ABSTRACT
Mindfulness practice, where an individual maintains openness, patience, and acceptance while focusing attention on a situation in a nonjudgmental way, can improve symptoms of anxiety, burnout, and depression. The practice is relevant for health care providers; however, the time commitment is a barrier to practice. For this reason, brief mindfulness interventions (eg, ≤ 4 hours) are being introduced. We systematically reviewed the literature from inception to January 2017 about the effects of brief mindfulness interventions on provider well-being and behavior. Studies that tested a brief mindfulness intervention with hospital providers and measured change in well-being (eg, stress) or behavior (eg, tasks of attention or reduction of clinical or diagnostic errors) were selected for narrative synthesis. Fourteen studies met inclusion criteria; 7 were randomized controlled trials. Nine of 14 studies reported positive changes in levels of stress, anxiety, mindfulness, resiliency, and burnout symptoms. No studies found an effect on provider behavior. Brief mindfulness interventions may be effective in improving provider well-being; however, larger studies are needed to assess an impact on clinical care.

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KEYWORDS: Health care providers; Inpatient; Mindfulness; Systematic literature review; Well-being

INTRODUCTION
Mindfulness is defined as “a way of being in which an individual maintains openness, patience, and acceptance, while focusing attention on an unfolding situation in a nonjudgmental way.” Accumulating evidence suggests that mindfulness-based therapies can improve symptoms of anxiety, burnout, and depression. Mindfulness training has been associated with an attitude of curiosity, connection to self and patient, attentive listening, error recognition, and clinical insight. Individual mindful practice has thus been offered as a method to improve medical decision-making, be it appropriateness of antibiotic treatment, placement of urinary catheters, or employee outcomes such as work engagement and job performance. It is not surprising then, that collective mindfulness (ie, collective capacity to discern discriminatory detail about emerging issues), is a hallmark of high-reliability organizations and...
is associated with lower turnover rates, improved quality, and safety.\textsuperscript{10,11}

An important barrier to broad implementation of mindfulness in health care settings is the time required for training and practice. For example, the mindfulness-based stress-reduction program developed by Jon Kabat-Zinn includes 8 weekly 2.5-hour didactic and practice sessions, one full-day silent retreat, and a recommendation for 45 minutes of daily independent meditation practice.\textsuperscript{12} Consequently, while participation in mindfulness-based stress reduction programs benefits the well-being of providers, one review concluded that attrition due to time and schedule requirements limits impact.\textsuperscript{13} Abbreviated interventions using principles of mindfulness have been introduced to overcome this barrier.\textsuperscript{14-27} However, whether these brief interventions improve well-being and provider practice is not known. Therefore, we performed a systematic review to examine the effectiveness of brief mindfulness programs on health care providers in the hospital setting.

METHODS

Protocol and Registration

This review was performed per the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guideline\textsuperscript{28} and registered with the International Prospective Register of Systematic Reviews (PROSPERO registration number 2016:CRD42016048388).

Data Sources and Searches

The business, theology, philosophy, psychology, social work, nursing, and medical literature were searched to identify brief (ie, lasting \(\leq 4\) hours) mindfulness-based practices, with a specific focus on bedside nurses and physicians in the hospital setting. On February 9, 2016, a research librarian searched multiple databases including MEDLINE, CINAHL, and PsycINFO, Cochrane/EBM Reviews, EMBASE, the PubMed Journals and Medical Subject Heading databases (Mesh), and the ISI knowledge databases for English language articles published in the peer-reviewed literature. Variations and combinations of the Mesh terms were used to enhance the search (Appendix A, available online). Additional studies were identified by manual review of bibliographies of included articles, review of published protocols on ClinicalTrials.gov, and systematic reviews registered in PROSPERO. The search was last updated on January 24, 2017.

Study Selection and Eligibility Criteria

All study designs (eg, randomized controlled trials, pre-post, qualitative) that reported either qualitative or quantitative outcomes following mindfulness-based interventions were included. The population of interest was practicing nurses, physicians, student nurses, or medical trainees 18 years or older employed in a hospital setting (eg, emergency department, inpatient wards, intensive care). This population was selected due to the presence of numerous workplace stressors in the hospital environment that impact the well-being of providers, and suggestions that mindful practice may enhance provider–patient relationships,\textsuperscript{3} medical decision-making,\textsuperscript{4,5} employee outcomes,\textsuperscript{6-8} and quality and safety.\textsuperscript{10,11} Psychologists, psychiatrists, social workers, and others in counseling roles were excluded, as were studies performed in primary care, outpatient, long-term care, or office-based settings. Dissertations, conference abstracts, and literature published in non-peer-reviewed journals were also excluded.

Interventions

Studies that evaluated brief mindfulness-based interventions using dedicated content (eg, mindfulness-based stress reduction-based programs), were included. We chose \(\leq 4\) hours as a cutoff because single, half-day interactive-didactic educational sessions are common for continuing professional education in health care and would thus enhance generalizability.\textsuperscript{29} Mindfulness-based interventions were defined using standard definitions, such as exercises that focused on paying attention on purpose, being in the present moment, and being nonjudgmental.\textsuperscript{10} Therefore, interventions such as sitting meditation, breathing exercises, guided imagery, relaxation methods, yoga, or desensitization-relaxation in person or through virtual modalities (eg, on-line module, compact discs, or smartphone application) were included. We also included brief mindfulness-based interventions embedded within multifaceted programs, recognizing that the impact of the mindfulness component within such courses could not be ascertained.

Outcomes

The main outcomes of interest were the effectiveness of the interventions on provider well-being and behavior. Provider well-being was assessed through self-reported levels of stress, anxiety, depression, resilience, mindfulness, relaxation, or burnout symptoms (eg, emotional exhaustion, depersonalization, and personal accomplishment), satisfaction with life, or quality of life. Provider behavior was assessed by reports of changes in academic performance (eg, improvements on school examinations); performance on tasks of attention (eg, attentional awareness and cognition measured by tests of memory or intelligence); changes in clinical practice (eg, increased adherence to evidence-based practices); or incidence of diagnostic errors related to the mindfulness intervention.
Data Extraction Process

Three authors (HG, AG, and MH) independently screened titles and abstracts against the inclusion criteria. Full reports of titles that appeared to meet the inclusion criteria were obtained. Citation abstracts and full text articles were uploaded to reference software. The following data were collected: authors, year, study design, study sample, setting, number and type of providers, attrition rate, type and length of intervention, outcomes measured, instruments used, primary and other outcomes, adherence to the intervention, and adverse events. A fourth investigator (VC) resolved disagreements in abstraction. Inter-rater agreement of study abstraction accuracy was assessed using Cohen’s $K$. When pertinent, study authors were contacted by e-mail, up to 3 attempts, to clarify results, obtain relevant missing data, or obtain unpublished information.

Risk of Study Bias

Two authors (HG, AG) independently assessed risk of study bias. Risk of bias among quantitative studies was evaluated using the Downs and Black (D&B) tool as recommended by the Cochrane collaboration. The D&B tool provides an overall score (max points = 28) for methodological quality in randomized and nonrandomized studies by asking 27 questions in 4 categories. A mean and standard deviation was calculated for each category within the overall score.

Risk of bias for qualitative studies was determined by the Critical Appraisal Skills Programme (CASP) tool. CASP assesses the validity of the results and the applicability of the findings using 10 questions. Studies were scored on a 10-point scale (range: 1-3 = low quality; 8-10 = high quality). Inter-rater agreement was assessed using Cohen’s $K$.

