Implementing Patient Family-Centered Care Grand Rounds Using Patient/Family Advisor Narratives

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Abstract
With the emerging trend of patient family-centered care in health care, it is essential that physicians be exposed to patient and family perspectives of care during medical education and training. Grand Rounds provides an ideal format for physicians to learn about patient family-centered care. At Brigham and Women’s Hospital, we sought to bring the voice of the patient to Patient Family-Centered Grand Rounds in order to expose clinicians to rich narratives describing the medical care received by patients/families and to ultimately change physician practice to reflect patient family-centered principles. We conducted a clinician survey and found promising results indicating that patient/family narratives can be effective at educating physicians about patient family-centered care.

Keywords
Grand Rounds, patient family narratives, patient family advisors, patient family–centered care

Case Study
As one of its core strategic initiatives, Brigham and Women’s Hospital (BWH) strives to promote patient family–centered care (PFCC). In spring 2012, the BWH chief medical officer (CMO) and chief nursing officer (CNO) asked the chair of each medical department to create a PFCC Grand Rounds presentation during the 2012-13 academic year. Their primary requirement for the PFCC Grand Rounds was to include patient/family advisors (PFAs) from BWH Patient and Family Advisory Councils (PFACs) as active participants. Because PFCC principles have only recently begun to be emphasized in medical school curriculum, the CMO and CNO believed the best venue to educate or re-educate physicians on PFCC practices was through Grand Rounds.

BWH Center for Patients and Families was asked to assist each of the medical departments with integrating the voice of the PFAs in PFCC Grand Rounds. The Center for Patients and Families was chosen to help with Grand Rounds as it manages all patient and family issues and concerns on behalf of the hospital, understands the issues patients and families experience, and oversees all PFACs and PFAs. PFAs were the ideal speakers because they have been trained in effective communication, are familiar with the hospital setting and working with clinicians, and have experience sharing their stories.

BWH PFCC Grand Rounds was designed to bring the patient/family perspective to the center of Grand Rounds. PFAs narratives were used to describe the patient’s perspective of the care they received from the care team while in the hospital and the family members’ perceptions of the care the patient received from the care team. PFCC Grand Rounds were built around these stories because, based on previous experience, sharing patient/family narratives can be powerful and help providers to have an “aha” moment if the “lived experience” the patient shares resonates with them.

The purpose of including PFA narratives in PFCC Grand Rounds was two-fold: to expose providers to rich narratives

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of the medical care the patient/family received from the clinicians on their service and to convey PFCC principles which clinicians can implement into their daily practice.

### Planning PFCC Grand Rounds

The Center for Patients and Families reached out to each department chair to meet, develop, and implement an hour-long PFCC Grand Rounds individualized for their specific service line. The Center for Patients and Families shared ways to integrate the PFA narratives as part of Grand Rounds. Options were to have one PFA narrative or have a panel discussion with 2-4 PFAs who would share their various experiences in their specific service line and answer questions from providers about the care they received and how it could have been improved. Most departments chose to have a panel discussion as they realized that having multiple narratives would provide different perceptions of care that could resonate with physicians.

The Center for Patients and Families helped department leadership select PFAs to present at their specific PFCC Grand Rounds. Since BWH PFAs are extensively interviewed by the Center for Patients and Families during the initial PFAC on boarding process, they were able to recommend PFAs who were articulate, offered compelling narratives, and could motivate physicians to potentially make a change to their practice. If there were not PFAs for a specific service line, the Center for Patients and Families asked the department chair to recommend patients they believed would be a good fit. The Center for Patients and Families then interviewed the patients to decide if they were a good candidate to participate in PFCC Grand Rounds. The executive director of the Center for Patients and Families assisted the PFAs and patients with the preparation of their narratives prior to grand rounds. Preparation included listening to the PFA and patient narratives, then providing feedback to enhance the story. Then the PFAs and patients practiced in the amphitheater or lecture hall prior to the grand rounds to strengthen their narrative–delivery skills and reduce presentation anxiety.

### Grand Rounds Format

Although each grand rounds was individualized, the overall structure of PFCC Grand Rounds consisted of a brief overview on PFCC principles, panel presentation, and open discussion.

Leadership from the Center for Patients and Families led the overview of PFCC principles and moderated the panel, allowing each PFA to share a 5-minute narrative before facilitating the discussion.

