RESEARCH ARTICLE

# Pediatric Schwartz Rounds: Influencing Provider Insights and Emotional Connectedness

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ABSTRACT

**BACKGROUND AND OBJECTIVES:** Schwartz Rounds (SR) is an interdisciplinary program that focuses on compassionate care by allowing the formation of an interprofessional community around the human and emotional testimonies of caregivers. The purpose of this study was to examine the impact of implementing departmental SR on pediatric care providers at a tertiary care children's hospital in New York.

**METHODS:** We applied the logic outcomes model for program evaluation to examine the impact of SR on pediatric providers. The standard evaluation form provided by the Schwartz Center was used to collect data after every SR. Descriptive statistics and qualitative data content analysis methods were used to analyze the evaluation data from the SR.

**RESULTS:** A total of 820 standard evaluation forms were collected from 17 of the 23 SR sessions offered (response rate: 74.8%). Most participants felt that, during the SR sessions, challenging social and emotional aspects of patient care were discussed and that they gained better perspectives of their coworkers and their patients/families. They reported less isolation and more openness to express their feelings about patient care to their coworkers. The analysis of 299 written comments identified 5 themes: understanding other people's perspectives, the importance of communication, empathy and compassion, awareness of personal biases, and maintaining boundaries.

**CONCLUSIONS:** Schwartz Rounds can provide an effective venue for pediatric care providers to gain insights into coworker and patient/family perspectives and process emotional experiences while providing patient care in a variety of circumstances.

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In recent years, there has been an increased focus on the wellness of health care providers.[1] Whereas most studies focus on burnout and its impact on patient care, namely, increased risk of patient safety lapses, decreased quality of care, and diminished patient satisfaction,[2–5] few have focused on personal and institutional factors that enhance provider wellness. The Accreditation Council for Graduate Medical Education and the American Board of Pediatrics Personal and Professional Development competency identifies components of provider wellness, including the formation of supportive social connections and increased self-awareness.[6] Schwartz Center Rounds can help support the goals of this competency by impacting health care providers and, thereby, indirectly improving patient care.[7]

The Schwartz Center for Compassionate Care was started in 1994 by Kenneth Schwartz, a 40-year-old terminally ill man.[8] In the Boston Globe, Schwartz recounted how "the smallest acts of kindness" made "the unbearable bearable." He recognized the need for expanding compassion in health care and giving health care providers the opportunity to process their experiences.[8] The mission statement of the Schwartz Center for Compassionate Care is: "to put compassion at the heart of health care through programs, education and advocacy" in "a world where all who seek and provide health care experience compassion."[8] The flagship program of the Schwartz Center is Schwartz Rounds (SR), a multidisciplinary discussion forum to help providers engage and discuss elements of their work that are not generally explored. SR focuses on compassionate care by allowing an interprofessional community to form around the human and emotional testimonies of caregivers, usually centered on their coping with a salient patient case that challenged their professional and moral identity. SRs are not about the case so much as the responses to it and how unveiling this human side of professional life can bring the care providers together with a renewal of empathic community that spills over into professional wellbeing and rededication to compassionate patient care.

In a systematic review of research on SR, there was a high degree of self-reported positive impact among attendees.[9] Two unique factors that differentiated SR from other similar interventions include openness to all health care providers and team members, regardless of title, and that there were no expectations, advance preparation, or speaking obligations. In other studies on the impact of SR, several common themes have emerged. Among them is the improvement in insight regarding how colleagues and patients/families think and feel.[10–12] Research suggests that attendees may be more likely to consider the psychosocial and emotional implications of patient care and focus on empathy and teamwork.[13] This has the potential to lead to a culture shift in some institutions.

