



**Do Schwartz Center Rounds® Hold Transformational Power? An Investigation into the Subjective Experiences of Panellists in Devon.**

Submitted by **Lisa Marie Morris**, to the **University of Exeter**  
as a thesis for the degree of **Doctor of Clinical Psychology, May 2017**

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Signature:

A handwritten signature in black ink that reads "Lisa Marie Morris". The signature is written in a cursive style with a large, decorative initial "L".

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**SCHOOL OF PSYCHOLOGY**

**DOCTORATE IN CLINICAL PSYCHOLOGY**

**LITERATURE REVIEW**

**The Impact of Schwartz Center® Rounds and Reflective Practice Groups  
on Healthcare Teams: A Systematic Literature Review**

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## Abstract

**Background:** Schwartz Center Rounds® (SCRs) are multidisciplinary reflective forums where healthcare staff can discuss the psychological and emotional impact of work. Two NHS trusts piloted SCRs in 2009. They now run in 150 UK sites to support staff and enable compassionate care. The investment into SCRs has not been evidence-based. Early studies indicating positive outcomes for healthcare teams at individual, relational, and organizational levels were criticized for lacking rigour. Reflective practice groups (RPGs) share similarities with SCRs but pose a lighter burden on resources. No systematic reviews have investigated the outcomes of these interventions. Therefore, it was important to consider the evidence for both.

**Objective:** To investigate the impact of SCRs and/or multidisciplinary RPGs on healthcare teams on individual, relational, and organizational levels.

**Method:** Qualitative, quantitative, and mixed-methodology empirical studies and autoethnographic evidence on SCRs and/or multidisciplinary RPGs were sought via PsycINFO, Scopus, and Web of Science, The Point of Care Foundation evidence library, the *Journal of Compassionate Health Care*, and from two recent SCRs studies' investigators.

**Results:** The search yielded 863 records; 83 were fully accessed and 21 included. The studies' quality was variable. All matched PICOS criteria and were maintained.

**Discussion:** Four themes were identified: 1. Reflection, learning, and development; 2. Emotional and psychological impact; 3. Storytelling: Connecting humans through narrative communication; 4. Leadership and culture: Openness and honesty. Enablers and barriers, specifically, resources and safety, were connected to, and discussed within, theme four.



**Conclusions:** SCRs and RPGs showed positive effects on healthcare teams at all levels. RPGs may be more conducive to establishing safety; SCRs held greater potential for staff to develop more holistic perspectives with opportunities for dialogue to effect organizational changes. The findings should be treated with caution given the potential bias of many participants and authors and the dearth of SCRs/RPGs' non-participants' perspectives. Whether SCRs have the power to effect sustained organizational change has yet to be established.

**Keywords:** Schwartz Center Rounds, Reflective Practice Groups, healthcare teams, compassion

## Introduction

This systematic literature review explored the evidence regarding the impact of Schwartz Center Rounds® (SCRs) and multidisciplinary reflective practice groups (RPGs) on healthcare teams.

## Background and Rationale

The Schwartz Center for Compassionate Care (SCCC) developed SCRs in 1997 to teach compassion to clinical and non-clinical healthcare staff (Penson, Shapira, Mack, Stanzler, & Lynch, 2010). Compassion has been defined as “sensitivity to the distress of self and others with a commitment to try to do something about it and prevent it” (Cole-King & Gilbert, 2011, p.30). SCRs are organization-wide<sup>1</sup>, multidisciplinary reflective forums with a set format: Typically monthly, hour-long, with lunch preceding a 10-15 minute presentation by a multi-professional panel focusing on the psychosocial aspects of care related to a pre-determined case or theme. Trained facilitators invite attendees to share reflections and guard against clinical problem-solving.

Working in healthcare can be highly stressful and place significant emotional demands on healthcare professionals (HCPs) (Kakunje, 2011), which may be managed through more or less adaptive coping strategies such as meaning-making or defence mechanisms (Wren, 2014). A fully developed theory of the mechanisms operating in SCRs has yet to be established (George, 2016). However, one method by which they may facilitate compassionate care includes offering professional caregivers a supportive space for meaning-making (Hopceck, 2016; Wren, 2014), where they might make sense of and process their feelings associated with work events. The supposition is that HCPs will be more able to foster compassionate connection with others if they

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<sup>1</sup> Oxford spelling is used in the main body of the thesis.

better understand their own emotional responses (Maben, 2014). SCRs may offer space to HCPs so they may “continually have “space” to offer others” (Wicks, 2007, p.7) to witness, reflect on, and make sense of their own and others’ experiences and responses, rather than acting on, or defending against, unconscious assumptions and unprocessed emotions.

SCRs run in over 375 North American organizations (Robert et al., 2017). UK SCRs were piloted at two sites in 2009. The Francis Report (2013) cited SCRs as one method to positively influence healthcare cultures to prevent systemic failings in patient care. Three months later, the Department of Health (DoH) awarded The Point of Care Foundation (TPoCF)<sup>2</sup> a £650,000 grant to launch SCRs in 40 further Trusts (DoH, 2013). As of January 2017, 150 UK sites were running SCRs (TPoCF, 2017b). The exponential rise in UK SCRs has been attributed to informal diffusion via professional networks that has not been evidence-based (Robert et al., 2017).

