



THE EMOTIONAL SIDE OF HEALING

The Kenneth B. Schwartz Center Uses Rounds to Promote Compassionate Healthcare

BY ADRIANE BISHKO

Ken Schwartz, a Boston healthcare attorney, died of lung cancer in September 1995. Before he died, recalls his sister-in-law Marjorie Stanzler, he summoned his lawyers to amend his will and establish a center “to study the patient-caregiver relationship.” The result was the Kenneth B. Schwartz Center, an independent nonprofit organization housed at Massachusetts General Hospital (MGH). The Schwartz Center embodies the ideas expressed in Schwartz’s article “A Patient’s Story,” which appeared in the Boston Globe Magazine in July of 1995. “We knew that all of the kindness and compassion that Ken’s caregivers showed meant so much to him and, in Ken’s words, ‘made the unbearable bearable,’” says Stanzler, who is director of programs at the Center. After he died, Schwartz’s family, friends, and caregivers at MGH worked to establish a board of directors and took on the task of ensuring that the human side of medicine, despite impending changes in healthcare, would not be lost.

The Center both funds and initiates programs designed to strengthen the patient-caregiver relationship. One of the most successful and fastest-growing programs is the Schwartz Center Rounds. Piloted at MGH in 1997, the Rounds is a multidisciplinary forum that allows caregivers — doctors, nurses, technicians, therapists, clergy, and other allied health professionals — to come together to discuss emotional and social issues that permeate the day-to-day practice of their profession.

The Human Side of the Interaction

Currently, Rounds are held at 60 different hospitals in 17 states. At Beth Israel Deaconess Medical Center (BIDMC) in Boston, Schwartz Center Rounds were established in February 2004. Each session has its own focus. For instance, in September 2004, the title of the Rounds was “Cultural, Racial and Socio-Economic Barriers.” Participants discussed the case of James (not his real name), who had advanced leukemia and

appeared to be very apathetic. He had little interaction with his doctors and received no visits from family members. Consequently, he was alone much of the time. It wasn’t that James wanted to be isolated, but because he was African-American, cultural boundaries got in the way of his communicating openly with his doctors. Things began to change after Andrea Williams, a patient-care advocate who was also African-American, took the time to establish a connection with him. As a result, James started opening up to his caregivers, and that made it easier for him to get the services he needed.

Other Rounds at BIDMC have focused on such topics as “Sexual Boundaries in the Patient/Provider Relationship,” “The Etiquette of Giving and Receiving Gifts,” “Go Ask Alice: The Challenging Experience of Treating Pain in Patients with Substance Abuse,” and “Trading Places in Health Care: Providing Care to a Colleague.”

The “Trading Places” topic struck a chord with Marion Longo, psychiatric clinical nurse specialist, who has been at BIDMC for more than 19 years. Three colleagues, she says, who had different forms of Hodgkin’s or cancer, talked about their experiences. “Suddenly, caregivers had a microscopic view of what it’s like to be a patient and have to make decisions about yourself — to be sitting in a clinic and think, ‘Gee, my hair is falling out but I still have to go to work.’ That provoked discussion about what [we each] would do in that situation and how [we would] feel about treating a colleague.”

For Claire Gerstein, LICSW, a patient representative at BIDMC, “Expanding Cultural Barriers” (February 2004) brought fresh insight to her work. In some cultures, adult children may be reticent to share medical information with their elderly, ill parent. “You have the sense,” says Gerstein, “that one of the dynamics driving that decision — to not use an interpreter, for example — is the desire to control what information is flowing.” The caregiver’s response to that, she points

Schwartz Center Rounds, such as the one held recently at Caritas Carney Hospital, give healthcare professionals from all areas of service an opportunity to share experiences and explore issues associated with compassionate care.



Linda Hagan, RN, and Michael Barza, MD, (top) served as part of a panel at a recent Rounds at Carney where participants also heard from (middle) David Dobroski, MD, and Huy Linh Vu, MD, and (bottom) food service worker Gerry Esdale.

out, is often anger, and it helps to be able to communicate those feelings in the privacy of Rounds, where everything is confidential. “In almost every Rounds,” says Gerstein, “you can almost feel an audible sigh of relief: ‘Gee, other people feel that way too.’ That helps caregivers feel less isolated in confronting the human side of the interaction.”

“When you’ve been a clinician for a long time,” says Longo, “the Rounds are an opportunity to synthesize one’s experience. There’s so much emotional stuff that goes into patient care that [caregivers] don’t give themselves credit for. Patients want people to be kind, to understand them and treat them as a human being. They don’t want to be the ‘leg’ in Room 10. That’s one of the most important things that Rounds do. It makes us all be human and puts things back on a one-to-one level.”

Changing the Relationship

Gerstein says the Rounds also provide an opportunity for staff to think about the caregiving experience at a time other than in the middle of a shift. In her work, Gerstein hears patients say that providers don’t know what it’s like to be a patient. “Caregivers are frequently so pressured to make medical decisions,” she says, “that they do not have time to process what’s being stirred up emotionally.” When the patient/caregiver relationship breaks down, patients are most likely to feel not well cared for. “But patients are incredibly forgiving,” she adds, “in the presence of a good relationship.”

