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Title Page

A qualitative exploration of the experiences of students attending interprofessional Schwartz Rounds in a University context

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Keywords: *Schwartz Rounds, Interpretative Phenomenological Analysis, interprofessional education, healthcare, compassion, students*

Notes to Examiner

1. This paper has been written in preparation for publication in the Journal of Interprofessional Care and has therefore been written to comply with their guidelines, which can be found in Appendix A.
2. The word limit for this journal is 8000 words. When removing the table (not included in the journal word count) and references to appendices, the word count is 7990. The table has been included in situ for submission for examiner ease, but for submission it will be on a separate document to meet journal requirements.
3. Appendices have been submitted with this research to evidence the level of work required for the Doctorate in Clinical Psychology course. These are in excess of what is required for the submission for the journal.
4. This paper uses first person to describe the author's position as this is in line with qualitative research and the paper's epistemological position.
5. This journal adheres to the following definitions:
 - a. 'Interprofessional education' occurs when members (or students) of two or more health and/or social care professions engage in learning with, from and about each other to improve collaboration and the delivery of care.
 - b. 'Interprofessional learning' is learning arising from interaction between members (or students) of two or more professions. This may be a product of interprofessional education or happen spontaneously in the workplace or in education settings and therefore be serendipitous in nature.
 - c. 'Professions' are occupational groups who in general provide services to others, such as nurses or social workers. It can be used as a term of self-ascription to avoid the need to apply regulatory criteria which differ between groups.

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Declaration of Interest

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of this article.

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Abstract

Schwartz Rounds are a cultural change initiative for interdisciplinary staff to reflect on their work to preserve the human connection. Their recent implementation in educational contexts means that there is limited research exploring the experience of students attending Rounds. This study aimed to develop understanding of how healthcare students experience participation at Schwartz Rounds in a University context. Using an Interpretative Phenomenological Analysis approach, semi-structured interviews were conducted with eight healthcare students about their experience of attending Rounds. Three inter-related superordinate themes were identified: “would it reflect badly on me?”: ambivalence about safety to share; “you’re not alone in feeling that”: unifying through sharing emotions; and “there’s not normally space given to that”: space to question professional cultures. The findings suggest that Rounds promote connectedness through humanising professions and focusing on shared emotions; however safety to share within Rounds can be limited by fear of judgement. This supports previous literature and suggests that Rounds may be well-placed in educational contexts to support cultural change from the beginning of training.

Keywords: Schwartz Rounds, Interpretative Phenomenological Analysis, interprofessional education, healthcare, compassion, students

Introduction

There is increasing need within the National Health Service (NHS) for cultural change to promote person-centred approaches with a focus on compassion and support for staff to improve safety and patient care (Francis, 2013). To create cultural change, initiatives must target both qualified and pre-qualification professionals (Pecukonis, Doyle, & Bliss, 2008). One initiative being introduced to address cultural change during education is Schwartz Rounds (Rounds).

Originating in the United States (called Schwartz Center Rounds), Rounds were developed as part of the legacy of Kenneth Schwartz, a healthcare lawyer who, during treatment for lung cancer, observed variability in staff compassion towards him. He noted how the high pressured hospital context can “stifle inherent compassion and humanity” (Schwartz, 1995, p.3). Rounds aim to provide space for interdisciplinary staff to reflect upon their work to preserve the human connection (Point of Care Foundation, 2015). Each Round lasts one-hour, beginning with a panel of staff who present stories about a theme or experience of patient care, such as ‘a patient I will never forget’. The audience are invited to join the discussion, and two facilitators encourage focus on thoughts, feelings and mutual understanding, as opposed to problem-solving. Since their introduction in the UK in 2009, over 100 NHS Trusts now deliver Rounds, and more recently three Universities have introduced Rounds as part of pre-qualification training for healthcare students.

Attendance at Rounds has been found to have a number of benefits for staff wellbeing, including increasing compassion, strengthening interdisciplinary working, promoting less hierarchical working, reducing isolation, and increasing empathy to both staff and patients (e.g. Maben et al., 2017; Reed, Cullen, Gannon, Knight, & Todd, 2015; Goodrich, 2011; Lown & Manning, 2010). Multiple attendances at Rounds has been found to

increase their impact (Lown & Manning, 2010), and in an evaluation of Rounds, psychological wellbeing significantly improved in regular attenders, with a 13% decrease in psychological distress scores compared to 3% in non-attenders (Maben et al., 2017).

Such change is thought to occur through the creation of a counter-cultural space. Here, staff can share their experiences, witness self-disclosure and role-modelling of vulnerability, and feel emotionally safe and contained (Maben et al., 2017). This 'third space' promotes connection with humanity, enabling reflection and resonance both individually and as a group. Story telling has been viewed as a form of authentication of experience (White & Epstein, 1990), and doing so in Rounds can normalise and validate feelings that may have otherwise remained hidden (George, 2016). Through these processes, compassionate care and wellbeing are likely to improve (George, 2016; Maben, 2013).