The data in pediatric-specific SRs are more limited. In 2019, Silke et al[14] studied the impact of SR in a pediatric setting in Ireland. SR attendees had a positive perception of the program, but further impact has not been studied. In general, SR is believed to be associated with improvements in insight, connectedness, and empathy among health care providers, both nonclinical and clinical. Previous research has discussed the unique impact of caring for children on provider wellbeing[15]; however, the specific effects of SR on pediatric care providers have not been studied. In this study, we examine the impact of implementing departmental SR on pediatric care providers at a tertiary care children's hospital in New York by analyzing qualitative and quantitative evaluation data from participants, with a focus on its impact on shifts in perspective among pediatric providers.

## METHODS

### Context and Logistics

Schwartz Rounds began at Stony Brook Children's in the spring of 2015. Two physicians served as coleaders; the leader joined the group as a facilitator. The leaders took part in standard Schwartz Center training, including attendance at an SR at another institution, online modules, and coaching from Schwartz Center personnel. Continuing medical education credits were arranged to be awarded for SR participation. Funding for membership in the Schwartz Center and related expenses were originally provided by the department of pediatrics and subsequently through the New York hospital association. An interdisciplinary committee was formed, consisting of physician coleaders, a facilitator, nurses, social workers, and child life leadership, chaplaincy, and administrative support, to help guide programming. The first SR at Stony Brook Children's was held in July 2015.

The SR committee meets monthly to plan upcoming SRs and critically evaluate previous sessions. The committee brainstorms topics, either through the framework of memorable cases that resonated or caused moral injury, or broader topics of interest, which are often linked to illustrative cases. Once a topic is chosen, the committee members select and invite possible panelists (2–4). Effort is taken to choose a multidisciplinary panel. Parents of patients have also been included occasionally as panelists. The facilitator and physician coleaders then coordinate a "dry-run" with the panelists. The dry-run is an opportunity to provide "on-boarding" regarding SR, including the overall goals of the program, the structure of SR, and the way in which it differs from other case-based discussions (such as morbidity and mortality or quality improvement conferences). Panelists hear the overall goals for the session and discuss the case and/or topic. The facilitators and physician coleaders ask questions and probe deeper into discussion points raised by the panelists. Physician coleaders summarize the discussion and send a summative e-mail to the panelists, also encouraging them to bring their own notes to SR to remember important points.

An administrative support person advertises SR via e-mail to the department

of pediatrics, including faculty, staff, and trainees. Participants are requested to RSVP and cannot enter >5 minutes later than the posted starting time, to maintain a "safe space" for participants and panelists. A meal is served to participants. The facilitator introduces SR, including reminders for participants to shut off their devices and reviewing the concepts of "circles of trust" (a space, as defined by Parker Palmer,[16] which allows participants to" rejoin[ing] soul and role,") and confidentiality. SR last for ~1 hour, with 5 minutes of introduction, 5 minutes of case/topic discussion by one of the physician coleaders (designed to help panelists avoid reporting facts and focus on their personal experience), 5 to 7 minutes for each panelist, and an open conversation with the participants, who are encouraged to share their own experiences and insights. Physician coleaders develop a curated list of provocative questions for both panelists and participants, which they use as needed to further spark discussion or highlight certain points. These questions are not previously known to the panelists or participants. The facilitator then uses the last 5 minutes to summarize the discussion that has taken place.

## Data Collection and Analysis

The Schwartz Center provides a standard evaluation form, given to participants at the start of SR. The evaluation asks participants to identify their discipline but is anonymous. The evaluation consists of 10 questions with the choices No/Yes/Not Sure/No Response, and a question about the overall experience, which is rated on a 5-point Likert-type scale (1 = Poor, 5 = Excellent). There is also an area for free-text responses related to the ways in which the current SR "will change how you relate to or communicate with patients and/or colleagues" and future suggestions for SR. Evaluations are collected in real time and results are summarized. This study was exempt from institutional review board approval (IRB2020-00560) given that data were collected anonymously and in the practice of routine Schwartz Rounds procedures.

