Chapter 9

Schwartz Rounds: What are they and how do they support all staff groups working in healthcare?

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The need for support amongst healthcare staff

Healthcare staff are confronted with brutal situations on a regular basis. For instance patients and families angered by long waiting times or delayed discharge, patients suffering drawn out and sometimes painful deaths, increasingly complex clinical presentations and the daily pressures of working in under-resourced settings. These are just a few examples of the challenges faced by healthcare staff. It is therefore unsurprising that self-reported stress and sickness absence of health service staff is greater than that of the general population (Jones *et al,* 2013). Doctors have higher rates of mental health problems (depression, anxiety, alcohol or substance addictions and burnout) compared with the general population (Brooks *et al,* 2011) and 38% of nurses reported feeling unwell as a result of work-related stress in the past year (Royal College of Nursing, 2013). Yet, while forms of organisational support and supervision have been shown to bolster the drive for improved quality and safety of patient care, good examples of robust support are scant. Where good practice is identified it is often under threat of being squeezed out by regulatory and managerial demands (Tomlinson, 2015). In this chapter we will explore the value of Schwartz Rounds as an effective tool to foster and encourage staff support.

Staff experience has been shown to affect patient experience. Analysis of survey data from over 150,000 NHS staff and patients found that factors such as staff stress and additional working hours predicted poorer patient experience, whereas good managerial support for staff predicted improved patient experience (Raleigh *et al,* 2009). Dixon-Woods *et al* (2014) found that good staff support and management are linked to organisational culture and also relate to patient experience and quality of care. Goodrich and Cornwell (2008) outlined numerous individual and organisational elements of staff experience such as staff morale, support, accountability and health status, all of which can affect the quality of patient experience. This is supported by evidence that suggests positive staff experiences are linked to decreased absenteeism (Powell *et al,* 2014), quality of care and patient satisfaction (Boorman, 2009). Interestingly, one study demonstrated that staff well-being (both physical and emotional health) was an antecedent to patient experience rather than a consequence, which further emphasises the need to pay attention to the well-being of healthcare staff (Maben *et al,* 2012). It seems logical to assume that in order for staff to deliver high quality care, they need to feel well in themselves, and one way of improving staff experience is to introduce greater support for them.

Historically, healthcare staff have supported one another over cups of tea during a lull in activity on the ward or in a chance corridor meeting. The term 'informal communities of coping' has been used to describe the means by which front-line service staff develop informal mechanisms in the form of 'collective emotional labour'. Korczynski (2003) describes the value of informal support networks of nurses and medical social workers, ascribed to the public venting of what are often deemed to be inappropriate emotions.

> *'Rest rooms, galleys, corridors and other "off-stage" areas provide an opportunity to employees to drop their corporate mask, free from the scrutiny of supervisors and customers. "Undesirable" emotions such as fear, anger, hurt and frustration can be vented or expressed... in the presence of a "willing" audience of colleagues.'* (Korczynski, 2003, p84)

These informal sources of support are valuable, but as demands build within 21st century healthcare environments, shared staff time is often pushed aside in the face of competing priorities. The design of big new modern hospitals may also impact on the ability of staff to work effectively together. A UK hospital was used as a case study for a two-year project that examined the impact of the interior design. They moved the setup from large bays and traditional 'Nightingale-style' wards to single room accommodation each with an ensuite bathroom (Maben *et al,* 2015). Staff reported that the single room accommodation made it harder for them to find other staff members and a reduction in contact with

colleagues meant that it was more difficult to observe others' work, share ideas or ask for help.

The introduction of technology has increased the pace of organisational activities and could well have led to a reduction in face-to-face conversations and connections. While the pace and demands of 21st century healthcare have intensified, some cultural barriers to emotional expression and support in healthcare remain. In 1960, Isabel Menzies Lyth described how defences against distressing work were used by staff and enabled by organisations in the form of emotional withdrawal (e.g. working with symptoms not people) and the ability to hide behind professional roles and organisational targets.