Data Synthesis

Owing to clinical heterogeneity, formal meta-analyses were not attempted. A narrative synthesis was conducted with information presented in text and tables to describe the characteristics and effectiveness of included studies. The narrative synthesis explored findings within and among included studies, in accordance with the guidance from the Centre for Reviews and Dissemination.

RESULTS

The literature search yielded 4181 citations. After removal of duplicates, 3561 articles were reviewed by title and abstract. Of these, 221 full-length articles were reviewed and 14 met inclusion criteria (Figure). All included publications reported findings from studies that used volunteer/convenience samples. One of the 14 studies reported qualitative findings, while 7 were randomized controlled trials. Sample sizes ranged from 10 to 245 participants, with most being female (78% across all studies). Studies were conducted in the United States, Canada, Thailand, and Tasmania.

The 14 studies spanned 833 health care providers and were published in the last decade: 5 in 2015, 2 in 2016, and one in 2017. Half of the studies offered mindfulness-based interventions to nurses or nursing students, while the other half offered the same to physicians or medical
students/residents. Inter-rater reliability for study abstraction was excellent (Cohen’s $K = 0.91$).

**Interventions**

**Mindfulness Modalities.** All studies incorporated brief mindfulness interventions. Nine studies focused solely on mindfulness; five studies embedded mindfulness within multifaceted resiliency programs or a program to reduce medication errors. Nine of 14 studies used a combination of lecture, discussion, and group or independent practice sessions. Three studies offered only guided meditation sessions. Among these, one was guided by a Buddhist monk, one via audio recordings designed for the study, and another via the smartphone application Headspace (Headspace Inc., Santa Monica, Calif.). Two studies tested on-line modules with prerecorded audio meditation sessions.

**Types of Mindfulness Used.** Interventions included general mindfulness practices such as increasing awareness, presence, or acceptance through breathing meditations, mindfulness-based stress reduction-inspired content, Buddhist Anapanasati breathing meditation (ie, emphasis on awareness of the breath), or Vipassana meditation (ie, emphasis on mindfulness of breathing, thoughts, feelings, and actions).

**Dose, Duration, Setting.** For the studies that tested in-person mindfulness interventions, the dose and duration ranged from 5 to 20 minutes once a day to 30 minutes a week over 4 weeks. Adherence to the group sessions was reported in a single study: 40 (89%) participants attended at least one 5-minute session over the 4-week study, while 19 (42%) attended 8 sessions. The average attendance was 2 sessions a week. Four studies tested virtual mindfulness interventions through 5- to 20-minute online modules, 1-hour online modules, 30-minute daily audio-guided sessions over 8 weeks, or 10-minute daily smartphone app-guided sessions for 10 consecutive days. Home practice was recorded by 20 (65%) participants over the 8-week audio-CS study with a mean practice of 27 days (range 0-52).

Five studies embedded mindfulness content within multifaceted programs. A single program specified the amount of mindfulness training in the curriculum: 30 minutes of a 3-hour program. Studies were conducted within a hospital, university classroom, or virtually.

Three studies reported the credentials of the meditation instructor (ie, ordained Zen Buddhist priest or trained meditation instructor) (Table 1).

**Effectiveness of Interventions at Improving Outcomes**

**Provider Well-Being.** Nine of 14 studies reported significant improvements in provider well-being (Table 2). Multiple validated instruments, including the Perceived Stress Scale, the Maslach Burnout Inventory, the Anxiety Scale, Connor-Davidson Resilience Scale, and Mindfulness Attention Awareness Scale were used across studies (Table 3). Five of 6 studies reported statistically significant improvements in stress scores after completion of the intervention. Four of 5 studies reported improved anxiety scores, 2 of 4 reported improved resiliency scores, and 3 of 6 reported improved mindfulness scores post intervention. Burnout symptoms improved in a single study, while 2 studies reported improved relaxation, quality of life, and satisfaction.

Two studies reported no improvement in provider well-being. The first embedded mindfulness content within a multifaceted Stress Management and Resiliency Training program as part of nurse orientation. The second examined the feasibility and impact of a free smartphone application on a 10-day program in mindfulness meditation.

**Other Outcomes.** Eight of 14 studies reported that participants were interested in the content, found time to participate in the intervention, and verbalized benefits from the program. Brennan and McGrady reported that participants requested ongoing mindfulness training, while Kemper and Khirallah. Warnecke et al reported that 49%, 32%, and 61% of respective participants stated they would continue mindfulness practices. Taylor et al reported that participants perceived mindfulness as a useful clinical tool in caring for hospitalized patients. Although high levels of interest in the content were noted by multiple authors, attrition and nonattendance did occur even in these brief sessions, especially when they involved more than a single session. Reasons for attrition included scheduling conflicts, time constraints, other priorities, and difficulties in starting a new habit or adjusting to a change in routine. Ease of accessibility was a benefit in the studies that offered meditations on the unit or through virtual platforms.