UK SCRs have been conceptualized as “staff wellbeing support” (Leamy & Maben, 2016), helping staff provide compassionate care (Goodrich, 2012); the former is an antecedent to care quality and patient experience (Maben et al., 2012). Reflective practice groups (RPGs) have been endorsed to support staff wellbeing and enhance teamworking (Heneghan, Wright, & Watson, 2014). Balint Groups<sup>3</sup>(BGs) also offer clinicians space for shared reflection on clinical cases (Salinsky, 2009). RPGs may be a resource-efficient means of supporting staff (McVey & Jones, 2012), whereas the resource outlay for SCRs (including

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<sup>2</sup> The Point of Care Foundation holds the UK licence for SCRs. It describes itself as “an independent charity with a mission to humanise healthcare” which developed from The King’s Fund Point of Care Programme (2007-2013) (TPoCF, 2017a). The King’s Fund defines itself as a charity working to ameliorate health and healthcare in England (The King’s Fund, 2017).

<sup>3</sup> The American Balint Society’s (2017) description of a Balint Group is “a group of physicians or other clinicians who meet regularly and present clinical cases in order to better understand the clinician-patient relationship,” and to “[enhance] the clinician’s ability to connect with and care for the patient.”

TPoCF contract investment<sup>4</sup> and lunch provision) has proved restrictive for some NHS trusts (Gardner & Bray, 2014).

Zwarenstein, Goldman, and Reeves (2009) advised increased governmental investment into interventions to ameliorate healthcare delivery and interprofessional collaboration should be informed by evidence-based research, including qualitative studies. TPoCF evaluation of the pilot SCRs (Goodrich, 2012) echoed the SCCC-funded evaluation's positive findings regarding US SCRs (Lown & Manning, 2010), indicating benefits on individual, relational (team/patient), and organizational levels: participants felt reduced isolation and stress, greater empathy, stronger multidisciplinary team (MDT) working, and a more open culture. These studies have, however, been criticized for lacking rigour (George, 2016). No systematic review has investigated SCRs.

Research into RPGs is also limited (Heneghan, Wright, & Watson, 2014). A systematic review on BGs (Van Roy, Vanheule, & Inslegers, 2015) demonstrated findings including clinicians experiencing increased awareness of their own and patients' feelings, greater self-awareness, and changed professional-patient interaction.

Although unidisciplinary/uniprofessional RPGs and BGs would not provide a forum for cross-disciplinary cultures and perspectives to meet, multidisciplinary versions may have greater similarity to SCRs, particularly RPGs as they are more likely to include colleagues from the same team than BGs. SCRs are perhaps qualitatively different from RPGs and BGs: They do not address clinical problem-solving, only focusing on the psychological and emotional impact of clinical work, and they are theoretically open to all

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<sup>4</sup> Newcastle Hospitals (2014) reported the rate for a two-year TPoCF SCRs training contract as £8,640 and £3,720 for years one and two respectively. The cost for large trusts (1,000+ employees) currently stands at £15,960 for the initial two year "training" contract, with the cost of subsequent two-year membership at £3,780 (Robert et al., 2017).

organizational staff (clinical and non-clinical). Yet RPGs are likely to pose a lighter burden on resources than SCRs. Therefore, it is important to consider the evidence regarding the different interventions' impact on staff working in healthcare teams; if the two interventions result in similar outcomes, this calls into question whether SCRs merit the greater level of resource investment they require compared with multidisciplinary RPGs given the current resource constraints faced by many NHS organizations.

### **Review Question**

What is the impact<sup>5</sup> of SCRs and/or multidisciplinary RPGs on healthcare teams on individual, relational, and organizational levels?

### **Method**

The *Preferred Reporting Items for Systematic Reviews and Meta-analyses for Protocols 2015 (PRISMA-P, Shamseer et al., 2015)* and *PRISMA (Moher, Liberati, Tetziaff, & Altman, 2009)* checklists are evidence-based guidelines to inform review protocols' development and the reporting of systematic reviews appraising randomized trials and therapeutic efficacy (Shamseer et al., 2015). Concordant with Shamseer et al.'s (2015) guidance, given the dearth of protocol guidelines, the present review followed the above standards to guard against selection bias. *PRISMA's* focus on quantitative outcome research has limitations when applied to qualitative inquiry and quantitative research evaluating complex organizational interventions, the effects of which may be difficult to measure and causality hard to attribute even when statistical data is obtained (Farr & Barker, 2015).

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<sup>5</sup> Impact in this context refers to the effects, changes, or resultant consequences on healthcare teams and the care they provide pursuant to members of those teams engaging in the two abovementioned interventions.

## Eligibility Criteria

Tables 1 and 2 outline the report and study characteristics (incorporating PICOS: participation, intervention, comparison, outcome, study design) used to determine studies' inclusion in, or exclusion from, this review. Exclusion criteria included participants not engaged in clinical practice amongst healthcare teams (intervention effects on the team were key to the review question); unidisciplinary/uniprofessional reflective group interventions; general MDT meetings without a reflective focus on emotional and psychosocial challenges, therefore also qualitatively different to SCRs; papers prior to the year SCRs began; publications in languages outside of the author's range; non-empirical papers, such as those offering opinions, and in-depth descriptions of single SCRs. "Balint Groups" was not an exclusion criterion; research on interdisciplinary Balint Groups may have appeared since Van Roy et al.'s (2015) review.