> *'Often the patient's ill-being will evoke difficult feelings in the worker, sometimes in very obvious ways, like felt disapproval, overprotectiveness, anger or fear, and sometimes more obscurely, with subtler disturbances to engagement, empathy or response.'* (Ballatt & Campling, 2011, p56)

These defences were reinforced by organisations as they were seen to protect staff against the emotional burden of care. The danger was that over time such defences created distance between staff and patients; when staff pulled away from seeing patients as individuals it was more difficult to deliver compassionate care. This suggests that compassion is, in part, enabled by seeing patients as people. Bilton and Cayton (2013) explored similar factors in relation to patient safety. They attempted to understand patient safety breaches using findings from Zimbardo's infamous Stanford prison experiment in 1973 (Haney *et al*, 1973). When a group of students were randomly assigned the role of 'guard' or 'prisoner' in a simulated prison, the 'guards' very quickly demonstrated an ability to inflict harm on the 'prisoners'. Zimbardo concluded that the behaviour demonstrated by the 'guards' was not due to flawed or immoral characters but the influence of the system in which they found themselves. He proposed that two conditions need to be in place for abusive behaviour to avail; 'deindividuation' of the perpetrators (a separation from personal identity), together with 'dehumanisation' of the maltreated.

> *'When identity is lost personal responsibility for one's actions is lost with it. In a professional setting, this is likely to result in a practitioner delivering unsafe care. In the light of these ideas we might want to draw parallels with care professionals not as the prison guards, but as themselves prisoners, subject to multiple, seemingly arbitrary and inconsistent orders, and thus becoming detached from decisions and judgements in which they should be fully engaged.'* (Bilton and Cayton 2013, p9)

While Zimbardo's experiment focused on extreme behaviours, the findings resonate with some of the shocking abuses exposed in a number of hospital enquiries over the last decade (Francis, 2013). To protect against these conditions arising in healthcare environments, organisations should themselves treat staff with compassion and make sure adequate support mechanisms are in place.

The hierarchy of many work environments can be an additional barrier to effective working relations. Lachman (2013) suggests that entrenched, medicalised and hierarchical structures are a significant factor which discourage teamwork and transparency. The pressures put on staff, working with people suffering increasingly complex co-morbidities, alongside the need to respond to emotional needs of patient and families, organisational demands and bureaucracies, can lead to adverse effects on clinicians' own well-being (Whitby *et al*, 2013).

Formal support for healthcare staff operates at a number of levels, normally within specific clinical disciplines. Psychologists, for example, undergo reflective practice and receive clinical supervision as a routine part of their job. Most professional forums in healthcare are made up of single professional groups such as psychologists or doctors. Multiprofessional clinical groups may also meet to look at clinical aspects of one particular case, but there are few forums where every staff member in an organisation is invited to attend, particularly non-clinical staff who also experience common stressors when working in healthcare settings. For example, receptionists are required to manage difficult and demanding patients; having to negotiate multiple roles as patient advocate, gatekeeper and even assessing the urgency of symptoms (Hammond *et al*, 2013; Eisner & Britten, 1999). But along with many other professionals, they are not routinely offered a forum to express the emotional impact of their work. Discussing the social and emotional aspects of care with colleagues across disciplines and positions, clinical and non-clinical, can help staff to understand shared challenges and foster a culture of connectedness. Schwartz Rounds, described below, are unique in offering reflective space to a broad, multiprofessional audience within health organisations.

What are Schwartz Rounds?

Schwartz Rounds provide a safe, confidential, voluntary, reflective forum for all staff, both clinical and non-clinical, to come together to discuss the emotional and social aspects of their jobs. The Rounds follow a standard model determining how they should be run, ensuring that they can be replicated across different settings. They normally take place once a month, for an hour at a time, usually at lunchtime with food provided. Food is an important sign that the staff are valued and cared for by the organisation. Audience numbers range from 20 to over 100 depending on the size of organisation. The basic format of the Rounds is that a panel of three or four staff members from different disciplines present stories of personal experiences. Their stories will relate to a particular topic, for example, 'giving bad news' or 'a patient I'll never forget'. Panellists take five minutes each to describe their story, focusing on how it made them feel and what emotional or social issues it raised for them. After the stories have been told and listened to, two trained facilitators open the discussion out to the audience. The facilitators guide the discussion, keeping it a reflective forum and drawing out themes from the audience's contributions. Schwartz Rounds are purely reflective, and the intention is that outcomes or solutions are not discussed. In healthcare, there is both individual and organisational pressure to identify solutions, so reflecting without solutions can feel new and perhaps uncomfortable.

Schwartz Rounds are not designed as a form of supervision and do not fit the traditional model of clinical supervision for several reasons: there is no expert and no advice is given, large groups of clinical and non-clinical staff attend, they do not focus on procedural or technical aspects of care, clinical outcomes or personal development. However, the Rounds

do have some points of comparison with supervision: they may help to alleviate anxiety and normalise difficult emotions, they may impact on personal development indirectly through listening and sharing experiences with others and they help people to feel more supported in their role.