**Quality Assessment**

Risk of bias for quantitative studies using the D&B tool was 18, suggesting moderate quality (range 14-25, SD 3.38). Most studies (64%; n = 9) scored poorly on measures of internal validity/bias (mean 4.1, range 3-6, SD 0.86) due to a lack of
<table>
<thead>
<tr>
<th>Author (Year)</th>
<th>No. of Weeks</th>
<th>No. of Sessions/Week</th>
<th>Total No. of Sessions</th>
<th>No. of Min/Session</th>
<th>Intervention Setting</th>
<th>Findings</th>
<th>Key Observations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brennan &amp; McGrady (2015)&lt;sup&gt;20&lt;/sup&gt;</td>
<td>36</td>
<td>Not specified</td>
<td>Not specified</td>
<td>1 to 2</td>
<td>Lecture duration not specified</td>
<td>Unit-based conference room</td>
<td>Program practical to implement and to integrate into clinical setting and residency curriculum. High level of engagement and acceptance of program by participants</td>
</tr>
<tr>
<td>Chesak et al (2015)&lt;sup&gt;21&lt;/sup&gt;</td>
<td>12</td>
<td>1</td>
<td>2</td>
<td>Ninety-minute session, optional 60-min follow-up at 4 weeks</td>
<td>Nursing orientation</td>
<td>No effect</td>
<td>Four participants (14%) attended follow-up session at 4 weeks</td>
</tr>
<tr>
<td>Durham et al (2016)&lt;sup&gt;25&lt;/sup&gt;</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>Thirty-minute portion of 3-h session, instructions to practice prior to every medication preparation and administration</td>
<td>Hospital</td>
<td>Error interception practices increased during medication administration and 14 of 23 respondents (61%) reported ongoing use of mindfulness strategy 10 weeks post intervention</td>
<td>A “STOP and focus on one breath” practice prior to medication preparation and administration was feasible and acceptable. Adherence to practice not reported</td>
</tr>
<tr>
<td>Gauthier et al (2015)&lt;sup&gt;14&lt;/sup&gt;</td>
<td>4</td>
<td>14</td>
<td>392</td>
<td>5</td>
<td>Huddle room next to nursing station</td>
<td>Improved stress scores ($P &lt; .006$)</td>
<td>Forty (89%) attended at least one session, 19 (42%) attended 8 sessions (average 2 sessions a week)</td>
</tr>
<tr>
<td>Kemper (2017)&lt;sup&gt;27&lt;/sup&gt;</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>Five to 20-min modules</td>
<td>Virtual (on-line)</td>
<td>Improved mindfulness scores ($P &lt; .001$) immediately postmodule completion for 3 separate mindfulness modules&lt;sup&gt;*&lt;/sup&gt;</td>
<td>Completion of brief, online training associated with improvements in mindfulness scores</td>
</tr>
<tr>
<td>Kemper &amp; Khirallah (2015)&lt;sup&gt;15&lt;/sup&gt;</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>Sixty-minute modules with option to access 20-min guided meditation recordings</td>
<td>Virtual (on-line)</td>
<td>Improved mindfulness scores ($P &lt; .001$) and resiliency scores immediately post-module completion ($P &lt; .01$)&lt;sup&gt;*&lt;/sup&gt;</td>
<td>Access to and impact of audio guided recordings not measured</td>
</tr>
<tr>
<td>Mackenzie et al (2006)&lt;sup&gt;16&lt;/sup&gt;</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td>Thirty-minute weekly sessions, plus instructions to practice at home 10 min per day, 5 days per week</td>
<td>Hospital</td>
<td>Improved emotional exhaustion ($P &lt; .05$), depersonalization ($P &lt; .05$), life satisfaction ($P &lt; .01$), relaxation ($P &lt; .05$) scores</td>
<td>Adherence to home-based practice not measured</td>
</tr>
<tr>
<td>Paholpak et al (2012)&lt;sup&gt;17&lt;/sup&gt;</td>
<td>4</td>
<td>5</td>
<td>20</td>
<td>20</td>
<td>University classroom</td>
<td>No effect</td>
<td>Program practical to implement, but no impact on normal, intelligent, mentally healthy students</td>
</tr>
<tr>
<td>Author (Year)</td>
<td>No. of Weeks</td>
<td>No. of Sessions/Week</td>
<td>Total No. of Sessions</td>
<td>No. of Min/Session</td>
<td>Intervention Setting</td>
<td>Findings</td>
<td>Key Observations</td>
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<tr>
<td>Poulin et al (2008)</td>
<td>18</td>
<td>4</td>
<td>4</td>
<td>Thirty-minute weekly sessions, plus instructions to practice at home 15 to 20 min daily</td>
<td>Hospital</td>
<td>Improved satisfaction with life ($P &lt; .05$), and relaxation ($P &lt; .05$) scores with both MBSR and control intervention</td>
<td>Adherence to home-based practice not measured</td>
</tr>
<tr>
<td>Ratanasiripong et al (2015)</td>
<td>19</td>
<td>Not specified</td>
<td>2</td>
<td>Not specified for training sessions, home practice expected 3 times per day for 4 weeks</td>
<td>University classroom</td>
<td>Improved stress ($P = .001$) in mindfulness group and improved anxiety scores in mindfulness ($P = .001$) and biofeedback ($P = .006$) group</td>
<td>Adherence to home-based practice not measured</td>
</tr>
<tr>
<td>Sood et al (2011)</td>
<td>8</td>
<td>1</td>
<td>1</td>
<td>Ninety-minute session, plus optional 30-min follow-up session and instructions to practice 5 to 15 min 1 to 2 times a day</td>
<td>Hospital</td>
<td>Improved resiliency ($P = .003$), stress ($P = .010$), anxiety ($P = .010$), and quality of life ($P = .029$) scores</td>
<td>Four (20%) participated in follow-up session Adherence to home-based practice not measured</td>
</tr>
<tr>
<td>Sood et al (2014)</td>
<td>12</td>
<td>1</td>
<td>1</td>
<td>Ninety-minute session, 2 follow-up phone calls, optional 30-min follow-up session, instructions to practice 5 to 15 min, 1 to 2 times a day</td>
<td>Hospital</td>
<td>Improved stress ($P = .02$), mindfulness ($P = .004$), anxiety, ($P = .038$), and quality of life ($P = .044$) scores</td>
<td>Eight (34%) participated in follow-up session Adherence to home-based practice not measured</td>
</tr>
<tr>
<td>Taylor et al (2016)</td>
<td>1.5</td>
<td>10</td>
<td>10</td>
<td>Ten-minute daily session for 10 days</td>
<td>Virtual (smartphone app)</td>
<td>No effect on burnout or mindfulness scores</td>
<td>Adherence to daily smartphone-guided practice not measured Eight weeks: 20 (65%) recorded practice Mean days: 26.7 (range 0-52) Sixteen weeks: 6 (31%) recorded practice Mean days: 12 days (range 3-29)</td>
</tr>
<tr>
<td>Warnecke et al (2011)</td>
<td>8</td>
<td>7</td>
<td>56</td>
<td>30-min daily sessions for 8 weeks</td>
<td>Virtual (audio CDs)</td>
<td>Improved stress scores ($P = .05$), and anxiety scores ($P = .05$), but had no effect on depression scores at 4 and 8 weeks</td>
<td></td>
</tr>
</tbody>
</table>

IPMR = brief Imagery and Progressive Muscle Relaxation program; MBSR = mindfulness-based stress reduction; RN = Registered Nurse.