Preparing future healthcare professionals for the challenges of working in the NHS is paramount, and nursing and medical professional bodies have stated that more needs to be done to develop their resilience during training (NMC, 2017; GMC, 2015). Stress has been found to be experienced from the onset of professional training and as training continues and demands increase, levels of empathy and caring behaviours decrease, particularly when social support is limited (Burks & Kobus, 2012; Park et al., 2015). Students become socialised into hospital cultures using their pre-existing assumptions of professional stereotypes and hierarchies often developed through the media to gain the attitudes, values and behavioural norms of their profession (Reeves & Pryce, 1998; Clark, 1997). This can create a professional social identity, leading to favouring those within their profession (Hogg & Terry, 2000). Professional socialisation can be impacted by challenges the NHS is facing, with overwhelmed and target-driven services. This can create dissonance between the reality of practice where resources and time need to be optimised and students' ideals of compassionate

care. Such dissonance can contribute to a decrease in empathy and an increase in work-based stress (Curtis, Horton, & Smith, 2012).

Stress is a prevalent problem for healthcare staff, who have been found to experience significantly more work-related stress than those in other professions (Health and Safety Executive, 2016). As part of managing stress and self-preservation, emotional detachment, suppression of emotions or burnout may occur (Maben, 2013). Burnout can be defined as a state of physical, mental and emotional exhaustion produced by sustained and excessive stress, and significantly affects the way that staff interact with each other and patients (Maslach, Jackson, & Leiter, 1996). It can lead to a lowered sense of self-efficacy, emotional exhaustion, and depersonalisation, a process of withdrawal whereby someone may protect themselves with organisational mechanisms such as language, uniform, procedures and targets (Maslach et al., 1996). Depersonalisation can impact on the ability to use good communication and act compassionately, and can produce cruelty when dealing with patients (Menzies-Lyth, 1988).

Organisational support can help protect staff from burnout and depersonalisation (Maben, 2013). Rounds are thought to reduce risk of burnout through providing space to manage stress and promote wellbeing (Maben et al., 2017). Supporting staff is important; positive staff wellbeing has been identified to be an antecedent to good patient care, rather than a consequence, suggesting that improving wellbeing may promote good care (Maben, 2013). Inextricably linked to this however is the impact of organisational culture (Boorman, 2009; Dixon-Woods et al., 2014).

Implementing Rounds during education is hoped to introduce reflective and interprofessional support at the start of professional development and thus contribute towards cultural change (Barker, Cornwell, & Gishen, 2016). Rounds provide an opportunity for

interprofessional education (IPE), which has been found to improve teamwork, communication, and attitudes to interprofessional working (e.g. Bridges, Davidson, Soule Odegard, Maki, & Tomkowiak, 2011). IPE is thought to counteract social and organisational challenges of power and professional identity that can impact on interprofessional working (Pecukonis et al., 2008). Interprofessional learning aims for learners to make sense of their own learning, therefore meaning that interactive facilitation and non-didactic teaching methods are most appropriate (Merriam, Caffarella, & Baumgartner, 2006; Lindqvist & Reeves, 2007). The format of facilitated discussions in Rounds suggests that they represent a suitable IPE initiative for use during professionals' training.

At the time of writing, to our knowledge three UK universities have introduced Rounds at pre-registration stage (Plymouth, Liverpool and University College London). Early evidence of effectiveness is limited though promising. Barker et al. (2016) introduced Rounds for medical students with an interprofessional panel, attended voluntarily on teaching days. Thematic analysis of focus group and free-text feedback indicated that students valued the ungraded opportunity, open space to normalise emotions and connect to others, role modelling, and developing their emotional resilience. A similar study by Gishen, Whitman, Gill, Barker and Walker (2016) identified that participants felt that Rounds provided a space to reflect on their emotions and provided insight into other perspectives. However, in both these studies Rounds were only aimed at medical students. No research to date has explored the experience of students attending interprofessional Rounds.

The current study explored students' experience of attending interprofessional Rounds in a University context. This study was conducted at the University of Plymouth, where Rounds were introduced in 2017 with a steering group of trained facilitators, University staff, clinicians, and learners. Students and staff from health and social care courses were invited to attend Rounds, including medicine, nursing, midwifery, mental health nursing, paramedicine,

physician associates, psychology, social work, physiotherapy, dentistry, occupational therapy, speech and language therapy, and optometry. This was designed to mirror the interprofessional teamwork within healthcare. Rounds were attended on a voluntary basis, held on University campuses, and could be attended during placement time (with approval from supervisors). Panellists included students and clinicians who shared stories based on a theme, such as ‘learning from mistakes’.

The aim of this study was to develop understanding of how healthcare students experience participation at Schwartz Rounds in a University context. It is hoped that this research can contribute to the development of Rounds in this context.

