (center) that is the basis of WPC. WPC, Whole Person Care.

comfortably in silence, accept uncertainty, give patients the necessary space to be emotional and acknowledge their emotions. Establishing a connection required maintaining a non-judgmental relationship, adapting to the patient's needs and putting their agenda first and empathising with uncertainty.

Key facilitators for this practice included self-awareness and mindfulness. Respondents emphasised that the ability to take a step back from an encounter and observe one's emotions and reactions was critical to developing the sense of trust and connection cited as fundamental to the patient–clinician relationship. As one respondent explained:

> Being a mindful medical practitioner enables the whole person interaction to occur because you are present yourself, you're present to the other person, you are aware of the context, you're aware of your own thought process, you are aware of your own experiences, your own responses, your reactions to things, while at the same time being aware of this person. (R33, Psychologist)

Demonstrating a curiosity to one's own reactions and a non-judgmental awareness of one's own emotions were cited as tools to help clinicians best practice WPC for the patient in front of them. As one clinician said:

> What's my physical feeling right now? What's the emotion behind that? Once I'm aware of that, then I can have some choices as to how to respond. If I'm aware that what I'm doing is actually more about my agenda to be this Whole Person Care type of doctor when the patient is saying, 'I just want you to fix pain. I don't want to talk about the fact that I'm dying. I don't want to talk about the fact that I saw my mother die. And I don't want to talk about the fact that I'm worried about my wife'. So it's about asking, OK, well how much of this is about me and how much of this is about what they need in it. So, I think for me some of it has been about self-awareness and trying to figure out what's going on in a given interaction. And then how best to serve within that. (R36, Palliative Care physician)

Respondents also reported barriers to practicing WPC. Many respondents reported structural barriers, especially time constraints, a high-volume practice and a shift towards the use of technology. Clinician-related barriers included stress, anxiety and compassion fatigue. Others reported they most struggled with practicing WPC when they were data-driven and preoccupied with their own objectives rather than the patient's objectives. Some respondents cited they were less able to practice WPC

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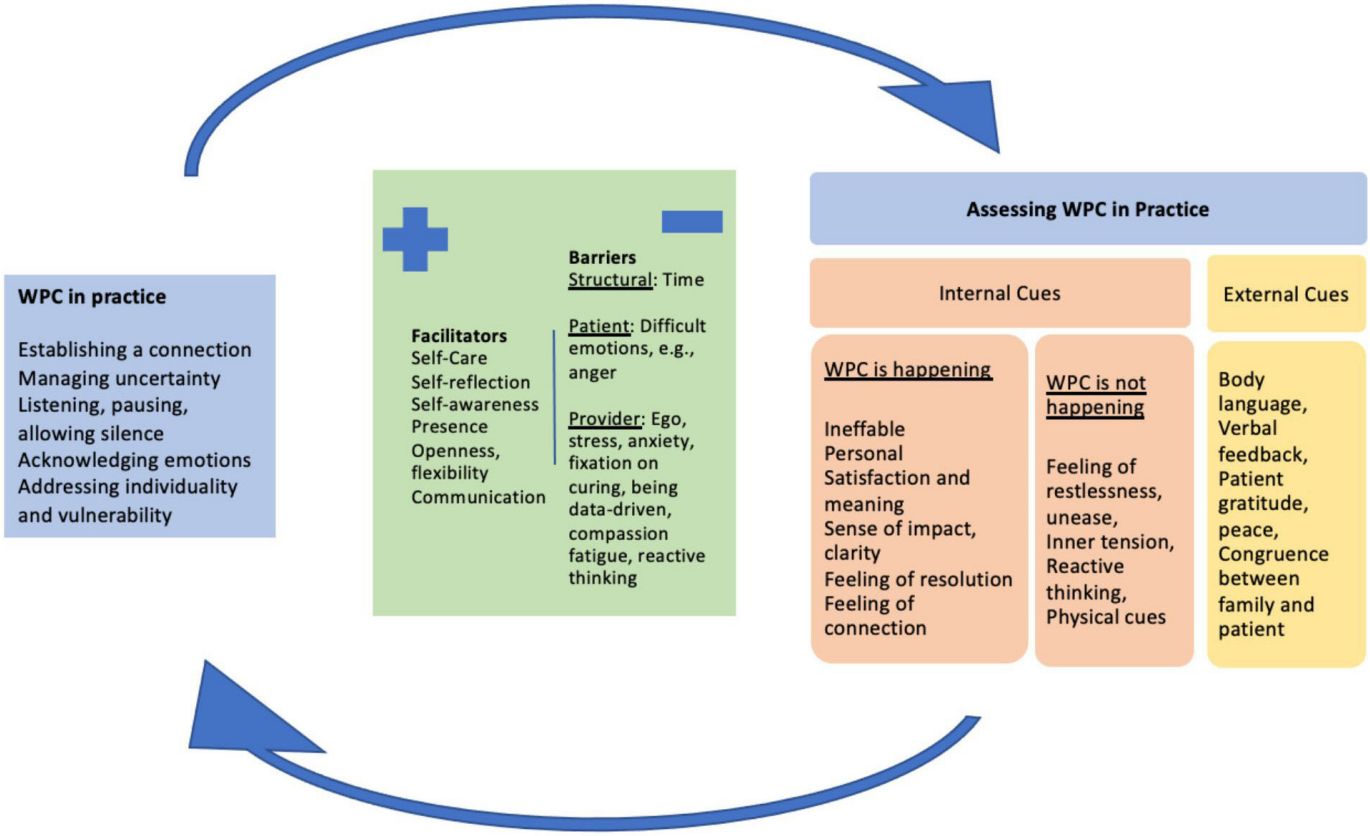

