Compassion Rounds

Caring for Parents of Our Tiniest Newborns

JOCELYN SHAW, MDIV
SENIOR CHAPLAIN
ADVENTHEALTH FOR CHILDREN

REINA MAYOR, MD
NEONATOLOGY
ADVENTHEALTH ORLANDO

Excerpted from

PHYSICIAN WELL-BEING DURING SUSTAINED CRISIS

Introduction

Compassion Rounds (CR) is a collaboration between physician and chaplain to better serve the psychosocial, emotional, and spiritual needs of the parents to the patients in the neonatal intensive care unit (NICU). The unique style of rounds requires attention to details and processes that are unique to health care in style and approach. The benefits not only impact our patients and families but simultaneously show great positive reward to the health care members who are engaged through the process.

Why Were Compassion Rounds Established?

Compassion Rounds were created as a partnership between the physician and the chaplain to communicate with the patient and family utilizing a psychosocial, emotional, and spiritual approach to medical care. Compassion Rounds were established within AdventHealth for the children's neonatal intensive care unit after adopting the concept from Dr. John Guarneri, who previously used a similar method in the adult areas of the hospital. From a physician's perspective, I was interested in participating in CR but uncertain how it would fit into our busy NICU schedule. On our first day of CR, I was having classic symptoms of physician burnout. I was coming off an intense service block that had taken its toll on me physically and emotionally. I was surprised how I was immediately drawn to the mothers' stories. My exhaustion was quickly forgotten as I sat there and listened to moms detail their concerns and struggles. I had spent three weeks speaking with these moms on a daily basis about their infants' medical conditions yet had no idea that they were silently suffering.

My experience with CR continues to be personally uplifting. It has been very rewarding to give my time to listen to moms, validate their struggles, and encourage them. The spiritual aspect of CR involving prayer has had the most profound impact on my well-being as a person and a physician. The burden of caring for critically ill infants at times can seem unsurmountable. Standing together holding hands, surrounding a baby's Isolette®, and praying together as a unified team is powerful and helps lift the burden that I carry as a physician. I often refer to CR as "chicken soup for a physician's soul."

Over the course of the past few years of conducting CR, Jocelyn and I have identified many moms struggling with postpartum depression and anxiety. The time that follows a NICU admission is "unnatural" and filled with many changes and struggles for the mother specifically. The NICU environment, infant's appearance, difficulties bonding, separation from baby, loss of parental role, spiritual upheaval, guilt for not carrying to term, and symptoms of postpartum depression are among the many reasons that NICU moms have increased risk of anxiety. In a study by Lefkowitz et al., 35 percent of mothers met the criteria for acute stress disorder after five days of NICU admission, and 15 percent met diagnostic for post-traumatic stress disorder after 30 days of the NICU admission.[1] It is not surprising that postpartum depression (PPD) is the most common medical problem a new mother will face, and mothers of preterm infants are twice as likely to experience PPD than women who deliver full-term infants.[2-5]

CR identified a significant gap in care for the parents/families of our NICU babies. We were thoroughly addressing the infants' medical needs but not addressing maternal well-being, which can impair maternal-infant interactions, leading to poor bonding, developmental delay, and social interaction difficulties in affected children.[6] As many as 46 percent of women who experience PPD symptoms continue to have symptoms one year after the birth of their child.6 It should be noted that while CR was created in the NICU working with postpartum parents, physicians and chaplains are caring for critically ill patients and families who frequently experience increased depression and anxiety.

Purpose of Compassion Rounds

The purpose for CR is to provide a safe place for parents/families to receive emotional and spiritual care. As the physician leads the interdisciplinary team's efforts, the chaplain works in tandem with the physician. The chaplain's role is to come alongside and partner with the physician and team to focus on the emotional and spiritual care of the family. The CR session creates a sacred place where the group can journey together for a designated time to assist the families in finding hope, strength, and peace. During this time of exploration and support, the CR team seeks to empower the families to uncover ways of coping. Consequently, finding new paths of coping will also improve the maternal well-being and strengthen the infant-mother bond.6 Spiritual care has been shown to help overall health and bolster the ability of individuals to cope with difficulties. "On examining the relationship between spirituality and health, it has been observed that spirituality helps to prevent disease, improve health, and facilitate coping with difficulties."[7-9]

What Compassion Rounds Are in Practice and How They Differ from Medical Rounds
Integral to the success of CR, the physician and chaplain must take time to develop a working relationship with one another. A strong trust between the chaplain and doctor is the key. The sacred place explored in the patient's journey is one of intimacy, and for this to take place organically, the chaplain and physician must have a true partnership and trust built prior to beginning this work.

