Ogbeide et al. *HCA Healthcare Journal of Medicine* (2024) 5:3
https://doi.org/10.36518/2689-0216.1776

Original Research

Resident Feedback on Incorporating Reflection Rounds Into a Family Medicine Residency Wellness Curriculum: A Brief Report

Stacy Ogbeide, PsyD, ABPP[1]; Jasmin Aldridge Hamlett, MD, MPH[2]; Inez Isabel Cruz, PhD, LMSW[3]

Author affiliations are listed at the end of this article.

Correspondence to:
Stacy Ogbeide, PsyD, ABPP
(ogbeide@uthscsa.edu)

Abstract

Background
We sought to understand well-being from the perspectives of residents in a family medicine residency program and to assess the residents' opinions on implementing "Reflection Rounds" (RR) to promote wellness and combat burnout through self-reflection. These aims were achieved through descriptive qualitative analysis of a focus group of family medicine residents.

Methods
Participation was voluntary and open to all 45 residents in the program. The final participant sample consisted of 14 residents who shared similar characteristics, including level of training and being exposed to similar training stressors. Both a priori and open coding were used for this analysis.

Results
An iterative process identified themes based on focus group responses. The residents were in favor of initiating RR and recommended discussion topics unique to family medicine residency. They also identified logistical preferences for this intervention, such as conducting confidential and unrecorded groups, splitting rounds by training year, offering RRs led by a trained facilitator, providing snacks if feasible, and making the RRs available on a regular basis during protected didactic time.

Conclusion
This project elucidates how residents are identifying and managing wellness and burnout as well as informs effective ways that family medicine residency programs can incorporate RR into their wellness curriculum.

Keywords
Reflection Rounds; wellness; family medicine; internship and residency; graduate medical education; psychological burnout; psychological well-being

Background
Residency training is a time to build autonomy and expertise in specific areas. With current experiences, particularly those surrounded by the COVID-19 pandemic and achieving the Quadruple Aim, concerns about burnout and wellness may be more prominent. The current project sought to determine resident interest in incorporating "Reflection Rounds" (RRs) into the physician wellness curriculum within a family medicine residency. RRs are a purposeful use of time in didactic learning, where residents are given the opportunity to reflect on their professional experiences as a physician-in-training to promote wellness and professionalism. A group setting allows residents to reflect on expectations and hopes while also gathering support from residents navigating similar

environments.[1] To accomplish this integration, family medicine residents were asked to define wellness, well-being, and burnout to build a case for the addition of RRs to their program. Developing operational definitions for such abstract constructs can be a challenging task. Although there may not be a direct definition for wellness and well-being in the context of residency, there are identifiable factors associated with these concepts.[2] These concepts include autonomy, competence building, and strong social connection or relatedness.[2] Similarly, burnout is another complex construct that can produce a diverse array of meaning, depending on the person. Nevertheless, burnout has been found to be inversely correlated to autonomy, a known contributor to well-being.[2] Therefore, it is reasonable to conclude that there is an inverse relationship between wellness and burnout.[3]

A variety of interventions have been aimed at addressing wellness and burnout in medical resident training. In a study by Foster et al, faculty members offered consultation meetings to residents to discuss progress, goals, and well-being.[4] Resident scores on a global well-being scale improved with the addition of this intervention. There have also been peer-led interventions, in which "wellness champions" taught mindfulness skills, such as deep breathing or gratitude, during protected didactics time.[5] In another example, emergency medicine residency RRs led by faculty were shown to improve the subjective well-being of volunteer participants who shared their experiences in high-stakes patient encounters.[6] Another approach to RRs included trained peer facilitators leading voluntary sessions during protected academic time.[7] A post-implementation survey of this initiative showed that 58.8% of residents felt that the sessions helped them cope with challenges in residency, as well as reported decreased burnout, stress, and anxiety after having experienced the RRs.