Inclusion criteria included qualitative, quantitative, mixed-methodology empirical studies, and autoethnographic evidence on SCRs or multidisciplinary RPGs published in peer-reviewed journals. Exceptions to this involved contacting investigators from two research projects (a three-year NIHR<sup>6</sup>-funded longitudinal national evaluation of UK SCRs and a TPoCF-funded action research study on SCRs) whose research findings had not yet been published. Given previous studies indicated SCRs had effects on healthcare teams at three levels, individual, relational, and organizational, these were chosen as the outcomes of interest.

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<sup>6</sup> National Institute for Health Research.

Table 1

*PICOS Inclusion Criteria for Systematic Review Eligibility*

<b>Domain</b>	<b>Criteria</b>
Participants	Professionals (including students/trainees) working in health and social care teams (including hospices/charities).
Intervention	Schwartz Center Rounds or interdisciplinary reflective practice groups.
Comparison	N/A
Outcomes	Individual (e.g., psychological; identity/ies; emotional; cognitive; behavioural) Relational (e.g., social cohesion/relationships; collaboration/communication; vision/goals/values) Organizational (patient outcomes/feedback/safety; policy/practice; leadership; culture; financial).
Study Design	Qualitative, quantitative, and mixed-methodology studies; autoethnographic.

Table 2

*PICOS Exclusion Criteria for Systematic Review Eligibility*

<b>Domain</b>	<b>Criteria</b>
Participants	Healthcare/medical students not yet engaged in clinical practice within health and social care teams.
Intervention	Unidisciplinary/uniprofessional reflective practice groups; MDT meetings without a reflective function related to the psychosocial/emotional aspects of care provision; interventions offering other training/learning methods aside from group reflection.
Comparison	N/A
Outcomes	N/A
Design	Non-empirical (e.g., editorial papers); conference abstracts; papers focusing on individual SCRs (previously regularly published in <i>The Oncologist</i> ).
Limitations	Languages other than English, French, or Italian. papers pre-1997; non peer-reviewed.

## Information Sources/Search Strategy

Table 3 delineates the sequence of terms and limits employed in the Scopus, Web of Science, and PsycINFO<sup>7</sup> databases searched on December 23, 2016, January 2, 2017 and January 13, 2017 respectively. The reference lists of peer-reviewed articles eligible for inclusion, TPoCF website evidence library, and the *Journal of Compassionate Health Care* were also reviewed for potentially relevant citations. I contacted the aforementioned research projects' (NIHR; TPoCF) investigators and authors of inaccessible papers directly, aiming to retrieve data.

Table 3

### *Search Strategy for Databases*

Term Sequence	Search Term
1	"Schwartz Cent* Round*"
2	"Schwartz Round*"
3	"reflective group*"
4	"group reflection"
5	"reflection in group*"
6	"group reflective practi*e"
7	"reflective practi*e group*"
8	"*disciplinary reflect* group*"
9	"*professional reflect* group*"
10	"*disciplinary reflective practi*e"
11	"*professional reflective practi*e"
12	"reflective supervision group*"
13	#1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9 OR # 10 OR #11 OR #12
14	#13 AND "health*"
15	#13 AND "health*care"
16	#13 AND "health* team"
17	13 AND "health*care team"

<sup>7</sup> For PsycInfo, each sequence term was followed by ti.,ab. Limits included: "human"; "humans"; unchecked box for "include related terms".



Term Sequence	Search Term
18	#14 OR #15 OR #16 OR #17
<b>Limits</b>	1997-current

### Study Selection

PICOS criteria informed initial screening of records' titles and abstracts generated by the search to determine inclusion or exclusion. Records deemed suitable, or whose suitability was unclear, were read in full to confirm or deny eligibility. Rigour and reliability could have been reinforced by an independent reviewer. Time and resources did not permit this.

### Data Extraction

Relevant data from studies included in the review were extracted and stored in Excel under sub-headings including: Author/s; Title; Setting/Context; Country; Journal; Aim/s; Design/Method; Sample/Participants Description; Analysis; Risk of Bias/Quality; Results/Findings; Themes; Other.

### Quality Evaluation

Two checklists were used to inform the assessment of risk of bias and study quality: The *Critical Appraisal Skills Programme (CASP) Qualitative Research Checklist* (2013) (Appendix A) was used for qualitative studies. The *Effective Public Health Practice Project Quality Assessment Tool (QAT, 2010)* (Appendix B) was used for quantitative research. For some papers, both were applied. Neither was used when the article type rendered applicability inappropriate. The QAT was designed for the public health field and therefore has limitations in its applicability to studies in the present review. It has been assessed as having higher inter-rater agreement than the *Cochrane Collaboration Risk of Bias Tool* (Armijo-Olivo, Stiles, Hagen, Biondo, & Cummings, 2012), therefore may be less susceptible to different interpretations.

## **Data Synthesis**

The process of data synthesis entailed reading the included records several times, reflecting on and developing lists of concepts/themes, using a thematic analytical approach to identify commonalities and differences across the papers, and deciding how these may be translated into each other and synthesized. A reflective log and supervision helped maintain a critical perspective regarding the strength of evidence in addition to quality assessment. They aided decision-making and conceptual exploration as I incorporated my in vivo experience of SCRs, steering group meetings, and RPGs with the review, by relating this to my reading of the extant evidence.