Figure 2 Clinician Conceptions of WPC in practice. This logic model outlines the practice of WPC and the iterative process of attending to internal and external cues. Key facilitators and barriers to the practice and assessment of WPC are displayed in the middle. WPC, Whole Person Care.

when they did not feel connected to themselves or when their own ego interfered. A few respondents emphasised the importance of self-care, with one respondent explaining that:

> Whole Person Care is when you're taking care of yourself and you're able to be present for the other person. But if you're not taking care of yourself, you're not able to give or offer Whole Person Care. I really think that they work together. (R11, peer support worker)

Other barriers included failing to establish a provider–patient relationship, sometimes due to anger on either side. For instance, a spiritual care provider explained that:

> Some people you just don't connect with, and I'm not sure it's possible to connect with everybody because (…) some people we feel heart-to-heart with and others we don't. And I remember one patient who had thrombocytopenia or something, and he was just a difficult patient, and I kind of liked the difficult patient challenges, I usually was able to find a way to connect with them. I never could with him. He was always really angry, and I never felt like it was possible for me to provide Whole Person Care for him. And truthfully I'm not sure I always wanted to. (R3, spiritual care provider)

There was one divergent perspective from one of the two non-clinicians. This respondent described that providing WPC may entail being so emotionally affected that a clinician is unable to continue working:

> The nurse quit after a few months in the ICU because she couldn't cope with the emotional aspect of it. So that touched me a lot to know the nurse cared about the patient. (R16, medical school applicant)

Overall, interview responses showed that clinicians practiced WPC by allowing space for emotions that may be inherent to the human experience of being a patient, while also reflecting on their own reactions and limitations. Though the stressors of volume and data-driven medicine constitute important barriers to WPC, the mindfulness involved in practicing WPC also constitutes an important tool for clinicians to assess their practice in real time.

Catching oneself: clinician's self-assessment of their practice

Many respondents identified a range of cues that helped them identify whether they were practicing WPC during the encounter or not. Cues were broadly categorised into internal and external cues. Internal cues refer to those originating from clinicians' own emotions and physical

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sensations, and external cues refer to those originating from the patient or interaction itself.

The internal cues of practicing WPC included feeling a sense of connection or trust, gaining clarity and a feeling of emerging resolution. For instance, one respondent recalled:

> When somebody divulges information to me that I think is really personal, that really affects them really deeply, and you can feel that 'wow, that person entrusted me', that's a gift, right?…I mean, you feel we're connected. So, when I feel that sense of gratitude that this patient has shared that with me, I think that's a measure of good connection. (R5, Oncologist)

On the other hand, clinicians reported other internal cues that suggested they were not practicing WPC. These included a sense of restlessness, inner tension, physical discomfort, reactive thinking, or feeling rushed or disappointed. Many respondents pointed to using these internal cues to help them stay on track, which they often described as 'catching themselves.' This allowed them to reorient their practice in the moment. Clinicians described:

> feelings of impatience, rushing, any kind of negative feelings like frustration, anger. I need to reorient, take a breath, slow down. (R27, Palliative Care Physician)