We used the logic outcomes model for program evaluation because it is an effective way to present and explain to relevant stakeholders the outcomes and impact of a program based on the resources and inputs needed to start and sustain it.[17] In addition to presenting the results of our program activities (or input), the logic outcomes model also describes the sequence and connection of related events so that it can serve as a road map for other institutions that are interested in establishing an SR program. Table 1 illustrates each component of the model with corresponding descriptions of our SR program. Descriptive statistics (frequencies and percentages) and qualitative data content analysis methods were used to analyze the output and outcomes data.

Content analysis of the free-text responses was performed to identify emergent themes. The content analysis was completed by 2 reviewers (Drs Meyer and Lu), 1 with extensive training in qualitative methodology (Dr Lu), with the aim of identifying themes elicited and discussed in each session. The reviewers also interpreted emotions alluded to by participants in the evaluation comments. After their independent analyses, the reviewers began an iterative process beginning with a discussion of their coding of the data. This led to an agreement regarding broad categorizations that could be directly linked to raw data. Software was not used for this analysis. The reviewers then methodically coded and recoded text as necessary for clarity and brevity. These categorizations were ultimately reviewed and refined by the research team as a whole (members of whom have experience and familiarity with qualitative methodology). Although some data points could be assigned to unique categories, many represented >1 theme and were therefore cross-categorized.

# RESULTS

## Outputs

From the inaugural SR conducted at our institution in July 2015 through January 2019, 23 sessions have occurred. Altogether there were 1359 participants (cumulatively over the 23 sessions), with many participants that have attended >1 session. Of the 23 SR sessions, standard evaluation forms were available for analysis from 17 sessions. In the 17 SR sessions, 1096 participants attended, and 820 standard evaluation forms were collected (overall response rate: 74.8%). Session participants represent various disciplines of health care, including physicians (32.1%), nurses (22.9%), medical students (19.4%), and other disciplines, such as social workers, chaplains, child life specialists, and administrative staff. Table 2 lists the titles, descriptions, participant numbers, and evaluation forms collected for each session.

## Outcomes

Almost all participants (99%) indicated that the session they attended had discussed challenging social and emotional aspects of patient care. A majority felt that the discussion gave them new insights into the perspectives of their coworkers (95.6%) as well as of patients and/or families (92.5%); 77.3% felt better prepared to handle tough or sensitive patient situations after attending SR. As a result of the discussions, 77% stated they felt less isolated in their work with patients and 89.6% felt more open to expressing thoughts, questions, and feelings about patient care with colleagues; 94.5% noted that they plan to attend SR again and 98% of the participants thought the discussions were well-facilitated. In terms of the overall experience, 72.7% of participants rated it as "Excellent," whereas 26% rated the experience as "Good." No one rated the SR session experience as "Poor."

A total of 299 participant written comments were reviewed and 5 emergent themes were identified. The 5 themes are as follows:

### Theme 1: Understanding Other People's Perspectives

A better understanding of the perspectives of colleagues as well as patients and their families was the most prevalent

**TABLE 1** Stony Brook Children's Hospital Department of Pediatrics Schwartz Center Rounds Program Evaluation Using the Logic Outcomes Model

| Logic Outcomes Model Components | Description |
|---|---|
| Resources/inputs (What resources does the program need?) | Funding for Schwartz Center membership |
| | Leadership support from various health care disciplines |
| | Administrative support |
| | Faculty and staff time |
| | Funding for meals |
| Activities (What does the program do with the resources/inputs?) | Schwartz Rounds committee monthly planning meetings |
| | Dry-runs with panelists |
| | Regular institution-wide advertisement |
| | Schwartz Rounds bimonthly sessions |
| Outputs (What are the direct products of the program activities?) | Number of Schwartz Rounds sessions |
| | Number of participants |
| | Number of Schwartz Rounds standard evaluations |
| Outcomes (What are the short-term, specific benefits of participation in the program?) | Informal feedback from program participants |
| | Formal feedback, including identification of themes on the impact of program participation by pediatric care providers |
| | Allowed opportunities for health care providers to share insights, become self-aware, feel a sense of connectedness, and foster empathy toward one another |
| Impact (What are the fundamental or unintended changes that occurred within the institution as a result of the program?) | Regular participants of the program may experience increased emotional wellbeing, professional satisfaction and interprofessional connectedness |

(56 comments) theme from participant comments. Being able to "walk in their shoes when discussing plan of care" as well as "recognizing their [patients'] underlying feelings" and "understanding where patient frustration may be coming from" were 2 examples. The sessions that received these comments were sessions that evoked emotions of frustration, anger, and anxiety.