For example, I reflected on the safety of panellists opening up emotionally in terms of both intra- and interpersonal factors, such as the individual's psychological preparedness for confronting particular emotions in relation to their role and the cultural milieu which may constrain both safety and the capacity for self-care and reflection; it might be that expressing guilt over an honest clinical mistake could be met with judgement and punishment not acceptance and the understanding that "we are all human". This helped maintain a distance, curiosity about, and awareness that much of the evidence present in papers in this review was perhaps not entirely without an agenda and that the whole narrative was not necessarily presently being written.

## **Results**

### **Studies Selected**

The initial search yielded 863 results. Figure 1 outlines the screening and selection process. Twenty-one references were identified and included in the review based on PICOS criteria: Fourteen focused on SCRs, six discussed

multiprofessional RPGs (including reflective debriefing and ethics reflection groups<sup>8</sup>), and one discussed an intervention adapted from the SCRs model. Most were evaluations of these reflective forums. Two related papers (1/9)<sup>9</sup> addressed SCRs' applicability to a UK medical school, their potential to engender increased reflection and support in this cultural context, and their possible mechanisms. Two other related papers (5/10) were based on the UK SCRs pilots.

The (non-peer-reviewed) preliminary findings from the two abovementioned research projects considered how context may impact on SCRs; the UK-wide evaluation (21) considered the interaction of context and possible mechanisms on outcomes. The healthcare contexts covered a broad range including hospices, forensic settings, intensive care, inpatient, psychiatric and community services, specialist services, a veterans' affairs hospital, two healthcare educational institutions, private care homes, and several acute hospitals and NHS trusts. Sixteen papers were UK-based, one was Norway-based, and four USA-based papers were SCRs-related. Twelve references were based on mixed-method designs, six provided autoethnographic/anecdotal or anecdotal combined with staff feedback evidence, and three were solely qualitative. All but two<sup>10</sup> of the 19 peer-reviewed papers were published in different journals.

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<sup>8</sup> Reflective practice groups with individualized names (including ethics reflection groups) are referred to as RPGs throughout the main body of the paper.

<sup>9</sup> See Table 4.

<sup>10</sup> Of these two, one appeared in the *Journal of the Royal Society of Medicine* and the other in the *Journal of the Royal Society of Medicine Open*.

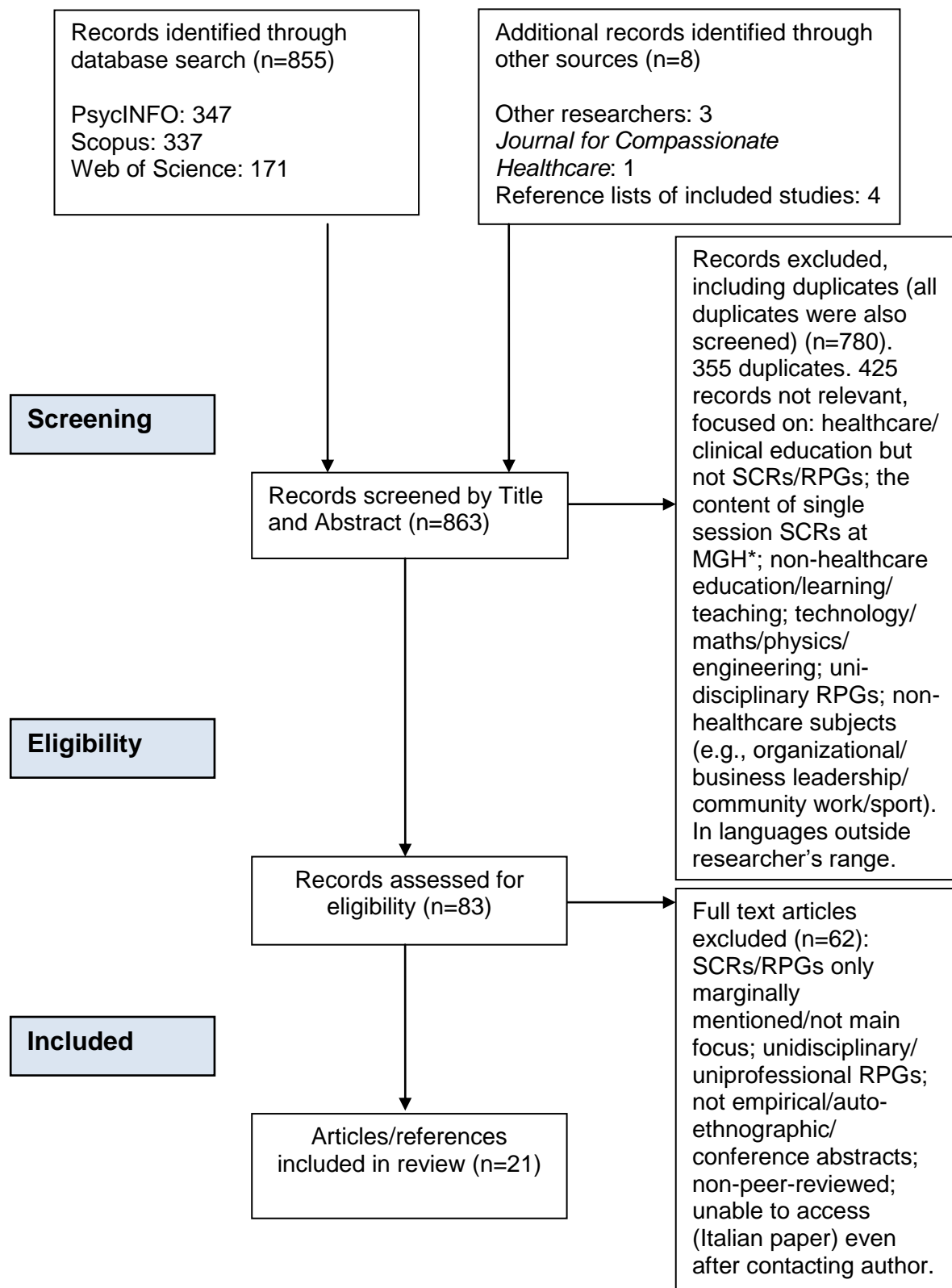


Figure 1. Flow diagram outlining the phases of article selection.