*These two studies were cumulative, participants and results from the 2015 paper were included in the 2017 paper.
<table>
<thead>
<tr>
<th>Outcome</th>
<th>Author (Year of Publication)</th>
<th>Measure</th>
<th>Statistical Significance</th>
<th>Intervention</th>
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<tbody>
<tr>
<td>Provider well-being</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Stress</td>
<td>Chesak et al. (2015)²¹</td>
<td>Perceived Stress Scale</td>
<td>NS</td>
<td>SMART program</td>
</tr>
<tr>
<td></td>
<td>Gauthier et al. (2015)²⁶</td>
<td>Nursing Stress Scale</td>
<td>P &lt; .006</td>
<td>Five-minute daily guided practice</td>
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<tr>
<td></td>
<td>Ratanasiripong et al (2015)²⁹</td>
<td>Perceived Stress Scale</td>
<td>P = .001</td>
<td>Three x a day home practice</td>
</tr>
<tr>
<td></td>
<td>Sood et al. (2011)²⁷</td>
<td>Perceived Stress Scale</td>
<td>P = .010</td>
<td>SMART program</td>
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<tr>
<td></td>
<td>Sood et al. (2014)²³</td>
<td>Perceived Stress Scale</td>
<td>P = .02</td>
<td>SMART program</td>
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<tr>
<td></td>
<td>Warnecke et al. (2011)²⁶</td>
<td>Perceived Stress Scale</td>
<td>P = .05</td>
<td>Thirty-minute daily audio CD practice</td>
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<tr>
<td>Anxiety</td>
<td>Chesak et al. (2015)²¹</td>
<td>Generalized Anxiety Disorder Scale</td>
<td>NS</td>
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<tr>
<td></td>
<td>Ratanasiripong et al (2015)²⁹</td>
<td>State-Trait Anxiety Inventory</td>
<td>P = .001</td>
<td>Three x a day home practice</td>
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<td></td>
<td>Sood et al. (2011)²⁷</td>
<td>Smith Anxiety Scale</td>
<td>P = .010</td>
<td>SMART program</td>
</tr>
<tr>
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<td>Sood et al. (2014)²³</td>
<td>Smith Anxiety Scale</td>
<td>P = .038</td>
<td>SMART program</td>
</tr>
<tr>
<td></td>
<td>Warnecke et al. (2011)²⁶</td>
<td>Depression, Anxiety, and Stress Scale</td>
<td>P = .05</td>
<td>Thirty-minute daily audio CD practice</td>
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<tr>
<td>Resiliency</td>
<td>Chesak et al. (2015)²¹</td>
<td>Connor-Davidson Resilience Scale</td>
<td>NS</td>
<td>SMART program</td>
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<tr>
<td></td>
<td>Kemper &amp; Khirallah (2015)¹⁵</td>
<td>Brief Resilience Scale</td>
<td>P = .004</td>
<td>One-h on-line modules</td>
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<tr>
<td></td>
<td>Sood et al. (2011)²²</td>
<td>Connor-Davidson Resilience Scale</td>
<td>P = .003</td>
<td>SMART program</td>
</tr>
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<td></td>
<td>Sood et al (2014)²³</td>
<td>Connor-Davidson Resilience Scale</td>
<td>NS</td>
<td>SMART program</td>
</tr>
<tr>
<td>Mindfulness</td>
<td>Chesak et al. (2015)²¹</td>
<td>Mindfulness Attention Awareness Scale</td>
<td>NS</td>
<td>SMART program</td>
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<td></td>
<td>Gauthier et al. (2015)²⁶</td>
<td>Mindfulness Attention Awareness Scale</td>
<td>NS</td>
<td>SMART program</td>
</tr>
<tr>
<td></td>
<td>Kemper (2016)²⁷</td>
<td>Mindfulness Attention Awareness Scale</td>
<td>P &lt; .01*</td>
<td>Five-minute daily guided practice</td>
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<tr>
<td></td>
<td></td>
<td>Mindfulness Attention Awareness Scale</td>
<td>P &lt; .01*</td>
<td>Five to 20-min on-line modules</td>
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<tr>
<td></td>
<td></td>
<td>Five-Facet Mindfulness Questionnaire</td>
<td>P &lt; .01*</td>
<td>Five to 20-min on-line modules</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mindfulness Attention Awareness Scale</td>
<td>P = .0002*</td>
<td>One-h on-line modules</td>
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<tr>
<td></td>
<td></td>
<td>Cognitive and Affective Mindfulness Scale</td>
<td>P = .0002*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Kemper &amp; Khirallah (2015)¹⁵</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sood et al. (2014)²³</td>
<td>Mindfulness Attention Awareness Scale</td>
<td>P = .004</td>
<td>SMART program</td>
</tr>
<tr>
<td></td>
<td>Taylor et al (2016)²⁵</td>
<td>Mindfulness Attention Awareness Scale</td>
<td>NS</td>
<td>Ten-minute daily guided practice</td>
</tr>
<tr>
<td>Burnout symptoms</td>
<td>Gauthier et al. (2015)²⁶</td>
<td>Maslach Burnout Inventory</td>
<td>NS</td>
<td>Five-minute daily guided practice</td>
</tr>
<tr>
<td></td>
<td>Mackenzie et al (2006)²⁶</td>
<td>Maslach Burnout Inventory</td>
<td>P &lt; .05</td>
<td>Thirty-minute weekly + home practice</td>
</tr>
<tr>
<td></td>
<td>Poulin et al (2008)²⁸</td>
<td>Maslach Burnout Inventory</td>
<td>NS</td>
<td>Thirty-minute weekly + home practice</td>
</tr>
<tr>
<td></td>
<td>Taylor et al (2016)²⁵</td>
<td>Maslach Burnout Inventory</td>
<td>NS</td>
<td>Ten-minute daily guided practice</td>
</tr>
<tr>
<td>Relaxation</td>
<td>Mackenzie et al (2006)²⁶</td>
<td>Smith Relaxation Dispositions Inventory</td>
<td>P &lt; .05</td>
<td>Thirty-minute weekly + home practice</td>
</tr>
<tr>
<td></td>
<td>Poulin et al (2008)²⁸</td>
<td>Smith Relaxation Dispositions Inventory</td>
<td>P &lt; .05</td>
<td>Thirty-minute weekly + home practice</td>
</tr>
<tr>
<td>Quality of Life</td>
<td>Sood et al. (2011)²²</td>
<td>Overall Quality of Life Score</td>
<td>P = .029</td>
<td>SMART program</td>
</tr>
<tr>
<td></td>
<td>Sood et al. (2014)²³</td>
<td>Overall Quality of Life Score</td>
<td>P = .044</td>
<td>SMART program</td>
</tr>
<tr>
<td></td>
<td>Poulin et al (2008)²⁸</td>
<td>Satisfaction with Life Scale</td>
<td>P &lt; .05</td>
<td>Thirty-minute weekly + home practice</td>
</tr>
<tr>
<td>Provider behavior</td>
<td>Paholpak et al (2012)²⁷</td>
<td>Self-Checklists 90 Wechsler Memory Scale, form 1</td>
<td>NS</td>
<td>Twenty-minute daily guided practice</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Raven’s Advanced Progressive matrices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Academic achievement</td>
<td>Paholpak et al (2012)²⁷</td>
<td>Psychiatric course examination score</td>
<td>NS</td>
<td>Twenty-minute daily guided practice</td>
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<tr>
<td>Medication administration errors</td>
<td>Paholpak et al (2012)²⁷</td>
<td>Observation of medication administration behaviors</td>
<td>Significance not reported</td>
<td>Mindful breathing moment prior to medication preparation and administration</td>
</tr>
<tr>
<td>Durham et al (2016)²⁵</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

CD = Compact disc; NS = P > .05; SMART = Stress Management and Resiliency Training.