Method

Research Design

This study employed a qualitative design using semi-structured individual interviews. The study was informed by Interpretative Phenomenological Analysis (IPA), following a social constructionist epistemology (Smith, Flowers, & Larkin, 2009). This is an established idiographic method, focusing on exploring and interpreting the meaning people make of their experiences within a certain context (Smith et al., 2009). IPA assumes that people are naturally inclined for self-reflection, and focuses on how they interpret their experiences (Chapman & Smith, 2002). The researcher is fundamental in making sense of participant’s experience and developing interpretations to explain their experience in their context (Smith et al., 2009).

Participants

Participants comprised of eight healthcare students including seven females and one male aged between 23 and 41 (mean=30.5, SD=6.48) enrolled in Mental Health Nursing (n=2), Adult Nursing (n=3), Clinical Psychology (n=1) and Medicine (n=2). They were recruited through purposive, opportunistic sampling of students who attended Rounds during the 2016-2017 and 2017-2018 academic years (see Appendix B for attendance breakdown). This is within the sample range suggested by Smith et al. (2009) and provided scope to reflect the individual and shared experiences of students from four courses, reflecting the interprofessional nature of Rounds. Inclusion criteria were attendance at one or more University Round and enrolment on a healthcare course at Plymouth University. Panellists, facilitators and staff were not eligible to participate, as this experience may differ to student audience attendance.

Participants provided demographic information including gender, course and number of Rounds attended, as shown in table 1. To ensure confidentiality, all identifiable information has been removed and pseudonyms have been used.

Table 1.

Participant demographics

| <u>Participant Name</u> | <u>Gender</u> | <u>Course</u> | <u>Number of Rounds attended</u> |
|-------------------------|---------------|-----------------------|----------------------------------|
| Eliza | Female | Mental Health Nursing | 2 |
| Charlotte | Female | Medicine | 1 |
| Neena | Female | Medicine | 1 |
| Isabelle | Female | Adult Nursing | 3 or 4 |
| Caryn | Female | Adult Nursing | 1 |
| Sue | Female | Adult Nursing | 1 |
| Vicky | Female | Mental Health Nursing | 2 |
| Sam | Male | Clinical Psychology | 1 |

Data Collection

Attendees at Rounds completed an evaluation form where they could opt-in to being contacted about research participation. Those who opted-in were sent an information sheet describing the research (see Appendix C). Interviews were arranged for those who responded and met the inclusion criteria, conducted in private rooms on the University campus (n=6) or a hospital site with University facilities (n=2). There was no recompense for participation.

Interviews lasted between 25 and 55 minutes and were audio-recorded. Interviews were conducted individually to provide space for participants to reflect on their experience more personally than may be possible in focus groups (Smith et al., 2009). Informed consent was obtained prior to the interview which explained confidentiality, right to withdraw, and gave an opportunity for questions (see Appendix D).

Interviews were semi-structured, guided by an interview schedule. Questions were informed by seven themes identified through a thematic analysis of qualitative feedback from

evaluation forms from the five 2016-2017 Rounds (see Appendix E) and using guidance from Smith et al. (2009). This allowed the questions to be grounded in the experiences of attending Rounds. Eleven open-ended questions with prompts were developed to encourage participants to reflect on their experience (see Appendix F). The schedule was amended following consultation with a Service User and Carer Consultative Group and finalised after piloting with an attender of University Rounds. Questions were used to guide the interview rather than as a fixed schedule, which meant the interviewer held a curious position and allowed participants to explore and give meaning to their experience (Smith et al., 2009). Following the interview participants were debriefed and thanked for their participation (see Appendix G).

Data Analysis

Interviews were transcribed and analysed case-by-case using IPA, following the stages detailed by Smith et al. (2009). Each transcript was read multiple times alongside the audio-recording to support immersion in the data. Initial notes were made relating to descriptive, linguistic and conceptual aspects, before emergent themes based on these notes were identified (see Appendix H for a sample analysis). Emergent themes were listed and connections made between them, before being clustered and checked against the data, ensuring connections were reflective of the original material (see Appendix I). Lastly, superordinate themes based on the clusters of themes were named. This process was conducted for each transcript. Once all transcripts were analysed, a table of themes was developed and patterns between themes explored. The final themes were based on connections between themes and their potency (see Appendix J for theme refinement). A final reading checking themes against the data was completed ensure that themes reflected the data.

Reflexivity and Credibility

It is important that qualitative research acknowledges the researchers' positions (Yardley, 2000). I am female and have worked in healthcare for six-years. I have attended University and hospital Rounds as a student on the Doctorate in Clinical Psychology, meaning I have personal experiences of Rounds as a student, similarly to my participants, and have experience of receiving care as a patient in hospital.

I received supervision from the second (AM) and third (CS) authors. AM is a Clinical Psychologist and trained facilitator and mentor for Schwartz Rounds, regularly facilitating University and hospital Rounds. CS is a lecturer in Clinical Psychology Research Methods, focusing her research on interprofessional teamwork, and has limited engagement with Rounds.