### Theme 2: Importance of Communication

The second most frequent theme (40 comments) was the importance of communication and being able to listen. "Listening more," "communicating with greater clarity," and realizing that "open, multidisciplinary discussions are needed" are examples that participants stated. The sessions that received these comments were those that evoked emotions related to frustration and helplessness.

### Theme 3: Empathy and Compassion

Having more empathy, compassion, and patience toward patients and their families was the third most reviewed theme (26 comments); specifically, being more compassionate and patient toward "special needs moms," "psychiatric patients" and "non-English speaking families." Also, "empathizing with the families and remembering to make them involved in the decision process" as well as "empathize towards health care workers that receive anger from upset patients" were thoughts shared by the participants. The sessions that involved themes of empathy and compassion evoked emotions of helplessness and hopelessness.

### Theme 4: Awareness of Personal Biases

Being conscious of one's own biases was the fourth most identified theme (23 comments). Participating in SR reminded providers "not to discriminate," self-reflect more to "mitigate personal biases that could affect patient care," and to "remember not to pass judgement on patients or their families even if their beliefs are not similar to yours." Such comments emerged from sessions that focused on emotions related to grief/loss, discomfort, burnout, and self-doubt.

### Theme 5: Maintaining Boundaries

The importance of maintaining boundaries/respect and setting boundaries early in the patient relationship (19 comments) was the fifth theme identified. Quotes from this theme include "drawing a line in the sand," "walking away from a tense situation," and "trying to separate oneself from situations and understand where they [the patients] are coming from instead of reacting". These comments came from sessions that evoked feelings of frustration.

## DISCUSSION

In reviewing 820 evaluations, SR at Stony Brook Children's helped pediatric providers to gain new insights into others' perspectives, feel less isolated and more willing to share their feelings, and process their emotional experiences with colleagues. In general, participation in SR