\* Massachusetts General Hospital (MGH). *The Oncologist* published a series of articles on the content of individual Schwartz Center Rounds which took place at MGH.

### **Limitations and Bias**

No papers were excluded on the basis of quality, which was variable. All were considered adequate based on PICOS criteria. Table 4 shows included papers' quality ratings/bias risk (also see Appendix C), limitations, and main findings. One significant area of potential bias was that most participants in studies were self-selected, somehow invested in SCRs/RPGs (10/11/13), or SCRs-facilitators-identified (14); findings may have been affected by participant characteristics, such as, having a pre-existing interest in reflective practice (11), appreciation of the psychosocial aspects of care (14), or significant investment in the intervention (1/10/11/17/18). In four papers (3/4/17/19) it was unclear how many repeat participants completed evaluation forms; regular SCRs attendees with specific characteristics and a potential vested interest in their continuation may have further increased bias, yet the possibility of repeat participants was often not addressed.

Not all papers provided a gender breakdown. Several samples were predominantly female (8/11/15), which may have affected results, especially if one considers "any discourse on emotion is [...] a discourse on gender" (Lutz, 1996, p.151). Only two of the peer-reviewed papers considered non-attendees' views (18/19), which are required to develop a balanced evidence-base, especially when considering the relational and organizational impact of SCRs/RPGs.

Twelve of the papers used self-report questionnaires, possibly susceptible to response bias and variable interpretation of ratings scales. Eleven used unvalidated questionnaires (predominantly SCRs evaluation forms)

with unknown reliability. Study two used validated questionnaires and data was triangulated through observation.

Many SCRs papers referred to the findings of study 14 which, although methodologically weak, may have resulted in confirmation bias of subsequent papers, particularly those with autoethnographic/anecdotal evidence regarding SCRs. Six of the SCRs papers were authored/co-authored by TPoCF employees. There was not sufficient reflexivity regarding how their roles and investment in SCRs may have influenced the research.

Willig (2001) differentiated between personal and epistemological reflexivity, the latter referring to how knowledge is constructed within a study and the theoretical approach underlying that. Of the 12 papers incorporating qualitative data, only two identified their epistemological approach. Six lacked personal reflexivity. Both are required to understand how findings may have been influenced and reached.

A limitation of this review is that only one researcher analysed studies for selection and appraised their quality due to resource constraints. I became aware at the outset that my positive perspective on the ethos of SCRs/RPGs appeared initially to bias my research question/PICOS criteria as I considered possible “beneficial” outcomes of these interventions rather than their impact, addressed through reflexive writing and supervision. I should also indicate my epistemological orientation which is social constructionism, with a dialogic and relational view of knowledge construction. Given the range of titles that may be attributed to RPGs, it is possible that this review has not retrieved papers in which they have individualized names.

Table 4

*Main Findings from the Systematic Literature Review*

Reference	Country & Context	Aim/s	Design/Methods/ Analysis	Sample/ Participants (Ps)	Quality Rating (QR) <sup>11</sup> / Risk of Bias	Themes/Results/Other Findings
<b>Peer Reviewed</b>						
1 Barker, Cornwell, & Gishen (2016)	UK Medical school – University of the City of London (UCLMS)	Discussion of possible mechanisms operating in SCRs. Based on data from Gishen et al. (2016) study (reference 9 below) of SCRs pilots at UCLMS.	This paper was based on the data from reference 9. SCRs hosted separately with year 5 (SCR 1) and year 6 (SCR 2) medical students. Focus group (FG) (year 5 students).	SCRs hosted separately with year 5 (n=258) and year 6 (n=180) medical students. FG: n=7 (year 5 students).	See ref. 9. <b>CASP: 5.5</b> Epistemological approach (EA) not stated. Barker & Cornwell work for TPoCF. Gishen introduced SCRs to UCLMS.	<b>Themes:</b> 1. A chance to learn/reflect that is not assessed; 2. Developing a culture of open/transparent communication; 3. Normalizing emotions via expression of vulnerability; 4. Developing connection with/understanding of other students/staff/professional roles. 5. Role-modelling (senior to junior staff - seeing the person); 6. Boosting resilience- protect against compassion fatigue. <b>Other:</b> Running SCRs not “cost neutral” –staff time & financial investment needed. “May” help ↓sickness, ↑engagement, ↑“output”. Large size could inhibit participation.
2 Blumenthal, Ruszczynsk, Richards, & Brown, (2011)	UK High security hospital	To "evaluate empirically the impact of psychodynamically-oriented consultation on a high-security hospital ward."	Mixed method. Prospective cohort study-3 mth post-intervention follow up. Weekly RPGs facilitated by external consultant (12 mths). Control changed to comparison when staff-patient communication programme implemented. Questionnaires (Qs), inc. MBI & WAS, & obs.	N=36. Consultation ward Ps (ConPs): n=18 (9f, 9m). Comparison ward (ComPs): n=18 (5f, 13m). ConPs experience in the work (M=5.5 yrs; SD=69.5 mths) > than ComPs (M=3 yrs 2mths; SD = 20.7 mths).	<b>QAT: Weak.</b> Confounding factors: 50% staff left during intervention; diffs in experience/ gender balance & possible cross-over between wards; control ward intervention compromised study. SR Qs. Self-selected Ps. Patient views unexplored. 3Ps prior consultation experience.	<b>Results:</b> Both wards +ve changes on WAS: ↑ staff supportiveness (r= 0.39)/involvement (r = 0.51)/spontaneity (r = 0.40). Anger expression ↑Con ward (r = 0.47). +ve changes in personal growth (of patients) post-intervention: ↑practical orientation (r = 0.36); ↑practical problems orientation (r = 0.40). NS change in staff wellbeing/stress but ComPs> ConPs for depersonalisation. Both wards: improvements in ward atmosphere/staff-patient relationships. <b>Obs:</b> improved quality of staff-patient interactions: ↑likelihood of accepting v tolerating/rejecting interactions on Con-ward v Com-ward. Con-ward ↑likelihood of accepting v rejecting/unknown interactions post-consultation/at follow-up. ↑likelihood of accepting v unknown interactions at follow-up.