Central to the analysis was making sense of the participant's own sense-making of their experience, termed the double hermeneutic cycle (Smith et al., 2009). This cycle involves consideration of the researchers own assumptions and experiences within the analysis. A cyclical approach to bracketing was taken to develop awareness of my preconceptions involving bracketing interviews prior, during and after the analysis (Rolls & Relf, 2006). A key area identified was my experience of Rounds, where I was struck by the emotional power of stories. Awareness of this as well as my position and preconceptions was important to explore the participant's own experience. Alongside these, a reflective journal was used to continually develop awareness of my assumptions, and conversations with the second and third authors challenged my pre-conceptions to allow new themes to emerge (Smith et al., 2009).

To improve the credibility of the analysis, an independent audit was conducted with both the second and third authors reading through a transcript coded with initial codes and

emergent themes, as advised by Smith et al. (2009). Two transcripts were part-analysed at a consultative IPA group, providing the opportunity to obtain other perspectives and improve credibility of the analysis. Credibility checks also included member checking, where seven participants who consented at interview were contacted via email with their themes and the overall themes to review. Five responded with agreement to their individual themes and three to the overall themes, with no changes recommended (Appendix K).

Ethical Considerations

Ethical approval was obtained from the Plymouth University Faculty Psychology Ethics Committee (reference number:16/17-786; Appendix L). Participants were sent an email containing a participant information sheet detailing the research prior to arranging an interview. Informed consent was obtained prior to the interview and a full debrief was given at the end. Participants had two-weeks to withdraw their data, before names were removed to maintain anonymity.

Analysis

This research aimed to explore students' experiences of attending Schwartz Rounds in a University context. Overall, participants described developing trust in the space through explicit expectations and boundaries and witnessing others share and be accepted, thereby permitting them to engage how they felt comfortable. However, many participants were ambivalent about this trust, fearing judgment from lecturers or other attendees if they shared. Participants described how normalising and validating feelings created connection to others through focusing on common emotions, rather than someone's job or status. This allowed them to gain insight into others experiences, challenging pre-conceptions. A dedicated space for reflection was considered important and allowed participants to question professional cultures concerning discussion of emotions.

Three inter-related super-ordinate themes emerged across participants:

1. “Would it reflect badly on me?”: ambivalence about safety to share
2. “You’re not alone in feeling that”: unifying through sharing emotions
3. “There’s not normally space given to that”: space to question professional cultures

Theme One: “Would it reflect badly on me?”: ambivalence about safety to share

This theme captured ambivalence about whether Rounds provided a safe environment for sharing. Reflection was considered an exposing process and for some, safety to share developed through boundaries, expectations and witnessing sharing. For others, fear of judgement from others associated with power and social acceptance limited their engagement.

Many participants spoke of Rounds as a safe environment where talking about emotions was permitted. Facilitation appeared to provide containment through encouraging emotional expression, with someone who “*let it go smoothly*” and “*set the scene really it for it being that kind of environment*” (Charlotte). Permission to focus on the “*shared experience in different roles*” (Sam), rather than solving problems, may have counteracted the natural inclination to problem-solve when someone shares vulnerability.

Participants described a sense of comfort which appeared to contribute to feeling safe, “*I wasn’t asked to do anything...I just listened and reflected and quietly acknowledge people*” (Eliza). Eliza’s description suggests an element of connection and safety in the group despite not directly participating. Safety and trust appeared to develop through witnessing panellists sharing their stories:

...once the first maybe 15 minutes of the Schwartz round had erm elapsed...I guess that ice started to melt a bit and people felt more comfortable talking, lots of people

who were sitting in the audience were able to talk about their own experiences and how those were similar or different to the ones that were being spoken about, it just felt like you know the flood gates had opened and everyone was able to connect with themes that were being discussed (Neena)

Neena's metaphor of ice melting may reflect the effect of witnessing the panellists share, facilitating personal engagement. Her later metaphor of flood gates opening suggests strength and power in stories shared. Metaphors are thought to indicate expression of powerful emotions (Shinebourne & Smith, 2010) and were frequently used by participants. All participants spoke of witnessing normalising and validation of emotions, suggesting this aided safety.

However, ambivalence emerged regarding whether it was truly safe to share. Whilst some participants described openly participating, others spoke of wanting to match their contribution in an effort to feel the same.

I was by far the youngest, I think in the group, umm, the least experienced, and I kind of felt like, you know, I'm only on my second placement, I'm in my first year of training...what on earth do I have to offer to this? You know, these doctors, these consultants...and I thought, what on earth do I have to offer these people?...I don't know if I would take me seriously if I was in their shoes so I guess I kind of presumed that they wouldn't take me seriously...it's kind of finding the right balance of saying, you know, I've heard your mistakes that you've made, here's one that I've made that is comparable (Vicky)

Vicky's focus on power and status, as a student in the presence of staff (especially in this Round with a high number of staff present), and her emphasis on what makes her different to others limited her engagement until she felt able to match her contribution. This social

referencing also stopped engagement; after attending a larger Round Vicky described how it was “*not quite so easy to speak up...the conversation moves so quickly so every time you think of something to say...it’s kind of moved on*”.