For the NICU team at AdventHealth for Children, the scheduled service blocks for physicians is based on a three-week rotation. Therefore, planning a one- or two-hour session for CR works well when scheduled once per month. This schedule allows room for the physician to get to know their patients by the end of the service block and for the chaplain to partner with them as they ascertain which patients might benefit the most from these rounds. Due to time constraints, only four to five families are offered CR each month. Since it is often not obvious which patients are the most in need of CR, educational information is provided in each NICU room inviting all NICU families to participate in CR. However, we have found that most families do not actively seek out CR unless the chaplain or physician personally speaks with them directly about the process. Thus, in our institution, the high-risk families are identified by the medical team and offered CR. Social workers and nurse leaders for the unit also help in identifying the families that might best be served by this type of support.

Once families are identified, the chaplain then works with the families, allowing time for them to ask questions and gauging if CR interests them. As the chaplain engages with the families, they are able to see that CR is different from the daily multidisciplinary rounds that they have experienced; the focus is not on the medical aspects but on the psychosocial, emotional, and spiritual support they need. This is a significant shift in focus that centers around how

the parents are coping. Prior to CR, the chaplain will connect with the families to ensure they are available to meet with the doctor and confirm participation. Each family is given approximately 20–30 minutes for their CR.

The day of the CR, the session begins with the doctor offering a brief overview of the patient's hospital stay with the team. The team enters the room, and the doctor introduces each attendee. CR may include a social worker, nurse practitioner, family care consultant, nurse, and a child life specialist. CR is most effective if it involves a maximum of only four people or fewer; at minimum, the physician and chaplain must be present.

The physician then intentionally describes the ground rules for the session; primarily, medicine will not be discussed. We do not discuss test results or the medical plan of care. This establishes a safe space for families. Families of critically ill patients live in a constant state of bracing themselves for more bad news.

At the start of CR, the physician often says, "During medical rounds, we discuss in detail the medical plan of care. However, we often do not have an opportunity to find out how you are doing and how you are coping. CR provides an opportunity for us to learn more about how you are." The chaplain then follows with further context by sharing, "Compassion Rounds is a time for key interdisciplinary team members to come and sit with you to understand and be a part of your journey and build support for you. It gives us a chance to understand your context and what is important to you." Following this, the physician and chaplain engage with real-time open-ended questions to invite the parents to share openly about their journey. Please note that chaplains typically use spiritual assessments to guide their pastoral intervention process during CR by utilizing a conversational approach.[10]

Learnings from Compassion Rounds

During the three and a half years that CR have been a part of the NICU experience, a few things have been noted. It is key that the chaplain engage the family ahead of time. Often, the family does not understand the role of the chaplain in general or as a part of these rounds. This puts the family at ease and educates them about the integral role of the chaplain. This step is imperative, and the chaplain takes the lead connecting with families prior to the rounds. The connection also provides context and education for the family while simultaneously building rapport. AdventHealth extends a unique health care approach that utilizes the chaplain as an "opt-out" versus an "opt-in" method. Essentially, the chaplain is considered a key part of the care team, and this is clearly demonstrated during CR, as the chaplain plays the role of the physician's right hand in partnering and navigating through the whole-care approach to the patient's needs. This symbiotic relationship between the physician and the chaplain is also illustrated by how both parties work together to provide whole-person care to the family during this unique style of rounds.

The family is accustomed to seeing the physician as the leader in medical rounds when medicine and care plans are discussed, but during CR, the focus is not on medicine. The chaplain seeks to find commonalities between patients and the care team.[11] Members of the team use the time to check in on the parents' emotional and spiritual well-being since not much time is allotted for this during medical rounds. Therefore, CR provides an established, safe space for the family to share and engage coping skills with members of the interdisciplinary team, with the primary emphasis on the psychosocial, emotional, and

spiritual support measures. Typically, medical professionals must focus on the medical conditions; however, CR invites the interdisciplinary team into more of the chaplain's area of work that seeks to understand the person as a whole.[12]

Personal Perspective from the Collaborating Chaplain and Co-Creator

After one of the first CRs was hosted, I remember turning to Dr. Mayor and hearing her share how CR had reconnected her to her passion for medicine. I recall her saying, "This is why I went into medicine." After spending the day deep in the trenches of the work I am so passionate about and hearing the doctor that I admire share how passionate she was for this collaboration, I was sold! I thought, "I'm in!" If AdventHealth and chaplain ministry had not completely won me over already, I was convinced in this moment that I was fully dedicated to this calling. As this CR journey unfolded, I felt invested in a work that was much larger than myself, and I was so grateful to be a part of this journey. What grew out of CR for me was a passion to continue to collaborate with physicians and team members. Another opportunity I saw evolving over the course of the rounds was a unique building of trust between the doctors and the parents. The parents saw the doctors in a new light. The doctor was able, within the emotional space created, to show their own empathy for each person as who they are—a mother, a father, a person. It was not that the doctor did not care prior to the inception of CR, but this time allowed for the parents to see the physician demonstrating, through conversation and time, how much they care for them by their simple presence. For me to be a part of this process and contribute, from my professional perspective, has been an inestimable honor.