<sup>11</sup> CASP scores are out of a maximum of eight. The higher the score, the more CASP criteria have been fulfilled. QAT ratings can be weak, moderate, or strong. See appendices for scoring and ratings criteria of the tools used.

Reference	Country & Context	Aim/s	Design/Methods/ Analysis	Sample/ Participants (Ps)	Quality Rating (QR) <sup>11</sup> / Risk of Bias	Themes/Results/Other Findings
3 Chadwick, Muncer, Hannon, Goodrich, & Cornwell (2016)	UK Acute general hospital (part of acute hospital trust with community services)	To evaluate the impact of SCRs "on the staff of a large acute general hospital over a three-year period."	Mixed method evaluation of post-SCR feedback forms. Thematic analysis of qualitative comments. Quantitative analysis of 5-point Likert scale statements on SCR standard evaluation form (EF).	795 EFs/18 SCRs: Nurses (36%); doctors (18%); AHPs/ other clinical (14%); admin/managers (9%); other: SW, porter, chaplain, domestic, volunteer (20%). 158 comments from (n=?) evaluation forms. Attendees: M=71.3 (range 56-97) per SCR.	<b>CASP: 4.5</b> EA not stated.  Unvalidated tool. Self-selected Ps. Total Ps/ repeat Ps/ unique Ps: N=? SR data from single site.  Cornwell & Goodrich work for TPoCF.	<b>Themes:</b> 1. Insight (new understanding). 1.1. Focus on speaker (new perspective; emotional response; support need); 1.2. Focus on self (emotional response; resonance; future intent). Appreciation (of honesty, openness, thoughtfulness, thought-provoking). 3. Conduct of the meeting (supportive, +ve, emotional environment; facilitation). 4. Suggestions for improvement (↑attendance across professions) <b>Results:</b> +ve staff response to SCRs-rated equally highly across professions: ↑insight re how others think/feel about caring for patients-help work better with colleagues; ↑knowledge-help work with patients. Anecdotal: broader organizational influence-managers' ↑understanding of clinical work.
4 Corless, Michel, Nicholas, Jameson, Purtilo, & Dirkes (2009)	USA Healthcare academic institution. First educational institution to implement SCRs (2003). Online Schwartz Center Educational Rounds from 2005.	To develop communication and compassionate care-giving skills in interdisciplinary, healthcare (HC) graduate students.	Change-oriented project: 4 SCRs/year (some compulsory attendance). Evaluation of 11 on-site SCRs (2003-2006) with post-SCRs questionnaire (5-point Likert scale: "poor"- "exceptional"). Summary scores of 7 statements. Descriptive analysis.	Multiprof panels inc. HC students & patients. Attendees: students/staff/faculty/guests. 329 evaluation forms. Attendees inc. graduate HC students from nursing, physical therapy, communication disorders, clinical investigation. No breakdown.	<b>QR: N/A.</b> Unvalidated SR Q. Proportion of attendees who completed forms not indicated nor if Ps self-selected. Total N=? Repeat/ unique Ps: n=? Unclear how representative free responses were of Ps. No reflexivity-how authors' investment in SCRs affected results?	<b>Qualitative responses:</b> *Discussions about communication with patients/families/MDT colleagues valued. *Appreciation of SCRs which resonated with respondents' disciplines or where facilitators underscored the interdisciplinary connections. *A need for opportunities to develop/practise communication skills re difficult issues (e.g., team conflict, ethical dilemmas). * Medical jargon required clarification for other disciplines. <b>Results:</b> 86% EFs rated SCRs excellent or exceptional. 67% "responses" would attend SCRs again. High ratings did not always correlate with intent to attend future SCRs. Authors attributed to work demands/ conflicting schedules/ perceived relevance of topic/ speakers.
5 Cornwell & Goodrich (2010)	UK Two acute hospital Trusts		Preliminary obs from UK pilot – UK SCRs launched in autumn 2009.	Staff from 2 acute trusts. Royal Free Hampstead Trust &	<b>QR: N/A</b>  Authors work for TPoCF and involved in	<b>Obs:</b> *Powerful for staff to witness senior managers/clinicians showing vulnerability. *Some staff braver to be critical of org'l power dynamics. SCRs transferred well US→UK despite cultural/HC diffs. Attendees from wide