This difficulty was present in other participants who felt uncertain about how others may respond. They appeared to fear judgement, perhaps reflecting a discomfort with sharing difficult experiences in a group and the contrast to their professional cultures. Sue described this as “*kind of an uncertainty*” and related this with not knowing anybody. Prior knowledge of others may increase safety and trust, which was difficult with strangers in Rounds.

Being a student in the presence of lecturers also limited this sense of safety. Two participants particularly were concerned that confidentiality would not be honoured, feeling vulnerable in their position as students to the power that lecturers have. Isabelle questioned whether the boundaries were sufficient to manage the risk of judgement:

...it’s quite nice having them involved because obviously yeh, it reinforces that it’s okay, but again on the other hand, there’s always that feeling that erm, although it is confidential and it stays in that Schwartz round that if you’ve said something that they don’t agree with would they then keep that, erm, and would that affect how they view you during your training (Isabelle)

Participants coped with the influence of power in different ways: Isabelle maintained a quiet role, whereas Caryn contributed through using “*courage to sort of like talk about it even when they are there*”.

Such uncertainty about the safety to share appeared to partly relate to experiencing reflection as uncomfortable and exposing.

it's difficult sometimes (reflecting), erm, as you're essentially analysing yourself and other people, erm...and it is on the whole beneficial because in a way you're learning, you're trying to learn from mistakes, whether its other people's mistakes or your own
(Charlotte)

Reflection alongside observing and sharing vulnerability appears to be uncomfortable and emotive, and the format of Rounds can increase this when silence occurs. However, some participants felt that, though it was not “*necessarily a comfortable experience*”, it felt non-judgmental and that “*people would listen*” (Neena), suggesting safety for some to expose vulnerability.

Overall there was a general recognition that discomfort was necessary to enable meaningful reflection; however the influence of power and need for acceptance impacted on how safe the environment felt to do this.

Theme Two: “You’re not alone in feeling that”: unifying through sharing emotions

A recurrent theme was of feeling unified through sharing emotional experiences. Relating with stories normalised and validated participants’ feelings and created a sense of connection through the focus on emotions. This broke down perceived barriers between professions and seniorities, allowing participants to gain insight into others and promoting knowledge and empathy.

...the Schwartz round gives you a space to acknowledge that some of, you know the things that, that we do in medicine are really difficult and some of the erm, you know actually it's okay if something really bad happens or, you know a patient that you've looked after for ages dies it's alright to have feelings about that you don't have to be this robot that keeps marching mechanically on and you know doing your job, erm I

think it's, it's really erm, it's really healthy to, you know for someone else to, to validate those feelings in you (Neena)

Neena's metaphor of a robot, something without the capacity to experience emotions, may reflect the medical culture which she places herself within. This normalisation and validation as "healthy" suggests that they are perceived as good and worthwhile, allowing her to feel human. Having feelings validated appeared to permit the experience of feelings within their work and feel connected to the group within the Round.

Vicky illustrated this sense of connection:

...there were about as many in the audience as there were on the panel it felt almost like the, you know, the Sharks and the Jets, like we were sort of there on their side and we were on our side but in the end, I don't think the chairs moved but it felt towards the end like we were almost sat in a circle. I don't know if people, if the panel moved their chairs out, it felt, it felt like we ended up in a circle, umm, very much on a level very much as equals, especially as everybody had spoken, umm, and I, I came out of that feeling better

Vicky compared the panel and audience to rival gangs from the film *West Side Story*, implying a difference in perceived power between groups that was shifted through the process of sharing experiences. Indeed Vicky questioned twice whether the chairs moved, perhaps reflecting her surprise at the equality that she experienced. It seems that focusing on "human realities" (Eliza) created a feeling of unity which was significant for all participants.

This unity may have been created by how Rounds "removed the barriers between the different health professions, and erm different seniorities..." (Charlotte). Participants described feeling equal, focusing "on the things you have in common" rather than "divide

themselves, the ol us and them thing, by defining themselves by their difference” (Sam). Sue noted that “take away like the symbol of the role and it’s actually you know, we’re all individual and we all have feelings”, suggesting that the professional role can be a barrier to seeing each other as human which is altered in Rounds where focus is on the shared aspects of care.