The history of Schwartz Rounds

In 1994 Kenneth Schwartz, a young health lawyer from Boston, was diagnosed with lung cancer. Before he died, he wrote a story about his care, in which he described the distress of the diagnosis and range of treatments he had to endure. But amongst the distress, Ken experienced moments of compassion and kindness from healthcare staff, which he highlighted as a vital part of care. He said:

> *'I have learned that medicine is not merely about performing tests or surgeries, or administering drugs...for as skilled and knowledgeable as my caregivers are, what matters most is that they have empathized with me in a way that gives me hope and makes me feel like a human being, not just an illness.'* (Schwartz, 1995)

Kenneth did not want this human side to care to be neglected, so before his death, he left a legacy for the establishment of the Schwartz Center in Boston, to help to foster compassion in healthcare. This is where the Schwartz Rounds were developed and are currently running in over 300 organisations in the US. In 2009, Schwartz Rounds were brought to the UK by the Point of Care programme at The King's Fund and continue to be implemented by The Point of Care Foundation. In March 2014, over 115 healthcare organisations in the UK were signed up to run Rounds. Demand for Schwartz Rounds continues and has been driven in part by the favourable policy environment in the wake of the Darzi Review *High Quality Care for All: NHS next stage review* (Department of Health, 2008), The Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis, 2013), which mentioned Schwartz Rounds as a means of supporting staff, the NHS England Business Plan (2014) that recommended them as an intervention to improve patient experience, and Delivering Dignity (Age UK, NHS Confederation & Local Government Association, 2012), which noted that staff must be given space to reflect on the care they deliver.

What is the evidence for Schwartz Rounds?

Evidence for Schwartz Rounds is growing alongside the number of organisations running them. There are two key studies that have quantitatively and qualitatively evaluated Rounds. Lown and Manning (2010) evaluated outcomes from US-based Schwartz Rounds using surveys and interviews. They looked at whether attending Rounds impacted on self-reported patient interaction and teamwork and found several changes, including increases in: a sense of compassion, energy, appreciation for other roles, connectedness to others, ability to manage sensitive and complex patient issues and insight into psychosocial elements of care. They also found a perceived decrease in stress and isolation. This study reported greater benefits in people who attended the Rounds regularly compared to those who did not. A UK study that analysed 41 interviews from acute hospital staff (Goodrich, 2012) supported the findings of the US study. Goodrich found that Rounds provided a space to validate concerns, mistakes and emotions and also diminished hierarchies. Attendees felt that they were treated as equals and were able to observe senior staff talking openly about the emotional side of care. This helped to build a shared vision of support.

However, these two key studies are limited by self-reported outcome. A large scale, three year longitudinal study, which began in 2014, has been funded by the National Institute of Health Research. It attempts to identify mechanisms of Rounds and possible causal changes in a methodologically robust way that does not rely only on self-reported measures. It aims to uncover to what extent participation in Schwartz Rounds affects staff well-being, relationships between staff and patients and delivery of compassionate care. The study is entitled, *Supporting NHS staff at work: Could Schwartz Centre Rounds hold the key to a happier, healthier workforce and enhance compassionate care?* (National Institute for Health Research, 2014).

Rounds across healthcare settings

Schwartz Rounds began in relatively large sites providing acute care. But with the rapid expansion of Rounds they are now being introduced in a range of different clinical settings in the UK, including community and mental health trusts, hospices, primary care and educational settings. The Point of Care Foundation is exploring the logistical, operational and relational factors associated with these different settings, to examine which factors facilitate or impede progress. While there appears to be a number of generic factors influencing the success of the Rounds across all organisations, there are other, largely logistical issues, which may affect progress and uptake in more dispersed settings.

Where Rounds have got off to a good start the success is almost always linked to a committed and stable leadership team and early identification of a motivated, skilled, core Schwartz team who have been given permission, time and licence from the organisation to get the Rounds going. Having the capacity to demonstrate Rounds' benefits through shared stories and routine sharing of data is also key to continued support and momentum.

What are the mechanisms demonstrating how Schwartz Rounds work?

Attempts have been made to articulate the mechanisms responsible for the beneficial outcomes reported from the Rounds (Goodrich, 2012; Wren, 2014), yet a full theory remains undeveloped. Here we present six hypotheses covering various levels where their impact may be felt.