RRs differ from other group interventions used to address physician wellness, such as Balint groups. Balint groups (eg, a group of physicians) meet regularly to discuss clinical cases to improve understanding of the patient-provider relationship.[8] In contrast, RRs focus on building self-reflection skills in all aspects of care (eg, clinical, interpersonal, teamwork). RRs can also benefit residency programs with building the Accreditation Council for Graduate Medical Education (ACGME) competencies of professionalism, interpersonal and communication skills, and systems-based practice, as there are few established approaches to teach these skills to residents.[9]

RR interventions have been implemented in pediatrics and emergency medicine residency programs but not yet in family medicine residency programs. Family medicine residency programs, which tend to have residents rotating through a variety of departments, including emergency medicine and pediatrics, can potentially benefit from adding RRs to their wellness curriculum. To proactively address resident burnout and wellness, we describe how our residency program engaged in a quality improvement project through the use of focus groups to receive feedback from residents on wellness, well-being, burnout, and the incorporation of RRs to address resident physician wellness.

Methods

The research question guiding this project was: What is wellness in resident training? Specifically, we hoped to learn about the sources and components of wellness and how residents felt about incorporating RRs in the wellness curriculum and their impact on wellness. Additional questions that support this exploration included: 1) What leads to wellness versus "unwellness"? and 2) How can the addition of RRs in the wellness curriculum aid in addressing self-care and wellness?

While prior studies used more comprehensive methods (ie, ethnography, grounded theory, or phenomenology), we used a qualitative descriptive method. Qualitative description is a specific method designed to stay close to the "surface of the data" and ensure that the experiences described are from the viewpoint of the participant, in this case, the medical resident.[10,11] The goal of our qualitative description was not theoretical development or interpretations of lived experiences; rather, the purpose was to provide a rich, easily understood description of wellness within a residency training setting.[11]

We recruited a convenience sample of current residents in our program. All 45 residents were

invited to participate if they were interested. Inclusion criteria consisted of being a resident in postgraduate year (PGY)-1, 2 or 3 in the family medicine residency program and being willing to allow their opinions on wellness to be recorded. Fourteen residents volunteered to participate in the focus groups.

The focus groups took place in May 2020. Residents were divided into 2 focus groups due to the size of the total group. Group 1 contained 8 residents, and group 2 contained 6 residents. Residents shared similar characteristics, such as being in the same city and being in a transitional period of their life. The focus groups were facilitated with the use of a guide consisting of open-ended questions developed by the investigators (**Appendix 1**). The group facilitator was also trained by the research team to conduct a focus group (ie, when to ask for clarification or follow-up to a response).

The residency coordinator, external to this research group, randomly divided the participating residents into 2 small groups and notified them of the focus groups' date and location. Due to the COVID-19 pandemic, physical distancing was required, so we provided the focus group as a virtual platform for their discussion. Each focus group lasted 1 hour. The audio was recorded and provided to a research assistant (RA). Data were first transcribed verbatim by a research volunteer, and the RA validated the transcription against the recording. The transcript was then provided to the Principal Investigator (PI) and the qualitative analyst who conducted the analysis. The analysis was an iterative process where codes were cohesively developed, discussed, and finalized to ensure that researchers were achieving agreement. We chose to honor the interpretive nature of the question being answered and recognized that not all nuances are conveyed through an intercoder reliability (ICR) score. The analysis honored the role of the primary investigator, serving as a clinical researcher in their last year of residency. Overall, a team of 3 coders, working with a diverse understanding of wellness in a residency program, supported and challenged the coding process.[12] Overall, 3 researchers were involved in the coding analysis. No translation was necessary as all residents were English speaking.

Data Analysis Plan

Based on Miles and Huberman's qualitative descriptive analysis method, the following 5 analytic strategies guided the analysis as the researchers explored the question: *What is wellness in resident training?*[13]

1. Review data collected from focus group interviews;
2. Sort through the data to identify similar phrases, patterns, sequences, and other important features [coding];
3. After sorting, extract commonalities and differences for further consideration and analysis [thematic development];
4. Gradually decide on a small group of generalizations that hold true for the data;
5. Examine these generalizations in light of current knowledge.

Data analysis began with researchers reading through the data and familiarizing themselves with the material. The data were then sorted to identify similar phrases, patterns, sequences, and other important features. Identification of more than 1 phrase, pattern, or sequence (ie, commonalities) was considered a code. The data were coded sentence by sentence to ensure that all data were being considered. After the initial primary coding, a secondary grouping occurred through which the researchers identified commonalities for further consideration. Finally, small groups of generalizations that were supported by the data were identified, considered, created, and then compared to the existing literature, including the gaps that existed.