Jocelyn Shaw, MDiv, serves as the senior chaplain for AdventHealth for Children. She has a passion for working in the areas of health care and spirituality. Jocelyn attended Southern Adventist University, receiving a bachelor of arts in pastoral care, followed by completion of her chaplaincy residency in 2012. She attended Andrews University Theological Seminary, completing her master of divinity degree alongside her husband, Martin Shaw. Providing psychosocial emotional and spiritual support to patients, families, and staff members are top priority for Jocelyn.

Reina Mayor, MD, completed her undergraduate degree in biology at San Diego State University. She attended George Washington University School of Medicine. She completed her pediatric residency at Texas Children's Hospital and neonatology fellowship at University of Texas Southwestern. Dr. Mayor has practiced neonatology at AdventHealth for six years. Her interests focus on postpartum depression and maternal anxiety in NICU moms.

References

1. Lefkowitz DS, Baxt C, Evans JR. Prevalence and Correlates of Posttraumatic Stress and Postpartum Depression in Parents of Infants in the Neonatal Intensive Care Unit (NICU). *Journal of Clinical Psychology in Medical Settings*. 2010;17(3):230-237.

2. Wisner K, Parry B, Piontek C. Clinical practice. Postpartum depression. *The New England Journal of Medicine*. 2002;347(3):194-199.

3. Gennaro S. Postpartal anxiety and depression in mothers of term and preterm infants. *Nursing Research*. 1988;37(2):82-85.

4. Logsdon MC, Davis DW, Wilkerson SA, Birkimer JC. Predictors of Depression in Mothers of Preterm Infants. *Journal of Social Behavior and Personality*. 1997;12(1):73-88.

5. Gönülal D, Yalaz M, Altun-Köroğlu O, Kültürsay N. Both parents of neonatal intensive care unit patients are at risk of depression. *The Turkish Journal of Pediatrics*. 2014;56(2):171-176.

6. Beck C. The effects of postpartum depression on child development: a meta-analysis. *Archives of Psychiatric Nursing*. 1998;12(1):12-20.

7. Dilek KA, Funda KÖ, Fatma GT. The Effect of Spiritual Care on Stress Levels of Mothers in NICU. *Western Journal of Nursing Research*. 2018;40(7):997-1011.

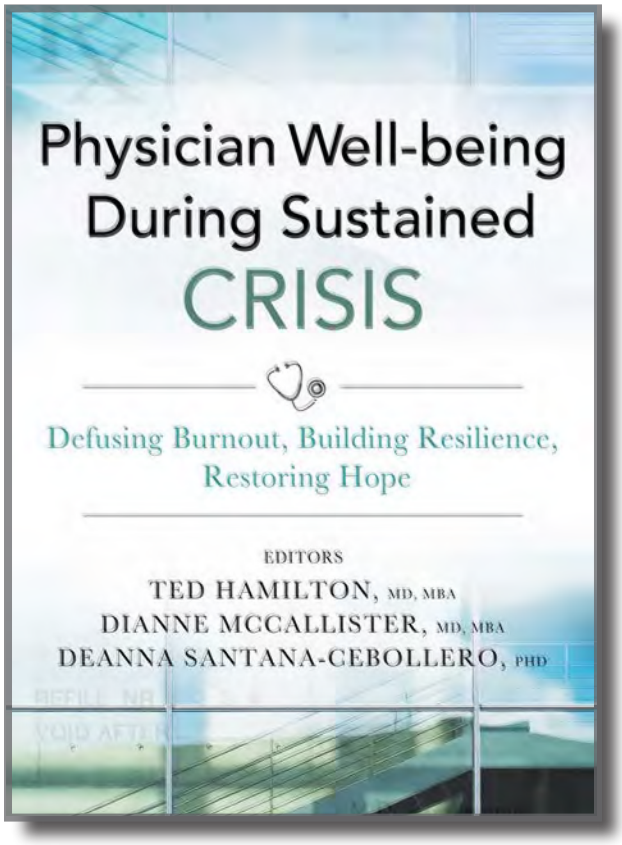
8. Modjarrad K. Medicine and spirituality. *Journal of the American Medical Association*. 2004;291(23):2880.

9. Wilson S, Miles M. Spirituality in African-American mothers coping with a seriously ill infant. *Journal of the Society of Pediatric Nurses* : JSPN. 2001;6(3):116-122.

10. Lewis JM. Pastoral Assessment in Hospital Ministry: A Conversational Approach. *Chaplaincy Today*. 2002;18(2):5-13.

11. Cadge W, Sigalow E. Negotiating Religious Differences: The Strategies of Interfaith Chaplains in Healthcare: INTERFAITH CHAPLAINS IN HEALTHCARE. *Journal for the Scientific Study of Religion*. 2013;52(1):146-158.

12. de Vries R, Berlinger N, Cadge W. Lost in translation: the chaplain's role in health care. *The Hastings Center Report.* 2008;38(6):23-27.



AdventHealth

Learn more at AdventHealthPress.com/PhysicianWellBeing

AdventHealth Press
605 Montgomery Rd
Altamonte Springs, FL 32714

The Coalition for Physician Well-Being