*These two studies were cumulative, participants and results from the 2015 paper were included in the 2017.
<table>
<thead>
<tr>
<th>Author (Year)</th>
<th>Study Design</th>
<th>No. Participants Enrolled (Included in Analysis)</th>
<th>Setting</th>
<th>Intervention</th>
<th>Duration and Frequency of Intervention</th>
<th>Measurement Scale</th>
<th>Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brennan &amp; McGrady (2015)</td>
<td>Program Evaluation</td>
<td>n = 10 (10)</td>
<td>Hospital-based</td>
<td>Combined elements: Educational sessions and on-the-unit guided meditation</td>
<td>Single academic year; 7 resiliency lectures plus daily offering of 1- to 2-min audio-guided meditation prior to rounds</td>
<td>Qualitative interviews</td>
<td>Average age and sex not reported, 100% medical residents, years of clinical experience or previous meditation practice not reported</td>
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<tr>
<td>Chesak et al (2015)</td>
<td>Prospective two group pre/posttest randomized controlled</td>
<td>n = 55 (40) n = 27 (19) intervention n = 28 (21) control</td>
<td>Hospital-based</td>
<td>Combined elements: SMART educational session or standard nursing orientation session</td>
<td>Ninety-min single group session, randomly assigned Follow-up class offered at 4 weeks</td>
<td>Mindfulness Attention Awareness Scale, Perceived Stress Scale, Generalized Anxiety Disorder Scale, Connor-Davidson Resilience Scale</td>
<td>Intervention group: Average age = 28 years, 95% female, 84% bachelors prepared RN, 79% no previous nursing experience Control group: Average age = 28 years, 95% female, 76% bachelor’s prepared RN, 62% no previous nursing experience, previous meditation practice not reported</td>
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<tr>
<td>Durham et al (2016)</td>
<td>Program evaluation: Observational time-series</td>
<td>n = 99 (26)</td>
<td>Hospital-based</td>
<td>Combined elements: Educational session and brief mindfulness meditative exercise</td>
<td>Single 3-h group training session. Single mindful breath practice prior to every medication preparation and administration</td>
<td>Observation of medication administration practice, post-program evaluation survey</td>
<td>Average age and sex not reported, 100% RNs, 6 to 8 years’ experience, mostly baccalaureate trained, previous meditation practice not reported</td>
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<tr>
<td>Gauthier et al (2015)</td>
<td>One group pre/posttest, repeated measures</td>
<td>n = 45 (38)</td>
<td>Hospital-based</td>
<td>Guided mindfulness meditation sessions</td>
<td>Five-minute daily group sessions prior to work shift for 4 weeks</td>
<td>Nursing Stress Scale, Maslach Burnout Inventory, Mindfulness Attention Awareness Scale, Self-Compassion Scale</td>
<td>Average age = 26-39 years, 93% female, 49% day shift RN, 64% 5 years or less clinical experience, previous meditation practice not reported</td>
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<td>Kemper (2017)</td>
<td>One group pre/posttest, repeated measures</td>
<td>n = 245 (178)</td>
<td>Virtual (On-line)</td>
<td>MBSR-based “Introduction to Mindfulness,” “Mindfulness in Daily Life,” and “Mindful Breathing and Walking” modules with prerecorded meditation audio</td>
<td>Three 5- to 20-min training modules</td>
<td>Cognitive and Affective Mindfulness Scale, Mindfulness Attention Awareness Scale, Five Facet Mindfulness Questionnaire</td>
<td>Average age not reported, 85% female, 34% RNs, medical assistant, Advanced Practice Nurse, 24% physician, 20% health care trainees, years of clinical experience or previous meditation practice not reported</td>
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<tr>
<td>Author (Year)</td>
<td>Study Design</td>
<td>No. Participants Enrolled (Included in Analysis)</td>
<td>Setting</td>
<td>Intervention</td>
<td>Measurement Scale</td>
<td>Demographics</td>
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<tr>
<td>Kemper &amp; Khirallah (2015)</td>
<td>One group pre/posttest, repeated measures</td>
<td>n = 204 (204)</td>
<td>Virtual (On-line)</td>
<td>MBRS-based “Introduction to Mindfulness” and “Mindfulness in Daily Life” modules with pre-recorded meditation audio</td>
<td>Cognitive and Affective Mindfulness Scale, Brief Resilience Scale, Mindfulness Attention Awareness Scale</td>
<td>Average age and sex not reported, 44% RNs, 39% physician/physician assistant, 46% health care trainees, years of clinical experience or previous meditation practice not reported</td>
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<td>Mackenzie et al (2006)</td>
<td>Prospective 2-group pre/posttest randomized controlled</td>
<td>n = not specified how many enrolled (30) n = (16) intervention n = (14) control</td>
<td>Hospital-based</td>
<td>Brief MBRS-based group sessions or wait-list control</td>
<td>Maslach Burnout Inventory, Smith Relaxation Dispositions Inventory, Job Satisfaction subscale, Satisfaction with Life Scale, Orientation to Life Questionnaire</td>
<td>Intervention group: Average age = 49 years, 94% female, 42% RNs Control group: Average age = 45 years, 100% female, 50% RNs, years of clinical experience or previous meditation practice not reported</td>
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<td>Paholpak et al (2012)</td>
<td>Prospective 2-group pre/posttest randomized controlled</td>
<td>n = 58 (58) n = 30 (30) intervention n = 28 (28) control</td>
<td>Medical School-based</td>
<td>Buddhist Anapanasati breathing meditation or nonmeditating activities (eg reading, chatting, napping)</td>
<td>Self-Checklists 90, Wechsler Memory Scale, form one, Raven’s Advanced Progressive matrices, academic achievement using a psychiatric course examination score</td>
<td>Intervention group: Average age = 23 years, 50% female, 100% 5th year medical students Control group: Average age = 23 years, 50% female, 100% 5th year medical students, years of clinical experience or previous meditation practice not reported</td>
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<td>Poulin et al (2008)</td>
<td>Quasi-experimental 3-group pre/posttest nonrandomized controlled</td>
<td>n = not specified how many enrolled (40) n = (16) MBSR intervention n = (10) bIPMR n = (14) control</td>
<td>Hospital-based</td>
<td>Brief MBSR-based group sessions or bIPMR program or control</td>
<td>Maslach Burnout Inventory, Satisfaction with Life Scale, Smith Relaxation Disposition Inventory</td>
<td>MBSR group: Average age = 49 years, 94% female, 69% nurses bIPMR group: Average age = 46 years, 80% female, 20% nurses Control group: Average age = 45 years, 100% female, 64% nurses Years of clinical experience or previous meditation practice not reported</td>
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<td>Intervention</td>
<td>Duration and Frequency of Intervention</td>
<td>Measurement Scale</td>
<td>Demographics</td>
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<tr>
<td>Ratanasiripong et al (2015)</td>
<td>Prospective three group pre/posttest randomized controlled</td>
<td>n = 90 (89) n = 29 (29) mindfulness intervention n = 29 (29) biofeedback intervention n = 31 (31) control group</td>
<td>Nursing school-based</td>
<td>Vipassana meditation or biofeedback or control</td>
<td>Two trainings of unknown duration of meditation or biofeedback, plus home practice 3 times per day for 4 weeks.</td>
<td>Perceived Stress Scale, State-Trait Anxiety Inventory</td>
<td>Average age = 19 years, 100% female, 100% 2nd-year nursing students, years of clinical experience or previous meditation practice not reported</td>
</tr>
<tr>
<td>Sood et al (2011)</td>
<td>Prospective 2-group pre/posttest randomized control</td>
<td>n = 40 (32) n = 20 (20) intervention n = 20 (12) control</td>
<td>Hospital-based</td>
<td>Combined elements: SMART educational session or wait-list control</td>
<td>Ninety-min, one-on-one session, plus 5 to 15 min of home breathing practice twice a day for 8 weeks 30-60-min optional follow-up session</td>
<td>Connor-Davidson Resilience Scale, Perceived Stress Scale, Smith Anxiety Scale, Overall Quality of Life Score, Fatigue score</td>
<td>Intervention group: Average age = 47 years, 45% females, 100% physicians Control group: Average age = 50 years, 50% females, 100% physicians Years of clinical experience or previous meditation practice not reported</td>
</tr>
<tr>
<td>Sood et al (2014)</td>
<td>Prospective 2-group pre/posttest randomized control</td>
<td>n = 30 (26) n = 13 (13) intervention n = 13 (13) control</td>
<td>Hospital-based</td>
<td>Combined elements: SMART educational session or wait list control</td>
<td>Ninety-min, small group session, plus 5 to 15 min of home breathing practice 1 to 2 times a day for 8 weeks 30- to 60-min optional follow-up session and 2 follow-up phone calls at 4 and 8 weeks</td>
<td>Perceived Stress Scale, Smith Anxiety Scale, Mindfulness Attention Awareness Scale, Connor-Davidson Resilience Scale, Overall Quality of Life Score</td>
<td>Intervention group: Average age = 47 years, 45% female, 100% physicians Control group: Average age = 48 years, 50% female, 100% physicians Years of clinical experience or previous meditation practice not reported</td>
</tr>
<tr>
<td>Taylor et al (2016)</td>
<td>One group pre/posttest, repeated measures</td>
<td>n = 33 (11)</td>
<td>Virtual (smart phone application)</td>
<td>Free, mindfulness meditation smart phone application</td>
<td>Ten-day program consisting of 10-min recording of educational material and short guided meditation</td>
<td>Maslach Burnout Inventory, Mindfulness Attention Awareness Scale</td>
<td>Average age and sex not reported, 100% medical residents, 71% reported previous meditation practice</td>
</tr>
<tr>
<td>Warnecke et al (2011)</td>
<td>Prospective 2-group pre/posttest randomized control</td>
<td>n = 66 (65) n = 31 (19) intervention n = 34 (32) control</td>
<td>Virtual (Audio compact discs)</td>
<td>Audio compact disc guided mindfulness practice or wait-list control</td>
<td>Thirty-minute audio guided mindfulness sessions for daily practice over 8 weeks</td>
<td>Perceived Stress Scale, Depression, Anxiety and Stress Scale</td>
<td>Intervention group: Average age = 23 years, 74% female, 100% 3rd-year medical students Control group: Average age = 24 years, 56 female, 100% 3rd-year medical students Years of clinical experience or previous meditation practice not reported</td>
</tr>
</tbody>
</table>