Grand Rounds began with a brief 10-minute overview of PFCC based on the Institute for Patient- and Family-Centered Care’s core principles. The PFCC principles that were introduced include (1) respect and dignity, (2) information sharing, (3) participation, and (4) collaboration. The principles, their definitions, and examples were illustrated in a PowerPoint presentation. Table 1 describes the definition of each principle in more detail. (1)

Next, patient/family narratives were shared. Patient/family narratives ranged from positive experiences, highlighting what went well in their care, to more negative experiences, which emphasized what could have gone better. Patients and families shared their or their family members’ medical status during hospitalization, the progression of care, how actions by clinicians affected them, and how they felt when things went well or badly. For example, a family member advisor shared her narrative at the intensive care unit (ICU) Grand Rounds. Her husband was diagnosed with pneumonia after being admitted to the ICU. Our advisor asked the resident each day what her husband’s daily chest X-ray revealed and whether his condition was better, worse, or the same. She shared her frustration that the resident used “textbook jargon” in responding to her questions, which made her feel excluded from her husband’s care. She also explained that she preferred her physician to give the results in a plainer language and to check about her understanding after doing so. While each narrative was specific to the PFAs’ lived experience, they each highlighted the PFCC principles that were or were not present during their medical care and what actions by physicians would have promoted PFCC.

### Table 1. Principles of Patient Family-Centered Care.

| Principles                  | Definition                                                                                                                                 |
|-----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|
| 1. Respect and dignity     | Health care practitioners listen to and honor patient and family perspectives and choices. Patient and family knowledge, values, beliefs, and cultural backgrounds are incorporated into the planning and delivery of care. |
| 2. Information sharing     | Health care practitioners communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete, and accurate information in order to effectively participate in care and decision making. |
| 3. Participation           | Patients and families are encouraged and supported in participating in care and decision making at the level they chose.                         |
| 4. Collaboration           | Patients and families are also included on an institution-wide basis. Health care leaders collaborate with patients and families in policy and program development, implementation, and evaluation; in health care facility design; and in professional education, as well as in the delivery of care. |

*Adapted from Institute for Patient-and Family-Centered Care. (1)*
The moderator followed up each narrative with clarifying questions to elicit any themes the PFA/patient did not fully articulate. For example, if the PFA didn’t explain what action they would have liked to see from their physician instead of what actually occurred, this was prompted by the moderator. Once each panelist had shared his or her narrative, the moderator opened the discussion to audience questions. The open discussion was designed to engage physicians and give them the opportunity to ask questions of PFAs that they may not otherwise have the opportunity to ask when they encounter a patient. The moderator also came with prepared questions for the speakers to support discussion as needed. Questions included: How did this make you feel?, What would you have preferred to have happen?, What advice would you give so that the interaction could have been more positive?, and How would you have preferred to hear the explanation that was provided to you?

Physicians often asked questions specific to the PFA/patient narratives, both about ways to promote PFCC in their behavior and tools which could be developed to support patient education and understanding of care. For example, a narrative about delirium prompted a question from a resident who wanted to know when was the best time for patients/families to discuss the possibility of delirium. An attending physician replied that this should occur in the preoperative session but PFAs shared that, for them, the idea didn’t resonate at preop because they did not think it would happen to their family member and they were absorbing the many other details about the operation. The discussion led to the idea that a video about delirium might be helpful for patients and families.

Evaluating PFCC Grand Rounds

Because the goal of PFCC Grand Rounds was to expose clinicians to patient/family narratives and convey PFCC principles that could be enacted in clinician practice, we sought to determine whether the providers believed they had gained new knowledge about PFCC and if they were willing to change their practice after listening to the PFA narratives.

To measure clinicians’ reaction and learning as a result of the PFCC Grand Rounds, we used a previously validated survey tool for assessing educational training programs. The survey asked providers if they gained new knowledge from PFCC Grand Rounds, if they would be willing to change the way they practice after listening to the PFAs narratives, and, if they were willing, how would they change their practice. This survey was provided to clinicians immediately after each PFCC Grand Rounds. Of the 11 PFCC Grand Rounds that took place, surveys were administered to participants of 9. The other two departments did not fill out surveys due to time constraints.

Of the 128 physicians who completed the survey, 44 were attending physicians and 84 were medical trainees (fellows, residents, and medical students). After participating, 75% of attendings and 58% of trainees agreed that PFCC Grand Rounds provided new knowledge. When surveyed about their willingness to change practice after listening to PFCC narratives, 45% of attendings and 60% of trainees said they would make a change to their practice.

These results were further reinforced by the comments we received in response to the open-ended question on the evaluation, “Will you make any changes to your practice as a result of this activity? If yes, please explain.” Overall, participants reported an increased awareness of the patient/family perspective and identified communication gaps that they could fill. One participant stated, “I will think more about how they [patients/families] would like to be treated.”