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				Gloucestershire Hospitals Foundation Trust	pilots' implementation.	range of profs/ +vely rated SCRs. <b>Comments:</b> ↓isolation; SCRs informative; impressed by panellists' openness; +ve to hear similar experiences in other depts; Would have been helpful as trainee.
6 Deppoliti, Côté-Arsenault, Myers, Barry, Randolph, & Tanner (2015)	USA Urban hospital	To "learn why people attend [SCRs], understand what is gained from [SCRs &] identify key elements to use in measuring [SCRs'] effectiveness."	Qualitative and descriptive case study. Thematic analysis.	N=30. 4 FGs (n=27; n=5-10/FG).3x1-1 intvws. "Low" & "high" attendees & panellists. MDT & non-clinical staff (MDs; RNs; RNMs; PTs; SWs; NPs; SP; nutritionist; counsellor; spiritual care; director; admin; pharmacists). 2-40 yrs' experience.	<b>CASP: 5.5</b> EA not stated. Limited MDs' participation but represented .25 attendance at SCRs. Transferability limited - Catholic community hospital.	<b>Themes:</b> 1. Culture change (norms/values/ beliefs +vely affected; everyone matters; emotions important, permission to explore; team members equal); 2. Exposing emotions/ sharing experiences→↑ appreciation/ ↑awareness own/others' emotions); 3. ↑Empathic awareness for colleagues; 4. Inequality of topics (↑learning from ethically challenging subjects); 5. Influence of rules/ boundaries (SCRs valuable but limits on safety –group size/who present); 6. Personal impact (thoughts/behaviour changes towards situations/others; seeing human in physicians). <b>Other:</b> SCRs +ve/helpful. Ethical dilemmas appreciated as topics.
7 Gardner & Bray (2014)	UK Acute hospital trust	Compassionate Conversations (CCs): A "ground-level initiative focused primarily on supporting and motivating individual staff" to enhance staff engagement.	Report on intervention based on SCRs (no funding allocated):1-hour, hospital-wide meetings led by psychologist and consultant. Coffee & doughnuts provided. Discussion pairs preceded 20-30 minute group discussion re pre-determined theme.	10% trust staff attended CC or departmental roadshow (no breakdown). 75% provided "some form of (voluntary) feedback."	<b>QR N/A</b> Limited results. Reflexivity/ authors' role in intervention not addressed. Ps self-selected. No indication of numbers/ staff groups/roles represented.	<b>Facilitators' perceptions</b> (during Plan-Do-Study-Act cycles): Second event ↑attendance over first (poor attendance) following managers inciting staff to attend/encouragement of managers to permit staff to attend; CCs too clinically-oriented - made more universal (topic relevance) post staff-consultation. <b>Other:</b> Refreshments £20/CC. Some staff attend -ed >1; many attendees informed about events by others. 64% Ps scored meeting 9 or 10/10 (unclear if referred to both CCs & roadshows), M=8.9. Staff, facilitators, exec board, and sponsor group "positive" re intervention. CCs planned to continue beyond initial 20-week project; org'l implications for resources/job-planning.