bIPMR = brief imagery and progressive muscle relaxation; CD = compact disc; MBSR = mindfulness-based stress reduction; MD = physician; RN = registered nurse; SMART = Stress Management and Resilience Program.
mindfulness in clinical care by including a mindful breath in a preprocedural medication administration checklist. In this way, mindfulness may promote switching from a state of automatic pilot to one of cognitive awareness, enabling a more thoughtful approach to clinical decision-making.

As illustrated in our review, health systems may select from several mindfulness interventions and offer them in various formats to enhance provider engagement. For example, virtual interventions, such as on-line modules, audio CDs, or smartphone apps are convenient ways to introduce providers to mindfulness. To increase engagement, these components may be paired with group sessions on the unit or with co-workers. Compared with traditional mindfulness interventions, the brief programs demand minimal time away from patient care activities and limited capital investment. Thus, they may be better suited to providers in health care settings.

Our review must be interpreted in the context of several limitations. First, systematic reviews are observational studies and can assess association, not causality. Second, inclusion of myriad study designs and populations introduces clinical and methodological heterogeneity, which may influence outcomes. Further, most studies were of moderate quality due to the omission of data pertaining to exposure and dose of the intervention, limiting generalizability and reliability of results. These limitations reflect the quality of this literature and suggest that methodologically rigorous studies are needed to unlock the potential of this science.

Despite these limitations, this is the first systematic review to examine the impact of brief mindfulness interventions in a health care setting. Our findings advance knowledge and provide deeper insights into this growing field of interest. Second, this systematic review was methodologically rigorous, with a thorough literature search and stringent inclusion and exclusion criteria to improve reliability. Third, the review was guided by previous research that concluded that participation in mindfulness-based stress-reduction programs benefits provider well-being, brief mindfulness interventions may be important in improving provider well-being.

The finding that brief interventions improved perceptions of stress and anxiety, in keeping with other forms of mindfulness interventions, is encouraging. However, it is important to note that not all interventions improved study outcomes. For example, the influence of brief mindfulness on resiliency, burnout, and state-trait mindfulness varied across studies. While the reasons for such variation are difficult to discern from this review, we theorize that brief, periodic practice over 4 to 12 weeks may not be enough of a dose to improve these dimensions. Future, more rigorous studies that include longer follow-up to evaluate the sustainability of brief mindfulness interventions on well-being thus appear necessary.

Substantial variability in the intervention approaches, dose, duration, population, and setting were observed between studies. For example, 4 mindfulness interventions tested over 1- to 30-minute sessions, for 1 to 12 weeks, with nurses and physicians from diverse demographic backgrounds, in 6 assorted settings, were tested. In the 6 studies that evaluated provider stress, different mindfulness interventions were used, while 3 interventions were used in the 5 studies that examined anxiety. Although 6 of 11 studies recommended daily mindfulness practice at home, only one study reported adherence via self-report. Dedicated studies that use standardized interventions, dose, and durations would help advance this field of inquiry.

Notably, the brief interventions included in this review were adapted to increase accessibility by providers. For example, by providing on-the-unit mindfulness interventions in 1- to 5-minute sessions, Gauthier et al found that when given the opportunity (eg, prior to starting a shift or rounds), the setting (eg, a quiet room on the unit), and the tools (eg, guided meditation), providers can effectively learn strategies to self-manage their reactions to stressful work environments. Similarly, Durham et al embedded mindfulness in clinical care by including a mindful breath in a preprocedural medication administration checklist. In this way, mindfulness may promote switching from a state of automatic pilot to one of cognitive awareness, enabling a more thoughtful approach to clinical decision-making.

As illustrated in our review, health systems may select from several mindfulness interventions and offer them in various formats to enhance provider engagement. For example, virtual interventions, such as on-line modules, audio CDs, or smartphone apps are convenient ways to introduce providers to mindfulness. To increase engagement, these components may be paired with group sessions on the unit or with co-workers. Compared with traditional mindfulness interventions, the brief programs demand minimal time away from patient care activities and limited capital investment. Thus, they may be better suited to providers in health care settings.

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Despite these limitations, this is the first systematic review to examine the impact of brief mindfulness interventions in a health care setting. Our findings advance knowledge and provide deeper insights into this growing field of interest. Second, this systematic review was methodologically rigorous, with a thorough literature search and stringent inclusion and exclusion criteria to improve reliability. Third, the review was guided by previous research that concluded that participation in mindfulness-based stress-reduction programs benefits the well-being of providers, but time and scheduling requirements inhibit participation and practice. Finally, our review suggests that the type of mindfulness-based training may be less important than adaptation to provider setting and schedule. Future studies should consider these elements when designing mindfulness interventions.

References


APPENDIX A
Ovid Medline: N = 1012

Mindfulness Block
1) exp Relaxation Therapy/ or exp Mindfulness/ or exp Meditation/ or “mindfulness*”.m_titl. or “stress management”.m_titl. or (mindfulness or psychological well*being or mental well*being or reflective practice or contemplative practice or psychological health or mini*meditations or stress reduction or mantra or mind*body or self*hypnosis).mp.
N = 16,421
AND

Population Block
2) Physician*.mp. or exp Physicians/ or nurse*.mp. or exp Nurses/ or student*.mp. or exp “Internship and Residency”/ or hospitalist*.mp. or exp Hospitalists/ or health care provider*.mp. or exp Health Personnel/
N = 1,122,315
AND

Intervention Block
3) intervention.mp. or exp “Early Intervention (Education)”/ or exp Simulation Training/ or exp Training Support/ or exp Computer User Training/ or training.mp. or exp Inservice Training/ or exp Sensitivity Training Groups/ or exp Education, Nursing, Diploma Programs/ or exp Self-Evaluation Programs/ or instruction.mp.
N = 713,653
4) 1 AND 2 AND 3
N = 1011

Sentinel Article Block
5) A brief mindfulness-based stress reduction intervention for nurses.m_titl. or (enhancing the resilience of nurses and midwives).m_titl. or A systematic review of stress-management programs for medical students.m_titl. or An on-the-job mindfulness-based intervention for pediatric ICU.m_titl. or A brief mindfulness-based stress reduction intervention for nurses.m_titl.
6) 4 AND 5
N = 5