Both a priori and open coding were used for this analysis as we had specific items that were searched (eg, a definition of wellness) in an effort to find narratives in the data. Codes included wellness, depth, sources, leads, low well-being, and RRs (**Table 1**).

Bias is a reality that must be addressed in qualitative research. The researchers in this group were a resident, researchers, and clinicians. Therefore, our data methodology involved a reflexive approach to our research, recognizing that we were both "insiders" and "outsiders."[14] Additionally, if we truly wanted to understand what residents thought, we believed that it was necessary to allow a resident to conduct the interviews and connect with participants

Table 1. General Coding Description

Code	Definition of code	Type of code
Wellness	As it is defined by residents	A priori
Depth	What is the complexity of wellness	Inductive/ Emergent
Sources	Things that impact wellness	Inductive/ Emergent
Leads	What leads to wellness	Inductive/ Emergent
Low well-being	How is it defined and what it is	Inductive/ Emergent
Reflection Rounds	Thoughts about and addition to the wellness curriculum	A priori

in a way faculty could not. While it is impossible to bracket or set aside one's previous knowledge, the researchers adopted a bridling approach.[15,16] Bridling acknowledges that both interviewer and interviewee are biased and that our perspectives impact our research but that we are able to "slow down" the process of understanding to allow the experience to be seen with an open mind.[17,18] Data analysis used ATLAS.ti data management software. This study was approved by the organization's institutional review board.

Results

Of the 14 participants, 13 identified as female and 1 identified as male. Six participants identified as Asian, 6 identified as Hispanic, and 2 identified as White. The data generated 17 grouping codes extracted from the commonalities found in the responses to the focus group questions. These grouping codes described the participants' definition of wellness, what impacts wellness and burnout, and the usefulness and preferred logistics of RRs. These were then analyzed for similarities and differences to determine relationships and patterns, which are outlined in **Table 2**.

Conclusions About Wellness

Wellness was defined as cultivating balance, having time to recuperate, and having a positive outlook. The general consensus was that unwellness was related to feeling overwhelmed. Based on the discussions, unwellness was closely related to burnout in the perspective of the participating residents. Managing burnout was associated with employing a variety of coping skills. The themes derived from thematic analysis included combating burnout, using entertainment as a distraction, participating in physical and spiritual activity, and meditating. The residents also cited processing with others and having supportive faculty as ways to debrief from difficult experiences in residency.

Usefulness of Reflection Rounds in Family Medicine Residency

When discussing the usefulness of RRs, 1 resident shared, "I think staying connected is really important…staying connected to your peers, staying connected to your team leaders, to your faculty, and not just through email. Talking to each other is important." This emphasizes how social connection during training relates to the theme of processing with others to combat burnout and to enhance wellness. RRs would offer a way to facilitate this type of social connectedness. When designing training experiences, programs should consider the impact of resident socialization on overall wellness. Another resident expressed the challenge of training under different specialty services as a family medicine resident, stating:

> "[We are] rotating in different services with different personalities and different aspects to medicine that could be particularly challenging, and because we rotate in so many different places, we oftentimes don't see each other enough or get together enough and truly talk about how we're doing in that service, especially if it's a completely different service. So, I do think that reflection rounds would be really beneficial—more so for family medicine."

This statement stresses the diverse training experiences of family medicine residents because they frequently rotate on different services, such as pediatrics or emergency medicine. Because of this, there exists more opportunities for family medicine residents to experience the stress of adjusting to new team members,

Table 2. Grouping Codes

Grouping code	# of transcript quotations	Questions asked during focus group	Conclusions
Balance	7	What is well-being? What does it mean to have "well-being"? How would you know if someone has high well-being? What are the indicators? How would you describe a resident in your program with high well-being?	Well-being and wellness are developed by cultivating balance and having time to recuperate
Recuperation	3		
Having a positive outlook	4	How would you know if someone has low well-being? What are the indicators? What is the difference between "unwellness" and wellness?	Low well-being is associated with feeling overwhelmed and having a lack of rest. Having a positive outlook is associated with wellness.
Feeling overwhelmed	5		
Lack of rest	1		
Distracting with entertainment	6	Currently, what resources do you typically use to debrief from difficult experiences in residency? Currently, what resources do you typically use to receive physical, emotional, or spiritual support to combat burnout?	Ways residents debrief from difficult experiences and combat burnout include distracting with entertainment, participating in physical activity and spirituality, meditating, processing with others, and supportive faculty.
Distraction	3		
Physical activity	7		
Spirituality	2		
Supportive faculty	4		
Processing with others	9		
Meditating	2		