Participants spoke of lacking exposure during training to other professions and expressed concern about finishing training without an understanding of those who they will work alongside in practice. They described being able to “*bust some of the myths” (Sam)* about other professions and gain insight into their emotions, “*It’s nice to know the doctors have feelings, umm, a lot of the ones I’ve encountered don’t seem to” (Vicky)*. This experience appeared to humanise a profession, promoting empathy and addressing assumptions that may be perpetuated in healthcare. This was particularly noticeable when participants described stories about new professions to the NHS, perceived as threats. Charlotte described feeling “*a bit mugged off that physician, PA’s are now a thing”* who “*were encroaching on medical students”*. Charlotte’s language suggests having something taken by something unwanted; the presence of a new role. She discussed her pre-conceptions and experiences after hearing a physician associate speak:

...my complete view of this other profession that I knew nothing about was completely changed, and I found it really valuable because they, as opposed to hindering junior doctors they’re actually a huge asset...it let me understand that next time I come across a physician’s associate I can understand the prejudgements that other people may think about them and will try not to make them and actually like work with them more efficiently.

Her initial lack of knowledge suggests an influence of professional or media culture as the source of her pre-conceptions. This shift in perception appeared significant for many participants, and was often described as tense or uncomfortable but beneficial. Exposure to the people within these roles outside of the placement environment supported participants to gain understanding of these new roles through airing assumptions, potentially aiding interprofessional working.

A final influence was role modelling of coping with difficult experiences, providing reassurance through normalising experiences. Participants appeared interested that “*people that you see all the time over the road [at the hospital] ...no one’s invincible*” (Caryn), and witnessing vulnerability provided permission to do the same, “*if this person is talking about this then you know it’s okay for me to also have similar erm feelings and experiences*” (Neena). This suggests that this is not happening sufficiently elsewhere. Indeed others identified a desire to see “*the classic scary consultants*” (Charlotte) speaking at Rounds. This may reflect Charlotte’s exposure to those roles as a student, but also suggests that Rounds are viewed as a place to break down hierarchy through seniors showing their humanity.

Overall, hearing and sharing experiences normalised and validated feelings, creating a sense of unity through breaking down barriers between professions and seniorities. This developed understanding and empathy for others.

Theme Three: “There’s not normally space given to that”: space to question professional cultures

This theme captured the positioning of Rounds as a separate space where discussions were considered different to those within placement and lectures. Participants appreciated coming together in an interprofessional space to reflect and question their experiences of healthcare and professional cultures.

Many participants spoke of the benefit of “*a dedicated forum*” (Eliza) to learn and reflect together. They described not having space or feeling able to reflect on the emotional impact of their work during placement.

I think sometimes it's too, you're in too much of a busy kind of, when you're doing your degree and like you're either at work or people are too busy to really listen to if you've got stuff going on, if you know that there's somewhere that you can go with it... (Sue)

Sue identified a lack of opportunity elsewhere to discuss her experiences. Others shared her view and spoke of Rounds providing a space to help put “*things in perspective*” (Eliza) where “*people reveal their own sense of erm, struggle or inadequacy is quite new*” and “*not something that's normally discussed at work, there's not normally any erm...space given to that*” (Sam), suggesting Rounds are a unique space.

Participants identified Rounds as distinct from other opportunities for reflection. Many compared written and spoken reflections and reflecting with their peers or other professions, enjoying the rare opportunity to reflect with others from different backgrounds, “*because they might have a different viewpoint or an angle on it that you didn't*” (Isabelle). Rounds were related with a type of supervision or as “*therapeutic*” (Eliza), perhaps reflecting how it made them feel or think about their feelings and work.

Rounds were perceived as particularly applicable to students by Neena:

...when you're training you are more malleable and you're more open to new or different ideas and I think, from on that basis people who, wouldn't necessarily engage with it later on might engage when they're you know, an undergraduate, I

think that it's the kind of little thing that you know might, you know spiral and change someone's entire outlook if they are able engage with it early enough in their careers.

Neena's description suggests that Rounds are well-placed in education due to students' openness to learning and stage in their career, and could "*change someone's entire outlook*" and impact on the care they provide.

However, participants emphasised the importance of addressing barriers to attendance, such as use of practice hours, ease of access when on placement in the hospital, and course and personal commitments. There was a sense that prioritising attendance was difficult, perhaps reflecting a culture which prioritises getting things done rather than discussing experiences.

...it's like when you've got so much going on it's like, what else is there for me to attend? ...how you feel, kind of just does get put to the bottom of the pile because it's more about what you've gotta get done...(Sue)

A particularly strong theme from participants was the use of Rounds to challenge professional cultures, which were perceived as dismissing of emotions. Though not exclusive to them, the medical students articulated this influence most strongly:

...I feel like in the medical culture in general we don't talk about mistakes well, we almost try to cover them up, not intentionally but the words that we use, and...there's less transparency than I think there should be...going back and reflecting on it helped me and helped me to try and think of learning from errors as a beneficial thing as opposed to a culture of blame (Charlotte)

Charlotte challenges the influence of the medical culture on her safety to reflect and learn from experiences. She places herself within the profession, suggesting her own use of

language as a defence for errors. It seems that the experience of a different ‘culture’ within Rounds led her to challenge her professional socialisation through shifting her belief about reflection. Others spoke of how the barriers between different professions, such as language and clothing, were removed during Rounds when conducted in the University context, leaving it “*harder to retreat behind that*” (Sam). Some reflected on role models in practice, some of whom appeared “*hardened*”, and whether this was a reflection of the lack of support they receive in practice leading to coping through acting “*as if they don’t even need it*” (Vicky). Rounds were positioned as a place to counteract this, and indeed Vicky spoke of emailing the organisers with ideas for other topics to discuss; ideas that she could not address within her placements.