> The tension is something that I feel internally, sometimes emotionally, physically, mentally or spiritually… there is a chance for me to recalibrate… I know I'm practicing WPC when I am aware enough and mindful enough that I see those things happen and I know to slow down to let the magic evolve. (R18, Family physician)

External cues of practicing WPC involved sources of information about the encounter that originated from the patient or others involved. These cues included body language and verbal or written statements from patients and their families. One respondent stated:

> They are giving feedback just in the way they're conversing with you. They will give you a head nod, they will say 'yes', and 'I appreciate what you just asked me'. (R37, Paediatrician)

Another respondent realised they were not practicing WPC when discordance between the clinician and patient's agendas became apparent, which then permitted a reorientation toward the patient's needs rather than being data-driven:

> I think once I clued in to where things were, you can see the family and the patient's tensions are very much relieved. We actually got palliative care involved and we made plans for her to be assessed. So that was kind of it, in the moment and you can see even the family said that. 'At first, I wasn't sure you knew where we were at', but we had a good long conversation, we had palliative care join us for this discussion of care. And I think it was a very satisfying experience for all of us in the room. (R34, Cardiologist)

The same respondent also reported receiving feedback from student learners and residents:

> Let's say I'm working with either colleagues or students or residents…It's another kind of feedback. I've had people point out things to me maybe during teaching moments that helps reinforce certain principles…Either it's something that I point out or that they will point out as an example of good communication. (R34, Cardiologist)

In contrast to the above stated cues, some respondents felt there was no specific way of knowing they were practicing WPC beyond an indescribable feeling. One respondent said:

> Sometimes it is ineffable, sometimes it's more of a feeling than anything objectifiable or measurable. (R36, Palliative Care physician)

Another respondent reported:

> Sometimes you have a sense that something happened. I would liken it to reading a great book or seeing a great play. When you leave… you've left with a sense that something happened there. (R32, Palliative Care physician)

When asked to elaborate, the respondent replied 'But that's the problem with that. It's the best analogy I could make.' (R32, Palliative Care physician)

Overall, clinicians described various cues which served to help them ensure they were practicing WPC in the moment. Positive feelings of connection, resolution and explicit feedback suggested to clinicians that they were practicing WPC successfully. Feelings of inner tension, restlessness and discomfort prompted many clinicians to 'catch themselves' during interactions so they could reorient their practice in providing WPC. Mindfulness was central to practicing and assessing the practice of WPC in real time.

Building on study results at the 2019 International Congress on WPC

The above results were presented in the form of a workshop at the 2019 International Congress on WPC, which included a logic model summarising the original interview responses (see online supplemental file 1 for the version of the logic model presented to the WPC congress). Participants at the workshop were asked to reflect on the logic model and identify any missing elements that were important to their practice of WPC. The consensus was that the logic model generally captured the central elements of WPC. However, some missing elements were proposed, which prompted further discussion. There was agreement that patient perspectives on WPC were missing, as well as the active role of patients in the practice of WPC.

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A further point of agreement was that the practice of WPC should extend beyond the in-office patient interaction and should also include other health professionals and administrative staff as well as in the importance of mental preparation between patient interactions. One divergent opinion supported by some participants was a concern of an overemphasis on clinician self-awareness. For example, some described knowing they are practicing WPC when they have lost themselves in the interaction. This prompted recognition of the fine balance between clinician self-awareness and awareness of the patient, acknowledging the agendas of each party, and building the necessary clinician–patient relationship to deliver WPC.

DISCUSSION

This study draws on the perspectives of clinicians attending a WPC conference to explore their conceptions of WPC as well as their strategies for monitoring their clinical practice in real time. These findings help construct a framework of WPC that is applicable across diverse clinical settings. More broadly, the collective insights will be of interest to any clinician seeking to translate their stated values into their clinical practice more reliably.

The WPC framework elicited from clinician perspectives in this study is generally consistent with conceptions of WPC described in the literature. The three overarching themes of WPC identified in this study (the individual personhood of each patient, the therapeutic relationship and the physician's way of being) have each been previously identified as foundational to the practice of WPC.[18 39–41] The pivotal role of mindfulness and self-awareness described by participants is also reflected in the existing WPC literature.[18 19 39–44] Further, a qualitative study interviewing general practitioners in Australia also identified the multidimensional nature of the patient and the therapeutic doctor–patient relationship as foundational to WPC.[40] However, in contrast to the above-mentioned study,[40] our study included diverse medical specialties and healthcare professionals spanning multiple countries and clinical settings. The general agreement between this study's results and the existing WPC literature helps demonstrate that its community of practitioners share a relatively well-circumscribed framework. The establishment of this shared framework helps to mitigate the practical challenges of its implementation and dissemination, which have been a recognised hurdle for other frameworks.[30 32 45]