1. Normalising emotions

Healthcare settings can be lonely places, particularly if staff feel unsupported when coping with the difficult emotions that arise during the course of their work. Thoughts of fallibility, incompetence, bullying and feelings of fear, jealousy, grief and shame are all common experiences that are expressed during Schwartz Rounds. Sharing these experiences normalises them and allows staff to move from a place of isolation to a community of shared understanding. Normalisation in this context does not refer to diffusion or lessening emotion (as described in Ashforth & Humphrey, 1995), but rather in realising that unpleasant emotions are experienced by all, staff more

openly express their own emotions. Normalising is recognised as a basic therapeutic skill in psychology, for validating others' experiences and reducing the sense of difference. When feelings are normalised, fears of personal failure and incompetence are reduced and there is a recognition that all people are prone to the same normal human fallibilities. This may help to overcome myths of healthcare staff as 'heroes' or 'automatons'. We suggest that in Rounds, the masks that help staff to defend against their daily work struggles are taken off and the person in the professional is revealed.

One nurse who attended a Round and heard a senior consultant talk of his/her own vulnerabilities reported:

> *'It's been so valuable hearing from different professional groups and learning that they too are vulnerable. When I was a newly qualified nurse there was one consultant who I was so terrified of. I used to hide in the toilets so that I wouldn't have to accompany them on the ward round. If I'd known at the time that consultants had the same emotions as me then I wouldn't have had to hide myself away!'* (Nurse at Round)

2. Changing narratives

Stories have the ability to empower both narrator and audience. The power of telling and witnessing stories has been formalised in some psychological interventions. In Narrative Therapy (White & Epston, 1990), for example, the patient invites someone to witness their story and subsequently listens to the witness's response. This approach hypothesises that having an external observer helps us to validate our identity. Narratives move from being isolated and internal, to being shared and changeable. New narratives may also help staff to reconnect with their values; reaffirming the motivation behind working in the healthcare profession. As well as individual narratives, healthcare organisations as a whole will harbour narratives and therefore Rounds may help to populate the colour of the organisational narrative. For example, one story told by a porter in an acute trust rapidly spread across the organisation and changed the perception of a porter's role. The porter told of how he had been called to take a baby who had died to the mortuary and described the mother not wanting to let go of her child. The porter gently persuaded the mother to let the baby go by asking her to accompany him to the mortuary and reassuring her that he would take care of the baby. In the eyes of those attending the Round the role of the porter was transformed from a 'transporter' to someone who was integral to care and patient experience.

The Rounds may have the power to change narratives and in turn change the way people interact with one another.

> *'Everything just slightly tilts, and the next time you see them you're different with them from how you were before, and if what they are saying resonates with you, you feel you have a different connection with them.'* (Nurse at a Round, from Reed *et al*, 2014)

3. Promoting connectedness

Healthcare environments are increasingly fragmented, hierarchical and tribal places, with each professional carrying out their own duties, but not necessarily with a sense of how their contribution connects with the complete patient journey. The Rounds appear to engender a sense of connectedness with the 'whole' system.

> *'I sometimes feel as if you're a little part of a jigsaw and going to a Schwartz Round you see all the other bits of the jigsaw, so you actually get the whole picture which is ... it's reassuring, it's comforting, it's enlightening, it's educational, it's all these things.'* (Volunteer at Round, from Reed *et al*, 2014)

Currently, Schwartz Rounds are the only forum that allow healthcare staff at all levels and from all departments to come together in a reflective space. Having a diverse mix of staff groups engaging in dialogue allows for a deeper understanding of each others' roles and a stronger sense of connectedness. In turn, the hierarchies that are often strongly pronounced within medicine are temporarily, or possibly more permanently, flattened (Goodrich, 2012). This links back to the 'person in the professional'; once the person is revealed, staff may connect more easily as human beings.

One social worker who attended a Round said:

> *'You don't feel quite so alone. I think sometimes when we're very stretched you feel it's just you, you know, it's just you that's carrying this burden and then you realise that actually the whole team is around you and they're carrying it too.'* (Social worker at Round, The Point of Care Foundation, 2014)

4. Creating a culture of openness

Schwartz Rounds not only create connections between individuals, but may contribute to a wider culture of openness. The discussions that occur in Rounds model new modes of interaction, in which staff can share experiences without judgement or solutions.

> *'I've been interested listening to the various contributions how many of my own emotions it's unlocked. Emotions that were deeply buried within me. I think we all tend to do this and the danger of locking things away is that you then don't recognise these feelings when other people are going through them.'* (Consultant at hospital Round, The Point of Care Foundation, 2014)

Over time, this consistent reflective space may impact on the organisation more broadly, encouraging staff to employ their reflective stance in their work outside the Round. For example, staff often disclose experiences of fallibility and mistakes in Rounds; if this is carried across into their everyday practice or work, a culture of increased openness and transparency could develop.