Table 2. Grouping Codes (Continued)

Grouping code	# of transcript quotations	Questions asked during focus group	Conclusions
Systemic stressors	6	Topics that have been noted in other residency programs' Reflection Rounds include difficult patient encounters, disclosure of mistakes, poor patient outcomes, challenges in residency, and ethical issues. What other topics would you feel are appropriate for the Reflection Rounds? These reflection rounds have been studied in the setting of emergency medicine and pediatric residency programs. What factors unique to a family medicine residency would make these Reflection Rounds beneficial?What factors unique to a family medicine residency would make these Reflection Rounds unbeneficial?	Systemic stressors relating to being a family medicine resident was the main theme for topics to be discussed during Reflection Rounds.
Logistical preferences	4	Would you prefer these sessions be voluntary or mandatory? Please explain your choice. What would make you feel that confidentiality is being upheld?	There is a preference for voluntary sessions.
Preference for voluntary sessions	4		
Facilitator preference	6	Who would you feel most comfortable with leading these reflection rounds?	Discussion between peer-led versus a trained facilitator from outside of the institution.
Preferred foods	10	Should snacks be allowed in these Reflection Rounds? Please explain your answer.	There are preferences for snacks to be provided.
Scheduling preferences	10	How frequent do you think the reflection rounds should be? When should the reflection rounds take place?	General consensus is to conduct during protected didactic time.

new workflows, and new patient problems in different contexts. This constant change has the potential to exacerbate baseline burnout that residents already experience. Therefore, this unique aspect of family medicine training further highlights the need for an intervention like RRs and was supported by the residents who participated in this study.

Logistical Preferences for Reflection Rounds

Logistics appeared to be an essential consideration in RRs. While what foods are available or how something is said can at times seem unimportant, residents actually reported that these details help to manage the stress in the room. For example, when discussing the logistics of RRs, a resident shared that, "[snacks] lessen some of the tension associated with sharing." Another resident shared the importance of logistics being considered carefully,

> "Whatever is discussed in this group is confidential. ... For the purposes of these meetings, we're trying to improve the overall culture of our program, so obviously part of it is going to be sent up to faculty and our leaders, but I think as long as it's done in an anonymous way [there shouldn't be an issue]."

For these residents, sharing their experience was appropriate so long as anonymity was guaranteed. Residents also expressed a preference for the facilitator to be trained in group facilitation. Doing so allows for a cathartic experience, in which residents feel like they are not only sharing with each other but also having their perspective heard. Additionally, residents asked that groups be confidential and split by postgraduate year, PGY-1, 2, and 3, respectively. Issues that arise year over year can be distinctive, and it was suggested that these topics should be discussed with peers who can most closely relate. Residents also voiced preference for the groups to occur on protected time, during didactics on a monthly or quarterly basis.

Discussion

Overall, the family medicine residents in this project described well-being and wellness as being developed by cultivating balance and having time to recuperate. Having low well-being that is associated with feelings of overwhelmingness and combatting resident burnout by using a variety of coping skills are consistent with previous literature published on physician wellness and supported by our findings.[18] Incorporating RRs into the wellness curriculum was welcomed by the residents, and recommended topics for group discussion included "being off-service" (ie, rotating through a department other than the family medicine core department, such as the obstetrics and gynecology or general surgery departments).

A strength of the project was that it identified an additional tool for training programs to consider when designing resident wellness programs. A limitation of this project was that it was focused on 1 residency program and may not be representative of other programs. Additionally, data was cross-sectional and not collected after the initiation of the RRs. To date, there have been no longitudinal studies completed on resident experiences with RRs—this would be an important focus for future studies. As residency programs build and refine their wellness curricula, consider the RR preferences recommended by the residents in this project. Suggestions included having confidential groups, unrecorded rounds, rounds split by training year, a trained facilitator lead the RRs, offering snacks if feasible, and making the RRs available on a regular basis during protected didactic time. Areas for expansion in future work include having peers who are trained in group facilitation versus a trained group facilitator from outside of the institution to lead the groups. There are pros and cons to both options, and since this was discussed in the focus groups, the researchers encourage future research to examine these constructs.