This study addresses an important challenge faced by clinicians. In the context of prevalent physician burnout and increasing psychological stressors,[45 46] consistently providing care that is congruent with one's values can be challenging. Observational studies have revealed discrepancies between clinicians' stated values and their actions in practice.[33 34] One qualitative study did explore how healthcare professionals seek to maintain their compassion over time and found that self-care behaviours were the most frequently cited.[47] However, to our knowledge there has been little exploration of clinicians' approaches to monitoring for this discrepancy in real time. This study demonstrates that clinicians use a wide range of cues and strategies to monitor their moment-to-moment practice. Many clinicians are actively attending to internal cues (eg, sense of connection, inner tension and unease) and external cues (eg, patient body language, and explicit feedback from patients and peers). Taken together, this study shows how these cues serve as a moment-to-moment barometer that signals to the clinician when they may not be providing WPC. To be sure, not all clinicians could articulate these cues so clearly. Some described the feeling of practicing WPC as 'ineffable', highlighting the difficulty in not only describing, but also monitoring, this complex process in real time.

The framework of WPC presented in our study has important implications for its implementation and dissemination. First, the diversity of cues identified by the respondents demonstrates the inherently personal experience of self-monitoring one's own clinical practice. Therefore, the cues identified in this study should not be interpreted as required experiences for any clinician monitoring their own practice. Rather, they may serve as a prompt for clinicians to reflect on what their own cues might be. Second, although the individual cues varied, the practice of self-reflection and mindfulness were overwhelmingly endorsed as facilitators to the practice of WPC. This finding corresponds with the growing evidence of the benefits of mindfulness meditation for healthcare providers.[43 44] Further, this supports the increasing attention toward providing mindfulness training as a part of undergraduate medical education.[48–55] Third, the identified barriers may be helpful for clinicians to keep in mind as they monitor their own practice. Although some barriers are beyond the clinicians' control (eg, time constraints), the majority of the barriers are related to the clinicians' mindset, expectations and emotions. Therefore, there is considerable opportunity for clinicians to learn how to address these barriers, in part with some of the strategies outlined above.

Qualitative methodology is a key strength of our study. Proxy outcomes and standardised metrics have been noted to be ill-equipped for disentangling the nuances of physician perspectives on facilitating patient healing.[56 57] Rather, some complexities are better interpreted through human narrative,[36] and qualitative methodology has been a proposed avenue for gaining explanatory insight of the 'doctor as person'.[25] Eliciting clinician reflections on their implicit knowledge can help render it into explicit knowledge which can be shared.[33] In this way, qualitative methodology helps to access the collective wisdom held by clinicians and transform it into actionable knowledge. A second strength of our study is the dissemination of our preliminary results in a workshop presented to the WPC Congress. This provided an opportunity to validate our results with relevant stakeholders.

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LIMITATIONS

An important weakness of our study is the absence of the patient perspective of WPC. Including patient perspectives is an essential component for corroborating clinician perspectives and may offer fruitful insights particularly on the implementation of new models of care.[30 58] A second limitation of our study lies in its dependence on the participants' ability to introspect and accurately convey their experience. A clinician may articulate their supposed theory and monitoring strategies without doing so in practice, while another may practice WPC without being able to articulate a clear conceptual definition. Observational and ethnographic studies, in addition to patient perspectives, will be important to correlate a clinician's self-reporting with the actual clinical encounter. Finally, the question of sustainability was not directly addressed in this study. Modifying clinician behaviour is a notoriously complex problem.[59 60] It will be important to explore what forms of support are necessary to sustain these practices beyond the scope of a dedicated research project. There is some evidence that professional development activities can encourage reflection on clinical practice,[61] therefore there may be a role for regular workshops to sustain these practices over time. This is an important question that will need to be explored in future research.

CONCLUSION

In conclusion, our study uses qualitative methods to explore how clinicians bridge the gap between theory and practice through the lens of the emerging framework of WPC. In this way, our study helps construct a broadly applicable model of WPC that describes what it means to provide WPC as well as the processes, facilitators and barriers involved in successfully implementing this practice. Clinicians may consider the cues described in this study as tools for monitoring how their own values are reflected in their clinical practice in real time.

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