**TABLE 2** Schwartz Rounds Session Dates, Titles, Description and Evaluation Form Response Rates

| Date | Session Title/No. of Participants | Description | No. of Evaluations (Response Rate) |
|---|---|---|---|
| July 2015 | Adolescents and treatment refusal: Who rules the roost? ($n = 63$) | Dealing with the guilt and frustration of a young patient who could have been saved but refused chemotherapy and later died. Dealing with anger at parents for supporting this refusal and also guilt for not working harder with child protective services to treat him coercively. | 52 (82.5%) |
| Sept 2015 | The heart is still beating: How can I let go? ($n = 59$) | How to tell parents that their newborn is brain dead. Challenges of having the difficult conversation of how the baby is taking up a bed in a full NICU. | 53 (89.8%) |
| Nov 2015 | When the switch flips: Managing psychiatric patients on a medical floor ($n = 69$) | Patient who had psychiatric issues and became aggressive toward the nurses who did not have support. Fear and trepidation of patients who have become unmanageable. | 42 (60.9%) |
| Jan 2016 | Why does being special make it so hard? Decision making in special needs patients ($n = 58$) | Child in a chronic care facility with frequent ICU admissions; debate over how much should be done, panelist included nurse manager from the facility. | 50 (86.2%) |
| March 2016 | Lost in translation: Navigating the health care system with an interpreter ($n = 53$) | Frustration with communication when there are language barriers. Situations when a translator is needed but none are available. Featured videos of 2 parents. | 43 (81.1%) |
| May 2016 | Navigating neonatal abstinence syndrome with compassion and professionalism ($n = 38$) | NICU team discussing challenges of infants with NAS. | N/A |
| July 2016 | I can't take it anymore: When adolescent suicide affects the team ($n = 43$) | Processing and thinking about teen suicide. Medical student spoke up about his own struggles with depression. | 32 (74.4%) |
| Sept 2016 | When is a Tweet more than a Tweet? ($n = 43$) | When does the use of social media cross professional boundaries? Patient inquiries through Facebook and the struggle of practicing medicine in the age of social media. | N/A |
| Nov 2016 | Transitioning to adult autonomy: Who gets to decide? ($n = 57$) | Treating personality disorder associated with eating disorder in a young adult; panel included parent. | N/A |
| Jan 2017 | What happens to compassion during an opioid epidemic? ($n = 71$) | How to sustain compassion and not be judgmental toward 2 new mothers who overdosed and died. | 58 (81.7%) |
| Mar 2017 | When faith and medicine collide: How spirituality impacts patient care ($n = 55$) | Jehovah witness patient who died because he refused a blood transfusion (life-saving treatment). Included members of Jehovah witness community. | N/A |
| May 2017 | When the boundaries get blurry: Navigating tricky patient family situations ($n = 84$) | When family members disagree, how to deal with who actually makes the decisions. | 50 (59.5%) |
| July 2017 | Please don't tell my parents: Having difficult conversations with adolescents ($n = 57$) | How to interact with family members while adhering to patient confidentiality regarding adolescent homosexuality and treatment of sexually transmitted diseases. | 50 (87.7%) |
| Sept 2017 | When the caregiver becomes the victim: Assault in the hospital setting ($n = 52$) | Dealing with the fear of how a dangerous situation was not responded to adequately (Code M). | 31 (59.6%) |
| Nov 2017 | Running on empty? Self-care and the care of patients ($n = 36$) | Health care providers who experience burnout, how it affects the care of patients and how they deal with it. Had speaker on meditation after rounds. | 36 (100%) |
| Jan 2018 | Meeting of the ages: From one generation to the next ($n = 107$) | Generational differences between younger and older physicians. Perceptions of how the younger generation of physicians were not tough enough and were not able to do what had to be done. Generational gaps in approach to patient care. Impact of technology. | 60 (56.1%) |
| Mar 2018 | Communication matters: Family experiences ($n = 53$) | Inadequate and miscommunication with patients and other health care providers. Had members of FAC as panelists. | 43 (81.1%) |
| May 2018 | Why am I mad at this patient? Dealing with frustration ($n = 57$) | Experiences of nonadherent patients who make health care providers feel inept | 48 (84.2%) |

**TABLE 2** Continued

| Date | Session Title/No. of Participants | Description | No. of Evaluations (Response Rate) |
|---|---|---|---|
| July 2018 | From detached concern to empathy: When tragedy hits home ($n = 55$) | How health care providers cope with personal experiences similar to the patient that they are caring for. Impact of medical experiences happening to coworkers/colleagues. | 44 (80.0%) |
| Sept 2018 | Wounded healers ($n = 55$) | Health care providers share experiences of how they deal with their own family members or selves who suffer illnesses similar to their patients, such as cancer. | 46 (83.6%) |
| Dec 2018 | Hidden voices ($n = 70$) | Highlighting the experiences of "behind the scenes" staff such as CAs, administrative personnel, etc. | N/A |
| Mar 2019 | Caregiver resiliency ($n = 36$) | How health care providers deal with the stress of caring for patients who require a lot of care but do not get better. Resiliency in dealing with a young patient's long and hard road to nonrecovery. | 29 (80.6%) |
| Jan 2019 | When a spoonful of sugar just isn't enough ($n = 88$) | Perinatal HIV patients. Noncompliance and its impact on team. | 53 (60.2%) |

is associated with self-reported improved compassion for patients, better teamwork, and reduced stress in staff members, and has a positive impact on organizational culture.[13,17] Given the high prevalence of psychological distress among health care workers[18] and the evidence that the wellbeing of care providers is connected to the quality of patient care,[18–20] it is not surprising to note that, since its inception, SR has rapidly expanded to many health care institutions across the United States and the United Kingdom.[8]