Conclusion

Physician wellness is an important part of practicing medicine given the increasing patient complexity as well as the institutional barriers health care systems inherently manifest.[19] To achieve the Quadruple Aim, wellness education focused on building self-reflection early in medical training may be of importance in addressing the wellness needs of those asked to consistently deliver competent and compassionate health care.[20]

Conflicts of Interest

The authors declare no conflicts of interest.

Author Affiliations

1. Long School of Medicine, UT Health San Antonio, San Antonio, TX
2. Lake Norman Medical Group, Mooresville, NC
3. School of Public Health, UT Health San Antonio, San Antonio, TX

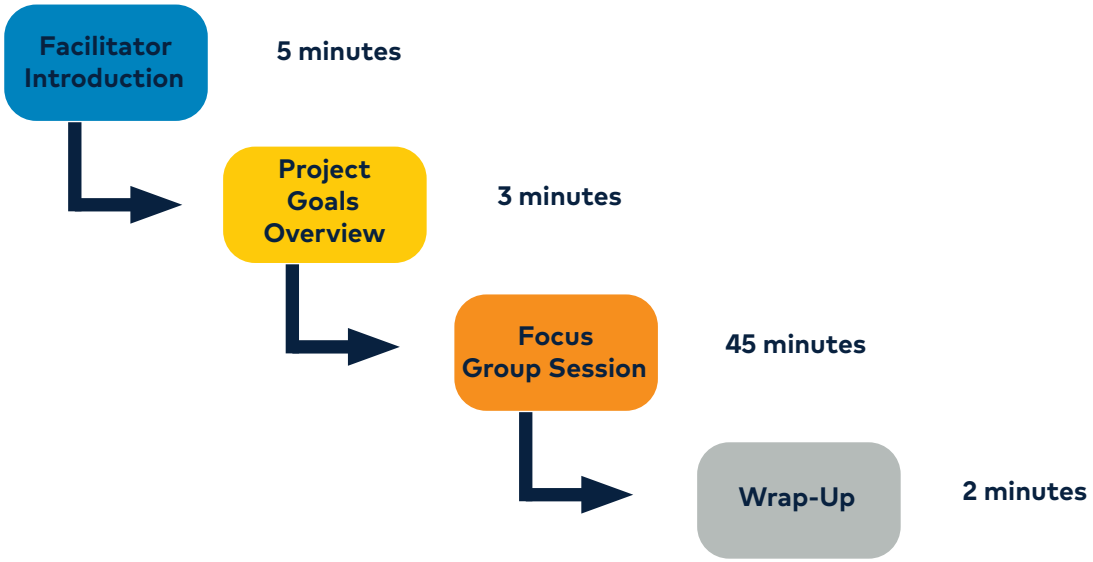
References

1. Janiczak D. Exploring humanism in medicine: reflection rounds with medical students and residents. *Am J Psychiatry Resid J*. 2017;12(10):8. doi:10.1176/appi.ajp-rj.2017.121005
2. Raj KS. Well-being in residency: a systematic review. *J Grad Med Educ*. 2016;8(5):674-684. doi:10.4300/JGME-D-15-00764.1
3. Stamm B, Yu M, Lineback CM, Bega D. Six steps to achieve meaning, wellness, and avoid burnout in a residency program. *J Med Educ Curric Dev*. 2020;7:2382120520978238. Published 2020 Dec 7. doi:10.1177/2382120520978238
4. Foster E, Biery N, Dostal J, Larson D. RAFT (Resident Assessment Facilitation Team): supporting resident well-being through an integrated advising and assessment process. *Fam Med*. 2012;44(10):731-734.
5. Aggarwal R, Deutsch JK, Medina J, Kothari N. Resident wellness: an intervention to decrease burnout and increase resiliency and happiness. *MedEdPORTAL*. 2017;13:10651. doi:10.15766/mep_2374-8265.10651
6. Wen LS, Baca JT, O'Malley P, Bhatia K, Peak D, Takayesu JK. Implementation of small-group reflection rounds at an emergency medicine residency program. *CJEM*. 2013;15(3):175-177. doi:10.2310/8000.2013.130935
7. Calder-Sprackman S, Kumar T, Gerin-Lajoie C, Kilvert M, Sampsel K. Ice cream rounds: The adaptation, implementation, and evaluation of a peer-support wellness rounds in an emergency medicine resident training program. *CJEM*. 2018;20(5):777-780. doi:10.1017/cem.2018.381
8. Balint groups. The American Balint Society. www.americanbalintsociety.org.
9. Chokshi KA, Vero E. Reflection rounds: fostering professional development and physician wellness through self-reflection. Abstract published at Hospital Medicine 2018; April 8-11; Orlando, FL. https://shmabstracts.org/abstract/reflection-rounds-fostering-professional-development-and-physician-wellness-through-self-reflection/
10. Sandelowski M. Whatever happened to qualitative description?. *Res Nurs Health*. 2000;23(4):334-340. doi:10.1002/1098-240x(200008)23:4<334::aid-nur9>3.0.co;2-g