CINAHL/PsychINFO: N = 19

1) (“Relaxation Therapy”/exp) OR (“Mindfulness”/exp) OR (“Meditation”/exp) OR mindfulness*:ab,ti OR stress management:ab,ti OR mental well*being:ab,ti OR psychological well*being:ab,ti OR mental well*being:ab,ti OR reflective practice:ab,ti OR contemplative practice:ab,ti OR psychological health:ab,ti OR mini*meditations:ab,ti OR stress reduction:ab,ti OR mantra:ab,ti OR mind*body:ab,ti OR self*hypnosis:ab,ti
N = 61,337
2) (MH “Physicians”) or (MH “Nurses”) or (MH “Students”) or (MH “Internship”) (MH “Residency”) or (MH “Hospitalists”) or (MH “Health Personnel”) or “Physician*” or “nurse*” or “student*” or “hospitalist*” or “health*care provider*”
N = 1,314,429
N = 17,563
4) 1 AND 2 AND 3
N = 19

Cochrane/EBM Reviews: N = 426

1) ((relaxation therapy) or (mindfulness) or (meditation stress management) or (psychological general well being) or (reflectiveness) or (contemplativeness) or (psychological general well being) or (stress management) or (mantra) or (self hypnosis)):ti,kw,ab)
N = 7195
2) (((physician) or (nurse) or (student) or (internship) or (residency) or (hospitalist) or (health care provider) or (residency) or (health personnel)):ti,kw,ab)
N = 33,320
3) ((intervention) or (early intervention) or (simulation training) or (simulation based training) or (training support) or (computer user training) or (training) or (inservice training) or (sensitivity training groups) or (education) or (nursing program) or (self-evaluation program) or (instruction)):ti,kw,ab)
N = 17,563
4) 1 AND 2 AND 3
N = 426

Embase: N = 137

1) (“Relaxation Therapy”/exp) OR (“Mindfulness”/exp) OR (“Meditation”/exp) OR mindfulness*:ab,ti OR stress management:ab,ti OR mindfulness:ab,ti OR psychological well*being:ab,ti OR mental well*being:ab,ti OR reflective practice:ab,ti OR contemplative practice:ab,ti OR psychological health:ab,ti OR mini*meditations:ab,ti OR stress reduction:ab,ti OR mantra:ab,ti OR mind*body:ab,ti OR self*hypnosis:ab,ti
N = 61,337
2) (“Physicians”/exp) or (“Nurses”/exp) or (“Students”/exp) or (“Internship”/exp) (“Residency”/exp) or (“Hospitalists”/exp) or (“Health Personnel”/exp) or Physician*:ab,ti or nurse*:ab,ti or student*:ab,ti or hospitalist*:ab,ti or health*care provider*:ab,ti
N = 79,513
3) (“intervention”/exp) OR (“Early Intervention”/exp) OR (“Simulation Training”/exp) OR (“Training Support”/exp) OR (“Computer User Training”/exp) OR (“training”/exp) OR (“Inservice Training”/exp) OR (“Sensitivity
Training Groups”/exp) OR (“Education”/exp) OR (“Nursing program”/exp) OR (“Self-Evaluation Programs”/exp) or (“instruction”/exp)
N = 1,783,527

4) 1 AND 2 AND 3
N = 137
Web of Science: N = 1329

1) (((TS = (relaxation therapy) OR TS = (mindfulness) OR TS = (meditation)) OR (TI = (mindfulness OR stress management OR psychological well*being OR mental well*being OR reflective practice OR contemplative practice OR psychological health OR mini*meditations OR stress reduction OR mantra OR mind*body OR self*hypnosis))))
N = 25,200

2) (TS = (physician) OR TS = (nurse) OR TS = (student) OR TS = (internship) OR TS = (residency) OR TS = (hospitalist) OR TS = (Health personnel)) OR ((TI = (physician* OR nurse* OR student* OR hospitalist* OR health*care provider* OR health personnel))
N = 744,386

3) (TS = (intervention) OR TS = (early intervention) OR TS = (simulation training) OR TS = (training support) OR TS = (computer user training) OR TS = (training) OR TS = (inservice training) OR TS = (sensitivity training groups) OR TS = (education) OR TS = (nursing program) OR TS = (self evaluation) OR TS = (Instruction))
N = 1,494,766

4) 1 AND 2 AND 3 AND LANGUAGE: (English) Indexes = SCI-EXPANDED, SSCI, A&HCI, ESCI, CCR-EXPANDED Timespan = All years
N = 1329

Search Update
Using the same search strategy as above, the search results were updated on January 25, 2017 by setting date restrictions to allow only articles published after the date of the original search. A total of 598 articles were found containing 92 duplicates. The remaining 506 articles were reviewed for inclusion.

APPENDIX B

Quality Assessment Quantitative Studies (Downs and Black Scale)

<table>
<thead>
<tr>
<th>Study</th>
<th>Reporting (Max 11)</th>
<th>External Validity (Max 3)</th>
<th>Internal Validity Bias (Max 7)</th>
<th>Internal Validity Confounding (Max 6)</th>
<th>Overall Score (Max 28)</th>
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Max = maximum; SD = standard deviation.
APPENDIX C

Quality Assessment Qualitative Study (Critical Appraisal Skills Program Tool)

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<th>Study</th>
<th>Validity Score</th>
<th>Results Score</th>
<th>Overall Score</th>
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<td>Brennan &amp; McGrady (2015)</td>
<td>2/8 (low)</td>
<td>1/2 (low)</td>
<td>3/10 (low)</td>
<td>Low</td>
</tr>
</tbody>
</table>

PROSPERO International prospective register of systematic reviews

Review title and timescale

1 Review title
A systematic review of informal mindfulness practices in health care providers

2 Original language title
For reviews in languages other than English, this field should be used to enter the title in the language of the review. This will be displayed together with the English language title.

3 Anticipated or actual start date
February 16, 2016

4 Anticipated completion date
December 30, 2016

5 Stage of review at time of this submission
Indicate the stage of progress of the review by ticking the relevant boxes. Reviews that have progressed beyond the point of completing data extraction at the time of initial registration are not eligible for inclusion in PROSPERO. This field should be updated when any amendments are made to a published record.

The review has started.

Review stage
Preliminary searches Yes
Piloting of the study selection process Yes
Formal screening of search results against eligibility criteria Yes
Data extraction Yes
Risk of bias (quality) assessment Yes
Data analysis No

Provide any other relevant information about the stage of the review here.

Review team details

6 Named contact
Jason Mann

7 Named contact email
majason@umich.edu

8 Named contact address
University of Michigan
Internal Medicine-General Medicine NCRC, Building 16, room 430w
Ann Arbor MI 48109-2800

9 Named contact phone number
734-232-1133

10 Organizational affiliation of the review
Full title of the organizational affiliations for this review, and website address if available. This field may be completed as “None” if the review is not affiliated to any organization.

Website address:

11 Review team members and their organizational affiliations
Give the title, first name and last name of all members of the team working directly on the review. Give the organizational affiliations of each member of the review team.