Studies of SR in pediatrics have been scant. We report on a series of SRs with carefully selected patient care challenges at our institution. Most of the participants felt positive about their participation and felt more open to expressing personal thoughts with other care providers and less isolated from the health care team. SR was received positively by pediatric providers from a variety of disciplines. In general, pediatric team members reported improved understanding of patient and family circumstances and a willingness to ask questions and listen more deeply. This may ultimately influence both feelings of interconnectedness and compassion fatigue, one of the hallmarks of burnout. Findings from our study are consistent with the systematic review by Taylor et al,[7] which revealed the value of SR to attendees, with a self-reported positive impact on individuals, their relationships with colleagues and patients, and wider cultural changes. Multiple recent studies[9–11] reveal that SRs enable participants to have better insights into how their patients and colleagues think and experience patient care activities. Our results in a pediatric setting are again consistent with what is known in the literature regarding SR on the adult units. Our first theme in the qualitative analysis was on understanding the other person's perspective. This is one of the key aspects of nonjudgmental communication and acceptance of other points of
view. With almost half of the unique participants attending at least 2 or more sessions, it appears that providers view SR as a place in which they can safely share their experiences and emotions with other care providers.

Although more research is needed, SR's impact on interconnectedness and understanding the insights of colleagues and patients may help to provide a safe space and a circle of trust in which pediatric providers can share and process their true feelings in a supportive environment. In the circle of trust literature,[21] the author discusses the role of the inner teacher and the critical importance of learning in a community in a nonjudgmental and noninvasive way. SR also helps providers gain perspectives on how these issues affect other interprofessional team members. Additionally, SR gives participants a chance to process emotions that are elicited by the cases and topics discussed. It is clear that SR provides participants with the opportunity for personal growth in a safe space.

Awareness of personal biases emerged as an important theme in the qualitative comments. Discussions during SR allowed participants to examine the concept of implicit bias and the impact of such bias on their practice, particularly as other participants commented on such topics. Awareness of one's own personal biases as well as recognition of the importance of clear communication in patient care may help increase connectedness among health care team members and between team members and their patients and families.

Patrick Leoncini[22] cites the absence of trust and fear of conflict as 2 of the 5 dysfunctions of a team. In professions that are dependent on collaborative, trusting, interprofessional teamwork, any intervention that can enhance the sense of connectedness and establish trust to allow the safe expression of alternative viewpoints is likely to enhance the functioning of the team and thereby improve patient outcomes. Interventions such as SR may positively influence care provider outcomes, such as reduced

burnout rates and improved job satisfaction and professional relationships, which, in turn, can potentially have a huge impact on important patient outcomes as well as the organizational culture. Having safe spaces such as SR in which care providers can process their emotions while dealing with challenging patient care situations remains vital to prevent burnout and maintain interprofessional engagement.

Our study is limited in that it is a report of the outputs and outcomes from a single pediatric institution and may not be representative of all pediatric care providers. However, given the large sample size, it is likely that the results are somewhat generalizable. We report data from standard evaluation forms and free-text comments, but we do not have specific measures of personal satisfaction, interprofessional connectedness, or organizational culture. We also do not yet have measures of behavioral change in participants.

Our experience of SR in pediatrics has led to the dissemination of these rounds into the obstetrics and gynecology department. There is also interest in expanding SR further throughout the organization, which has the potential to move organizational culture even further into a patient-centered direction. Our next step is to explore the impact of ongoing participation in SR on the personal joy and fulfillment of participants, using the Human Flourishing Index[23] scale in depth by comparing the changes in scores over time among regular participants of SR. This will allow us to continue to affect a change in the overall culture of the organization toward provider connectedness, increased insight and empathy, and overall provider wellness.

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