“Roles as Caregivers for Dying Patients,” a Rounds forum held last December, focused on what it takes for caregivers to be emotionally present with patients through the death and dying process. Gerstein says it’s important for patients to feel the presence of their physician — even when there is nothing more she or he can do for them. But what changes the patient’s experience is how emotionally present the physician is. “I remember people being blown away with Dr. Richard Parker’s narrative of what it was like for him,” says Gerstein. “The Rounds sanction what’s going on internally. It becomes a place where it’s safe to talk. And the more that people do that, the more they incorporate their feelings into their interactions.”

Mary Attardo, NP, from the clinical research center, has attended every Rounds at BIDMC. “There have been different sessions,” she says, “that result in my thinking, ‘I wonder if I handled the last experience in the best way possible.’ I look at the outcome and think how I might be better prepared.” Last November, “Sexual Boundaries in the Patient/Provider Relationship” focused on situations where caregivers, “blindsided” by a patient’s provocative behavior, had to respond quickly. “You have to regroup,” says Attardo, “address the patient in the way you need to, put a boundary up so you can continue to provide care. Hearing what those health providers did in response, and how it worked out, gave us a way of experiencing it vicariously so when it happens we’re prepared.”

Terry Smith, a community-resource specialist who works

with people from diverse backgrounds and cultures, says, “In my job, we try to do a quick fix right away to help people obtain the resources they need. The Rounds help me take a step backward, so I can listen to people — especially those from different cultural backgrounds — and not jump to a conclusion. [For a patient], sometimes, it’s just being heard that makes all the difference.”

Looking at Themselves

Unlike typical clinical rounds, the Rounds sponsored by the Schwartz Center may be based on more than one case, providing everyone with an opportunity to speak. Consequently, people feel more empowered to raise issues that get to the heart of caregiving. Last March, in “Lessons Learned From the Frontline,” phlebotomist Brenda Saucer told stories about a couple of patients who, as a result of talking to her, went further in their treatment than they might have otherwise. Saucer’s role is not as threatening as the nurse’s or physician’s, she noted, so fearful patients felt they could talk to her on a different level.

“What struck me,” says Longo, “was the importance of every single member of the team. We all have a role to play. It doesn’t matter who you are. But often we don’t give others credit. It was their moment in the sun to talk about what a good job they do.”

“We’re working with patients and families who are often very ill and struggling,” Longo says, “trying to cope with horrible things that are happening to them.” She says the Rounds help put the caregivers “back in the moment” so they can reflect on the work they do and feel the connection between patients and themselves.

January’s Rounds session was titled “Pray With Me.” The topic, Longo says, raised important issues that made her reconsider how a caregiver can remain an advocate for the patient and family even while her own cultural and religious beliefs may differ from theirs. Some participants at this Rounds said they could sit and verbally pray with their patient; others said they might hold someone’s hand and be a presence.

“The Schwartz Center Rounds reminds us how meaningful [visits] can be for a patient,” says Attardo. “We see so many patients each day. We collect information. We advise them. Then we leave. But then there are those visits that are so moving for a patient that they motivate them to do better in monitoring their own healthcare, or reassure them, or help them feel they can entirely trust us with their care.”

“In healthcare,” Smith adds, “it’s not just the medicine or the testing; it’s also the mental part of it — the support you give by accepting the patients as they are. Sometimes you want to do it one way and the patients see it another way. Sometimes just accepting patients and working with them is such a great approach to care.”

Training Caregivers

In addition to Rounds, the Schwartz Center offers a number of programs for caregivers. Clinical Pastoral Education (CPE) is a one-day-a-week, five-month program that increases caregivers’ ability to relate to their patients on a spiritual level.



Through its Foundation grants, the Center funds training for caregivers in cultural competency, end-of-life care, spirituality, and communication skills. Pictured above (left to right) are Gregory McSweeney, MD, and Virginia Grimes Allen, director of mission and spiritual care, both from Carney Hospital, and Win Hodges of the Schwartz Foundation.

“Graduates from this program report that they now have the tools, language, and confidence to talk to patients about religion or spirituality or whatever is most important in their lives,” Stanzler says.

Another offering is the Schwartz Center Speaker Series. In “The Power of Apology,” a program within the series, health-care providers learn what transpires when a caregiver apologizes and fully discloses what has happened. “There is growing evidence,” says Julie Rosen, the Center’s executive director, “that such disclosure and honesty actually reduce the rate of medical malpractice.”

The Center also funds programs by providing grants. Since 1997, the Center has awarded grants to more than 100 nonprofit organizations to train caregivers primarily in the areas of cultural competency, end-of-life care, spirituality, and communication skills.

“There is much scientific literature showing that good patient-caregiver relationships improve outcomes,” says Rosen. “Patients adhere to treatment protocols and medication. They feel better about their healthcare experiences, and they’re less likely to sue their physician. We believe,” she concludes, “that this organization, and the work we do, reminds all of us about what’s important in healthcare.” ■