<table>
<thead>
<tr>
<th>Title</th>
<th>First name</th>
<th>Last name</th>
<th>Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr</td>
<td>Heather</td>
<td>Gilmartin</td>
<td>Denver VA Medical Center, Denver, CO</td>
</tr>
<tr>
<td>Dr</td>
<td>Vineet</td>
<td>Chopra</td>
<td>University of Michigan Health System</td>
</tr>
<tr>
<td>Mr</td>
<td>Jason</td>
<td>Mann</td>
<td>University of Michigan Health System</td>
</tr>
<tr>
<td>Ms</td>
<td>Mary</td>
<td>Hamati</td>
<td>University of Michigan Health System</td>
</tr>
<tr>
<td>Dr</td>
<td>Anu</td>
<td>Gopal</td>
<td>University of Michigan Health System</td>
</tr>
</tbody>
</table>

Funding sources/sponsors
Give details of the individuals, organizations, groups or other legal entities that take responsibility for initiating, managing, sponsoring and/or financing the review. Any unique identification numbers assigned to the review by the individuals or bodies listed should be included.
13 Conflicts of interest
List any conditions that could lead to actual or perceived undue influence on judgments concerning the main topic investigated in the review.

Are there any actual or potential conflicts of interest?
Dr. Gilmartin: No actual or potential conflicts of interest to report
Jason Mann: No actual or potential conflicts of interest to report
Mary Hamati: No actual or potential conflicts of interest to report
Dr. Chopra: No actual or potential conflicts of interest to report
Dr. Gopal: No actual or potential conflicts of interest to report

14 Collaborators
Give the name, affiliation and role of any individuals or organizations who are working on the review but who are not listed as review team members.

<table>
<thead>
<tr>
<th>Title</th>
<th>First name</th>
<th>Last name</th>
<th>Organization details</th>
</tr>
</thead>
</table>

Review methods

15 Review question(s)
The first review question is to determine whether informal mindfulness practices have been formally studied in the peer-reviewed literature. Our specific focus is on the inpatient, hospital setting and how mindfulness practices by direct healthcare providers influence their clinical practice. The second question derives from the first: if there is an influence on clinical practice, and if so, what outcomes are modified?

16 Searches
The research will be limited to English language articles published in peer-reviewed journals. The literature search will be performed in a wide range of databases that include literature from business, theology, philosophy, psychology, and social work. The search will also be conducted in the traditional healthcare databases, such as CINHAL, EMBASE, MEDLINE, PubMed, PsychINFO, EBM Reviews, Web of Science, and the GoogleScholar database.

17 URL to search strategy
If you have one, give the link to your search strategy here. Alternatively you can e-mail this to PROSPERO and we will store and link to it.
I give permission for this file to be made publicly available
Yes

18 Condition or domain being studied
This review will target both formal and informal mindfulness practices. The conditions to be targeted include state and trait mindfulness, attentional awareness, modified cognition, perceived modified procedural or cognitive practice, modified risk of diagnostic errors, and patient safety or infection prevention, positive or negative affect, psychological or mental well-being, self-reflection, self-contemplation, psychological health, work related stress, burnout, resilience, quality of work life, and quality of life.

19 Participants/population
The population of interest is adult (>18 years old) healthcare providers, specifically practicing nurses, physicians and student nurses and physicians who work in the hospital setting. Clinical units of interest include the operating room, critical care/intensive care, emergency, and acute medical and surgical care units. Context exclusion criteria are healthcare providers in primary care, outpatient, long-term care, or office-based settings. Population exclusion criteria include psychologists, psychiatrists, social workers, and others in professional counseling roles.

20 Intervention(s), exposure(s)
Informal mindfulness meditation-based interventions (4 hours or less of formal education, training, or practice).

21 Comparator(s)/control
Comparators include formal mindfulness meditation-based interventions (>5 hours of formal education, training or practice) and other types of meditation (eg, reflective, mantra) or no active intervention of any kind (control/usual care).

22 Types of study to be included initially
We will place no restrictions on the types of studies to be included.

23 Context
The inpatient hospital setting, specifically the operating room, critical care/intensive care, emergency, and acute medical and surgical care units. Context exclusion criteria are healthcare providers in primary care, outpatient, long-term care, or office-based settings.

24 Primary outcome(s)
Tasks of attention; enhanced cognition; reduction in diagnostic errors; enhanced task awareness; enhanced performance on tasks of attention and sustained attention; regulation of attention; greater attention regulation capacity; improvement in attention abilities; other measures of cognitive or performance-oriented capacity in the same theme as above.

25 Secondary outcomes
Prevention of medical errors; prevention of healthcare-associated infections; prevention of catheter-associated urinary tract infections; prevention of central line-associated bloodstream infections; prevention of surgical site infections; improved hand hygiene performance or other measures of improved outcomes relevant to the inpatient setting. Self reported changes to affect; psychological or mental well-being; self-reflection, self-contemplation, psychological health, work related stress, burnout, resilience, quality of work life, or quality of life.
Data extraction, (selection and coding)
Three reviewers will independently extract the following data from each of the included articles: general information (authors, year, study design, study sample, number and type of healthcare providers), type of intervention, outcomes measured, instruments used and main findings. The reviewers will independently enter data into a table and compare information to check for accuracy. If extracted data are discrepant, the first author will return to the original article to clarify the correct information. We will contact study authors to obtain relevant missing data, as needed.

Risk of bias (quality) assessment
We will systematically assess risk of bias to weigh the evidence. Methodological quality of the studies will be assessed using the Downs and Black and GRADE tool for assessing the risk of bias and quality of quantitative studies. For qualitative studies, the CASP tool will be used. In both instances, rating of bias will be performed independently by a minimum of two reviewers. Discrepancies will be resolved through discussions involving all authors.

Strategy for data synthesis
We will provide a narrative synthesis of the findings from the reviewed studies, structured around the type of outcome. We anticipate that there will be limited scope for meta-analysis because of the range of different study designs and different outcomes measured. We will work to create a conceptual framework in which to organize this literature.

Analysis of subgroups or subsets
We may elect to evaluate effects using a conceptual framework based on the context of the intervention, type of intervention, or outcome measured. Analysis will be restricted to descriptive findings. No quantitative data synthesis is proposed given the expected heterogeneity in the studies retrieved.

Type of review
Select the type of review from the drop down list.

Language
Select the language(s) in which the review is being written and will be made available, from the drop down list. Use the control key to select more than one language.

Will a summary/abstract be made available in English?

Country
Select the country in which the review is being carried out from the drop down list. For multi-national collaborations select all the countries involved. Use the control key to select more than one country.

Other registration details
Give the name of any organization where the systematic review title or protocol is registered together with any unique identification number assigned. If extracted data will be stored and made available through a repository such as the Systematic Review Data Repository (SRDR), details and a link should be included here.

Reference and/or URL for published protocol
Give the citation for the published protocol, if there is one.
Give the link to the published protocol, if there is one. This may be to an external site or to a protocol deposited with CRD in pdf format.

I give permission for this file to be made publicly available

Yes

Dissemination plans
We will publish the review on completion and anticipate presenting at research and hospital conferences, based on interest.

Keywords
Mindfulness, psychological health, nurses, physicians, tasks of attention, prevention of medical errors, inpatient, hospital

Details of any existing review of the same topic by the same authors
Give details of earlier versions of the systematic review if an update of an existing review is being registered, including full bibliographic reference if possible.

Current review status
Review status should be updated when the review is completed and when it is published.

Any additional information
Provide any further information the review team consider relevant to the registration of the review.

Details of final report/publication(s)
This field should be left empty until details of the completed review are available. Give the full citation for the final report or publication of the systematic review.
Give the URL where available.