Challenging this focus on the technical aspects of care appeared difficult in practice:

...I think there still is a real erm, I don’t know, stigma or feeling within medicine I think it probably applies not just medicine but all the health professions so you know we have this kind of professional job to do and...we just have to do the technical side of it and you know, if you’ve got, if you’ve got the balls or if you’re strong enough you’ll just do it without complaining and you know you won’t have those feelings associated with or run into difficulty or that sort of thing, or that you know, the difficulties that you do encounter are a load of BS basically and really it’s just the technical side of the job that matters (Neena)

The dismissal of the non-technical aspects appears to be an emotive issue for Neena, perhaps reflecting the lack of validation of her feelings in this culture. Her use of masculine terms may relate with cultural perceptions about the expression of emotion as a female quality, whereas within the medical culture a stoic or masculine culture may be expected. During the interview Neena reflected on her fear of being judged by seniors for leaving the ward, “*this*

useful educational opportunity to go and talk about your feelings”, and how she has grappled with this since moving into Foundation Year One, *“I think they’d just be like there’s useful work to be done here so why would you want to go to this?”* Neena’s seniors not promoting Rounds represented a barrier to attendance that she wanted to challenge when she is more senior. This suggests that authority and culture is a powerful influence on attendance, whether promoting or impeding it.

Discussion

This study used an IPA approach to explore how healthcare students experience Schwartz Rounds in a University context. Three themes were revealed: (1)“would it reflect badly on me?”: ambivalence about safety to share; (2)“you’re not alone in feeling that”: unifying through sharing emotions; and (3)“there’s not normally space given to that”: space to question professional cultures. Though Rounds in clinical settings are relatively well-researched, this study adds to the emerging evidence base for their use in educational contexts.

Findings suggested that a significant part of participants’ experiences were how Rounds normalised and validated their emotional experiences. This is consistent with existing literature within clinical and University contexts (e.g. Maben et al., 2017; Barker et al., 2016) and supports notions that sharing stories authenticates experiences (White & Epstein, 1990). Role modelling by senior staff appeared particularly influential for participants to feel permitted to share and feel emotions in relation to their work. This is concordant with previous findings (Barker et al.) and may reflect professional hierarchies and students status as learners.

Rounds were also found to facilitate connection and equality through the shared focus on common humanity. This removed professional barriers of job or seniority and promoted

empathy towards others. This is consistent with existing literature finding Rounds reduce isolation, increase empathy and promote compassion for others, and replicates this in University Rounds (e.g. Maben et al., 2017; Goodrich, 2011; Reed et al., 2015). Empathy and caring behaviours have been found to decrease and work-related stress increase as students' progress through their training, however social support has been found to increase empathy (Burks & Kobus, 2012; Park et al., 2015). The connectedness within rounds could impact on isolation and stress, developing resilience and providing interprofessional support sooner in training (Barker et al., 2016). The connection experienced may also relate to improvements in psychological wellbeing found by Maben et al. from regular attendance.

Furthermore, participants in this study described how airing assumptions was an uncomfortable but necessary experience to develop an understanding of other professions. Improved understanding could impact on interprofessional working (Maben et al., 2017) and the implementation of Rounds during training may support this from the onset of students' careers. Without exposure, participants may not have adjusted their perceptions which could then be perpetuated in clinical contexts. The need for IPE opportunities has been emphasised in the literature to address professional culture and interprofessional working (e.g. Bridges et al., 2011). Rounds share factors associated with effective IPE initiatives, including relevant topics for all professions, setting expectations, and diversity and equity of professions (Boet, Bould, Burn, & Reeves, 2014), and therefore may be well-suited for IPE.

The third theme, space to question professional cultures, is consistent with Maben et al.'s (2017) finding that Rounds created a counter-cultural space where staff can discuss their experiences. This was particularly notable for the medical students which may reflect the contrast to their professional culture concerning the non-technical aspects of care. Indeed, students in Gishen et al.'s (2016) study discussed suppression of emotions in the medical

culture. This suggests that initiatives targeting pre-qualification education as well as those for qualified staff are important for cultural change.

A finding not emphasised in wider literature was participants' fear of judgement impacting their confidence to share. Though boundaries, clear expectations and permission to share were sufficient for some participants to feel safe, it was striking that others felt unable to share due to fearing judgement from others. Participants spoke of using courage, matching contributions to others, or avoiding sharing to cope with this. This may reflect individual differences in personality or social anxiety, or a lack of familiarity with discussing emotional experiences in a group. Additionally it may relate with literature regarding power in reflective practice, where professional hierarchies and perceived monitoring can affect enhancement of knowledge and practice (e.g. Gilbert, 2001).