11. Sullivan-Bolyai S, Bova C, Harper D. Developing and refining interventions in persons with health disparities: the use of qualitative description. *Nurs Outlook*. 2005;53(3):127-133. doi:10.1016/j.outlook.2005.03.005
12. O'Connor C, Joffe H. Intercoder reliability in qualitative research: debates and practical guidelines. *Int J Qual Methods*. 2020;19:160940691989922. doi:10.1177/1609406919899220
13. Miles MB, Huberman MA. *Qualitative Data Analysis: An Expanded Sourcebook*. 2nd ed. Sage Publications; 1994.
14. Dodgson JE. Reflexivity in qualitative research. *J Hum Lact*. 2019;35(2):220-222. doi:10.1177/0890334419830990
15. Kvale S. *Interviews: An Introduction to Qualitative Research Interviewing*. Sage Publications; 1996.
16. van Manen M. *Researching Lived Experience: Human Science for an Action Sensitive Pedagogy*. 2nd ed. Routledge Taylor & Francis Group; 2017.
17. Dahlberg K. The essence of essences – the search for meaning structures in phenomenological analysis of lifeworld phenomena. *Int J Qual Stud Health Well-being*. 2006;1(1):11-19. doi:10.1080/17482620500478405
18. Johansson K, Ekebergh M, Dahlberg K. A lifeworld phenomenological study of the experience of falling ill with diabetes. *Int J Nurs Stud*. 2009;46(2):197-203. doi:10.1016/j.ijnurstu.2008.09.001
19. Katerndahl D, Wood R, Jaén CR. Complexity of ambulatory care across disciplines. *Healthc (Amst)*. 2015;3(2):89-96. doi:10.1016/j.hjdsi.2015.02.002
20. Buck K, Williamson M, Ogbeide S, Norberg B. Family physician burnout and resilience: A cross-sectional analysis. *Fam Med*. 2019;51(8):657-663. doi:10.22454/FamMed.2019.424025

Appendix 1. Focus Group Procedure and Protocol

Protocol Overview

This document serves as the protocol for conducting Online Focus Group Sessions under the Family & Community Medicine (FCM) Residency Wellness Quality Improvement project. Focus group facilitators will introduce themselves and the goals of the project before conducting the focus group session.



Team Introduction *Read the Following*

- This focus group is part of the Family & Community Medicine (FCM) Residency Wellness Quality Improvement project.
- I'm XXX, and I'm a PGY-1 interested in provider wellness initiatives.
-

Project Goals Overview *Read the Following*

- Today we will be discussing wellness, well-being, burnout, and your thoughts on the implementation of Reflection Rounds within the FCM Residency. Our goal is to learn from you and capture your ideas to drive program change and improve this program's culture.
- We want to learn about the depth of wellness, its causes, and the incorporation of Reflection Rounds in the Wellness Curriculum by exploring the following questions:
    - What is wellness?
    - What leads to wellness vs. low well-being?
    - How can the addition of Reflection Rounds in the wellness curriculum aid in addressing self-care and wellness?