5. The 'failure to cure'

Healthcare services and staff are often judged on their ability to 'cure'. Improving health is the fundamental purpose of healthcare, however sometimes patients cannot be healed. This not only applies to end of life care, but to populations with chronic physical and mental health conditions, in which improvement is sometimes difficult to achieve. Gawande (2014) in his book *Being Mortal* describes the tendency of the medical profession to want to fight death at all costs, often without honest consideration of what this means to the patient's deteriorating quality of life. Yet, he reminds us, death eventually wins. He advises:

> *'You don't want a general who fights to the point of total annihilation. You don't want Custer. You want*

Robert E. Lee, someone who knows how to fight for territory that can be won and how to surrender it when it can't, someone who understands that the damage is greatest if all you do is battle to the bitter end.' (Gawande, 2014, p187)

Gawande highlights with great sensitivity the difficulties that healthcare staff have in facing issues of immortality and of initiating the discussions that need to be had with patients to help them make decisions around their treatment and care. Schwartz Rounds are a rare opportunity to tackle some of the unresolved issues that healthcare staff feel, e.g. when patients can't be 'cured' or have been treated by a series of brutal and possibly ineffective interventions. The Rounds can provide a space for staff to reconnect with the importance of open communication and demonstrate that kindness and empathy (not just clinical outcomes) are integral to good quality care.

6. Role modelling

More than a century ago William Osler proposed a model of medical education based largely on teaching by example (Scott *et al,* 1998). Today, role modelling continues to be seen as integral both to medical education and the ongoing acquisition of professional skills. Schwartz Rounds can provide opportunities for positive role modelling and the promotion, through example, of good professional practice; specifically related to the more human side of care. Junior staff and students may in particular find it useful to witness senior staff reflect on the emotional side of care, which is often masked by professional barriers and entrenched hierarchies.

'...that surgeon is so high up I would normally be intimidated by him. I'm a medical student and don't want to say anything stupid, but his presentation made him so much more approachable. So if I now had him [for a teacher] *and you find a situation upsetting you would be much more likely to say something or be more open with him. Not to be so scared to say something ... it's good bridging.'* (Medical student attending a Round)

Rounds won't work for everyone

We have looked at mechanisms that may work to accrue positive benefits of attending Rounds. But it is important to acknowledge that Rounds won't suit everyone and people have different styles of coping with the emotional burden of care.

'Some people cope by pushing things to the side – that's OK – it's one way of coping. There is no right or wrong way. We don't need to judge. In order to build your own resilience everyone needs to find their own way.' (Round facilitator)

Conclusion

This chapter has highlighted the need for more formalised forms of emotional support for staff working in health care settings and has showcased Schwartz Rounds as an evidence-based way of helping to alleviate some of the stress, anxiety and sense of fragmentation that can build up. The unique potential of Schwartz Rounds to offer support for all groups of staff in a non-hierarchical forum has been particularly appreciated by those involved. The experience is levelling and offers a rare insight into the emotional impact of the everyday routine on healthcare staff. Porters, secretaries, consultants, nurses, allied health professionals, catering staff, all come together and offer a glimpse of the stresses and strains of each other's lives. The recognition of different roles within the organisations and the ability to see the person in the profession helps build team cohesion. The conversations that unravel appear to impact at an individual, team and organisational level, highlighting that all staff contributions are integral to the overall ambition of improved patient outcomes.

While Rounds can't be equated to supervision, they share a number of common outcomes, specifically relating to an increased sense of support, alleviating anxieties and normalising emotions. The clearly defined model for running Rounds is welcomed by users and ensures replicability across settings. The outcomes from Rounds are generally perceived positively by staff, though the complexities of the different contexts in which they are operationalised present challenges and there are notable factors that may hinder successful implementation. Importantly, Rounds require top level support; organisations need to prioritise resources to set them up and sustain them and to encourage and enable attendance by everyone.

Their rapid growth in the UK is to be celebrated and is a clear demonstration of the need for improved staff support. While the Rounds were first developed within acute trusts, they are now running in a variety of settings including: hospices community trusts, mental health trusts, an ambulance trust and a medical school. There is growing interest shown in the model from a number of different sectors including education and business. We are in the process of building a more coherent framework, articulating the mechanisms at work during the Rounds and demonstrating how successful outcomes can be routinely achieved across a variety of different settings. One of our particular ambitions is to develop a cost-effective model which can be implemented in organisations where opportunities for support and reflection are at best limited, and where staff numbers are comparatively small, such as GP practices. It is hoped that the growing body of data and evidence being collected, coupled with the National Institute for Health Research study currently underway, will contribute to an even more robust evidence base.

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