Professional socialisation involves gaining the norms and identity of a profession and thus developing a professional social identity, leading to favouring those within their profession (Reeves & Pryce, 1998; Clark, 1997; Hogg & Terry, 2000). The unity within Rounds may have supported development of a shared identity, such as 'healthcare professional'. Experience of Rounds early in professional careers may support cultural change through forming norms around discussing non-technical aspects of care.

Furthermore, the shift in perceptions from difference to commonality may be facilitated by the conditions within Rounds and explained by contact theory. This states that under conditions of equality, shared goals, support and personal interactions, negative affect or prejudice can decrease towards an outgroup and positive affect towards them increase (Pettigrew & Tropp, 2006; Tausch & Hewstone, 2010). This theory has been applied to many types of prejudice (Pettigrew & Tropp, 2006) and may relate with Rounds, whereby equality and shared expectations develop a space to safely challenge assumptions and gain

understanding, reducing perceptions of others as threats and promoting empathy. Contact theory has not been applied to Rounds in wider literature however appears relevant within this study. Participants transitioned from perceiving new roles as threats to seeing them as people, suggesting that contact under the conditions of Rounds created safety to air assumptions and improved understanding, which could thereby promote interprofessional working.

Staff wellbeing has been identified as an antecedent of good care and linked to organisational culture (Maben, 2013; Dixon-Woods et al., 2014). Rounds may create cultural practices of discussing the non-technical aspects of healthcare and promote wellbeing, thereby reducing work-related stress and risk of burnout (Maben et al., 2017). Rounds within education come at a cost, requiring time and effort from a variety of staff. However, their use as part of IPE may provide this support sooner and reduce attrition and stress. Rounds may promote resilience in students, supporting their preparation for working in healthcare through developing coping skills, openness to reflection on the emotional aspects of work, and promoting compassionate care (Barker et al., 2016).

In terms of practical implications, it may be helpful for facilitators to consider the difficulty of sharing experiences and the vulnerability of students in relation to their anticipation of judgements from others. This may apply to all Rounds, as learners can be present within clinical Rounds. Facilitators could explicitly state that attendees may feel nervous to share and provide reassurance that it is a non-judgemental space. Furthermore, the presence of senior staff on the panel to role model to students sharing experiences may continue to break down professional barriers and contribute to changing perceptions through humanising all professions.

Future studies might explore the effect of regular attendance at University Rounds on psychological wellbeing, to replicate findings by Maben et al. (2017). Studies could further consider what aids or hinders active participation, perhaps exploring the impact of increased familiarity through multiple attendances, social support, personality factors, or stage in education. It is also important to acknowledge that Rounds may not be suitable for everyone, and multiple opportunities for reflection and promotion of compassionate care should be available within education (Clancy, 2017).

There were a number of methodological limitations. Firstly, participants were not homogeneous, varying in profession, age and gender. However, this variation was representative of Rounds and despite this, commonality between participant's experiences was found. Interestingly, participants ages were higher than typical student ages; further exploration of ages of those attending Rounds may identify whether this is reflective of Rounds overall. Furthermore the sample contained only one male, however there were no identifiable differences between genders. This is proportionate to the number of males attending Rounds (see Appendix B) and may require consideration regarding engaging males. Thirdly, the sample size was inevitably restricted by the detailed analysis, which limits the ability to generalise results to all students attending Rounds. Additionally, a self-selection bias may be present with those most interested in Rounds participating. However, the sample size provided scope to qualitatively explore individual's experiences and other experiences may also exist. Despite this, the results are consistent with wider literature which suggests a degree of credibility.

IPA is reliant on participants' articulation of their experiences and the researchers' attempts to understand their experience (Smith et al., 2009). The reflexive processes used within this research enabled me to identify and acknowledge my preconceptions, allowing participants experiences to emerge. The second bracketing interview highlighted my safety to

share within Rounds, which contrasted with participants in this study. This finding arguably illustrates some validation to the analysis through revealing different perspectives.

Furthermore, credibility checks by the second and third authors alongside feedback from the IPA group enabled consideration of my position as a student, professional and patient on the analysis, ensuring that participant's own experiences were able to emerge.

Concluding Comments

This study employed an IPA approach to explore the experiences of students attending Schwartz Rounds in a University context. Rounds are commonly used in clinical settings to create cultural change through promoting compassionate care and staff wellbeing to reduce patient neglect and staff burnout (Francis, 2013). This study adds to the emerging evidence base for Rounds within education settings to enhance compassionate care and wellbeing early in careers. Findings highlight Rounds role in humanising healthcare and promoting connection across professions through focusing on common humanity. However, fear of judgement requires further consideration within educational contexts and perhaps beyond into qualified practice. Promoting interprofessional support earlier in training may support cultural change, permitting discussions about the non-technical aspects of care and ultimately impacting on interprofessional working, staff wellbeing, and compassionate care.

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