Others stated that they would be, “more mindful,” “more aware of patient anxiety,” and show “increased sensitivity to patients’ perspectives.” The second theme, communication, was identified by comments such as, “Ask patients how they would like care to be given,” and “be clear in explaining process.” These two themes suggest that, having become more aware of patients’ and families’ experience of care, Attendings and trainees will devote more time when providing information.

Lessons Learned

The Center for Patients and Families was involved in every step of planning and preparing for the PFCC Grand Rounds with each department. This was integral to the success of the PFCC Grand Rounds because the department leadership did not have experience integrating PFAs narratives into Grand Rounds. Additionally, the Center for Patients and Families had existing relationships with the PFAs, which facilitated the identification of appropriate advisors and supported them to feel comfortable sharing their narratives in front of a large group of clinicians. The successful implementation of the PFCC Grand Rounds was made possible by hospital-level leadership’s support of department-level engagement and participation. The PFCC Grand Rounds required buy-in from the department chair, whose support enabled the significant coordination of resources. The initiation of the PFCC Grand Rounds by hospital-level clinical leadership (CMO/CNO) exemplified the importance of PFCC at BWH and spurred department chairs to host PFCC Grand Rounds.

When initially approached to host PFCC Grand Rounds, some departments were hesitant to do so as they perceived their interactions with patients to be limited. Although they did not initially understand how PFCC Grand Rounds would be beneficial to them, the Center for Patients and Families believed PFCC Grand Rounds was relevant because all physicians are part of the patient experience. Although physicians in these departments do not often have direct contact with patients, their work plays a vital role in patient experience as the results they provide and how they are conveyed can have a significant impact on care. With this encouragement, these departments were willing to host PFCC Grand Rounds and had robust discussions with the PFAs during the open discussion forum as they were curious to learn how
patients perceived their role. One of the additional challenges of implementing some of the PFCC Grand Rounds was sparking a dialogue with physicians during the open discussion. When physicians were reticent to participate, the moderator coaxed the physicians to ask a question by asking, “After hearing the PFA narratives, how would you have addressed their concerns differently?, Did the PFA narratives surprise you, and why was it surprising to you?” These questions generally worked to engage the audience and led to productive conversations.

Despite these challenges, our survey results indicate that the PFCC Grand Rounds were successful at informing physicians about PFCC principles and behaviors, which promote PFCC. Furthermore, the PFA narratives and discussion led the majority of physicians, and especially medical trainees, to indicate they would change their practice to promote these principles.

Additionally, there were requests by the physicians in the audience for the inclusion of PFA narratives in future Grand Rounds, indicating that they valued the contribution of patient/family narratives to their education.

Conclusion

Including PFA narratives in PFCC Grand Rounds promoted understanding of PFCC and provided physicians the opportunity to listen to and reflect on the patient/family “lived experience” in a way they may not have previously. Based on the feedback we received from physicians, PFCC Grand Rounds were successful in conveying PFCC principles and leading to possible practice change. As such, we believe this format for implementing PFCC Grand Rounds has wide applicability to support continuing education around PFCC for physicians. We also see opportunities to use patient/family narratives in Grand Rounds and other education forums for physicians to promote learning around a wide variety of topics beyond patient family-centered care. Further study should be done to evaluate these programs, including the measurement of behavioral and clinical outcomes influenced by PFCC Grand Rounds.

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Celene Wong is the Project Manager for the Center for Patients and Families at Brigham and Women’s Hospital. She is deeply committed to patient family-centered care and believes in bringing the patient and families “lived experience” to promote communication and patient and family engagement among hospital staff.

Martha B Carnie, is the Senior Patient Advisors at Brigham and Women’s Hospital. She brings 27 years of experience as a three time cancer survivor and patient advocate. She is a frequent spokesperson at conferences and seminars about patient-centered care, the patient experience, patient safety and the Voice of the Patient in Design and Research.

Stanley W Ashley is Chief Medical Officer and Senior Vice President for Medical Affairs at Brigham and Women’s Hospital as well as the Frank Sawyer Professor of Surgery at Harvard Medical School. A gastrointestinal surgeon, Dr. Ashley’s current interests include practical aspects of quality measurement and credentialing. Closely related to this, he has an interest in physician education, both at the graduate and postgraduate (MOC) levels, and its integration into a certification/recertification process that ensures quality of care.

Jacqueline G Somerville PhD, RN, FAAN is an accomplished nurse executive experienced in nursing practice development and management. In her current role as Chief Nursing Officer and Senior Vice President Patient Care Services at Brigham and Women’s Hospital, she serves the staff, patients and their families.