We want to get a diverse set of views and arrive at a final consensus about how you all collectively view wellness and the use of Reflection Rounds. This consensus will be shared with the FCM Residency Program.

- We recognize that wellness and well-being are abstract constructs. We are going to take time together to discuss these constructs at various conceptual levels. When we're thinking at ground level, we are going to talk about wellness for you (personally). When we're thinking at the 10,000ft level, we are going to talk about wellness and the influencing factors related to the program.

- **What are Reflection Rounds?** These are 1-hour sessions that occur on a reoccurring basis (e.g., monthly, bimonthly, quarterly, etc.) with trained facilitators. Residents will be provided with a confidential environment to discuss difficult ethical and interpersonal encounters from their clinical experiences. Reflection Rounds offer a forum for residents to discuss difficult issues in a safe environment that will promote reflective practice (i.e., self-reflection) and foster cooperative learning around the communication, professional, and ethical challenges inherent in family medicine practice.
- Lastly, within our goal to understand wellness and the use of Reflection Rounds, as it relates to your development as a medical trainee, we'll pivot accordingly to understand how COVID-19 has possibly impacted your approaches to self-care and well-being. We will take some time toward the end of this focus group session to discuss this topic with you to get your perspective as it connects to your well-being.
- Next, I would like to explain the ground rules for the focus group.
    - Participation in the focus group is voluntary.
    - It's all right to abstain from discussing specific topics if you are not comfortable.
    - All responses are valid. There are no right or wrong answers.
    - Please respect the opinions of others, even if you don't agree.
    - Please stay on topic. I may need to interrupt so that we can cover all the material.
    - Speak as openly as you feel comfortable.
    - Avoid revealing detailed information about your personal health.
    - Help protect others' privacy by not discussing details outside the group.
    - Are there any questions? (If questions, address the questions. If none, begin the focus group).

Questions – Focus Group Session

1. Well-being
    a. What is well-being? What does it mean to have "well-being"?
2. Well-being indicators
    a. How would you know if someone has high well-being? What are the indicators?
    b. How would you know if someone has low well-being? What are the indicators?
    c. What is the difference between "unwellness" and wellness?
3. Describe
    a. How would you describe a resident with high well-being in your program?
4. Observation
    a. What would you notice about what they say and do?
5. Currently, what sources do you typically use to debrief from difficult experiences in residency?
6. Currently, what sources do you typically use to receive physical, emotional or spiritual support to combat burnout?
7. Topics that have been noted in other residency programs' reflection rounds include difficult patient encounters, disclosure of mistakes, poor patient outcomes, challenges in residency, and ethical issues. What other topics would you feel are appropriate for the reflection rounds?
8. These reflection rounds have been studied in the setting of emergency medicine and pediatric residency programs. What factors unique to a family medicine residency would make these reflection rounds beneficial?
9. What factors unique to a family medicine residency would make these reflection rounds unbeneficial?
10. Would you prefer these sessions be voluntary or mandatory? Please explain your choice.
11. Who would you feel most comfortable with leading these reflection rounds?
12. What would make you feel that confidentiality is being upheld?
13. How frequent do you think the reflection rounds should be?
14. When should the reflection rounds take place?
15. Should snacks be allowed in these reflection rounds? Please explain your answer.

COVID-19

- Prevention
  - How has the efforts and directives to prevent COVID-19 impacted your current wellness?
  - What elements of this prevention do you appreciate?
  - What elements are barriers or stressors?
- Protection/Response
  - What are the measures taken by the program, university, or hospital that helped you feel protected?
  - Describe how the institutional response (e.g., clinic, university, hospital, program) has impacted or facilitated your wellness?
- Recovery
  - What advice would you give future residents and program leadership as it relates to well-being during COVID-19?
  - If you were to write a plan, what would you include to enhance health and well-being of trainees during such a time?

Closing the focus group (when there are 5 minutes left): As the focus group comes to an end, please reflect on the main ideas that were discussed today. Does anyone have any additional thoughts to share? (If anyone does, allow the participant(s) to speak. If not, please go to the next session and read the ending script to close the focus group).

Facilitator ends focus group session by saying: "Your participation in this focus group is now complete. Thank you for your time and feedback to help us improve the wellness curriculum within the FCM Residency Program."