Reference	Country & Context	Aim/s	Design/Methods/ Analysis	Sample/ Participants (Ps)	Quality Rating (QR) <sup>11/</sup> Risk of Bias	Themes/Results/Other Findings
8 George (2016)	UK Acute hospital trust (5 hospitals /community services). SCRs implemented in 1 hospital - part of Special Measures Action Plan.	To "examine the impact of [SCRs] on staff wellbeing & patient care" & whether SCRs reduce staff stress. Organizational Response to Emotions Scale (ORES) developed to test whether it captured SCR-related changes in stress.	Mixed methods. Sequential exploratory case study: Secondary data collection on staff stress from Picker Institute Europe/ OH; intws re staff stress/org'l wellbeing initiatives. ORES developed from intvw themes. Qualitative analysis- intvw data re stress: grounded theory. EA: Interpretivist.	Team intws re stress: n=11 (9 nurses & 2 HCAs) (10f, 1m). Time in post: M=19 yrs (range: 8.5-28 yrs). ORES: n=65; 10f interviewees completed & n=55 (42f, 4m, 9=?) SCRs attendees completed ORES pre/post SCR. 20-69 yrs old. 83% white.	<b>CASP: 7.5</b> <b>QAT: Weak</b> Ps self-selected. Unvalidated SR tool. Low sample size. No control group. George on SCRs SG - confirmatory bias? Trust in special measures- (high staff stress?); high levels bullying (46% v UK average of 26%).	<b>Intvw themes</b> re stress: lack of support, advocacy, supervision. OH-punishment; staff interconnection buffered stress. <b>ORES Q:</b> Sig. ↓reported emotional labour of work for new SCRs attendees: "epiphany moment" of 1st SCR. NS↑self-reflection. ↑-ve view of line managers post-SCR; author reported <b>anecdotal evidence</b> re ↑+ve view of peers, ↑interconnection/compassion post-SCRs. <b>NHS staff survey:</b> Improved senior management-staff communication and staff engagement (3.51 in 2014 v 3.66 in 2015). Not possible to identify staff sickness/survey results pre/post-SCRs as planned. <b>Author's obs:</b> panellists' stories rectified cognitive distortions (ultimate attribution error) re non-clinical staff's behaviour after ↑awareness of pressures on them.
9 Gishen, Whitman, Gill, Barker, & Walker (2016)	UK Medical school - University of the City of London (UCLMS)	To assess the applicability of SCRs to undergraduate medical schools and determine whether SCRs may engender a reflective, supportive culture in this context.	Mixed methods: 2x one-off SCRs (1. "A Patient I will never forget"; 2. ("In at the deep end" )-multi-disciplinary panels. Q based on SCRs feedback form (5 point Likert scale: (poor to exceptional). 1x FG 10 days post-SCR. Q: Available case analysis (ACA) due to omissions. Descriptive statistics. Q comments & FG: Thematic Analysis.	SCRs hosted separately with year 5 (SCR 1) and year 6 (SCR 2) medical students at major medical school. FG: n=7 (year 5 students). <b>SCR attendance:</b> Yr 5: n=258/334 (77%); yr 6: n=180/343 (52%). <b>Q:</b> Yr 5, n= 96%; Yr 6 n=70%	<b>CASP: 5.5.</b> EA not stated. Self-selected attendees, Q & FG Ps. Q: Unvalidated. SR. Missing data; ACA can't properly be compared - different samples with each. Generalizability/ transferability ltd. Only 1 FG. SCR 2 prior to students' final exams.	<b>Q Themes: Yr 5:</b> 1. Inhibition in large group; 2. Value-emotive topics discussed (vulnerability/ empathy/team-building); 3. +ves re personal reflection; 4. Attendance-"emotional". <b>Yr 6:</b> 1. Worries re topic; 2. Schedule SCR to better time; 3.+ves re reflection; 4. Smaller groups preferred. <b>FG Themes:</b> 1. +ve feelings re SCR; ↑self-reflection; preferred to reflective essays; large group inhibited participation; post-SCR talk. 2. Psychological aspects-aided emotional expression; valued hearing HCPs' stories; seniors' "human" side; emotions normalized. <b>Results</b> SCR ratings: <b>Yr 5:</b> M=3.5; <b>Yr 6:</b> M=3.3 292/365 (80%) would attend again; 235/366 (64%)-SCRs on curriculum; 340/370 (92%) valued storytelling-medicine's "human side"; 301/366 (82%) ↑insight-how others think/feel re caring; 296/366 (81%) presentation helpful. Sig more yr 6 v yr 5 Ps thought discussion helpful/worried about compassion fatigue/burnout.

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10 Goodrich (2012)	UK Two acute hospital trusts: 480+ bed hospital in South West England (SWE); 1000+ bed hospital in London (Ldn)	To assess 1. whether SCRs "could transfer from a US to a UK setting"; 2. whether UK SCRs "would achieve a similar positive impact on individuals and teams, and hospital culture."	Qualitative case studies. Qualitative intvws. Framework analysis.	N=28 (n=13 pre/post intvw Ps; n=15 unique intvw Ps). Purposive sample-regular SCRs attendees. Pre: n=18. Attended ≥1 SCR (n=17); on SG (n=14) facilitators (n=2); panellists (n=2). Post: n=23 inc. SG staff (n=11); facilitators (n=4); panellists (n=4).	<b>CASP: 3.5</b> EA not stated. Most Ps "key players"- bias for SCRs. Ps asked what <i>hoped</i> to observe (v what observed). No research re non-attendance. No intvw protocol. Analysis/ credibility/ transferability not discussed.	<b>Individual:</b> *↓staff stress. *Space to discuss difficult cases/feelings/coping with stress valued. *Chance to validate staff concerns/ stresses/feelings re daily work valued. <b>Teams/staff/relationships:</b> ↑compassionate care to patients. *↑empathy/ respect/ understanding between staff. *"Powerful" for junior staff to see senior staff modelling vulnerability. *↑appreciation of how others felt about work - aided MDT work. *↑collaboration. <b>Org'l</b> *Attenuated hierarchy via sharing experiences. *Supported strategic vision-supporting/not punishing staff. *Shared values-caring/open culture. *When leaders value/ support SCRs => value/support staff.
11 Heneghan, Wright, & Watson (2014)	UK Inpatient psychiatric services (IPS)	To (i) describe Clinical Psychologists' (CPs) practice in RPGs for IPS staff, and (ii) explore how RPGs are conceptualized/ put into practice and explore enablers/ barriers.	Mixed methods: Online Q and six intvws. Q: descriptive and conventional content analysis. Intvws: thematic analysis. EA: Contextualist.	CPs with interest in and/or experience of facilitating RPGs in IPS settings. N=73 (59f, 14m). Yrs post-qualifying: range =0.5-40 (M=12; SD =10.1). <b>Q:</b> n=73. <b>Intvws:</b> n=6f.	<b>CASP: 8</b> Self-selected Ps with pre-existing interest in RP. Outcomes reported by RPGs facilitators. Several Ps reported co-facilitators from other disciplines but not investigated further. Forensic contexts over-represented in interview data.	<b>Themes:</b> 1. Org'l context: (i) Culture/leaders. Leaders key to supporting attendance in "doing v "thinking" culture. (ii) Power. Hierarchical power imbalances mirrored in RPG attendance /non-attendance. 2. Emotional/ relational understanding: (i) Protecting space. Attending RPGs can be upsetting/disturbing. (ii) Containing: staff need to feel safe/heard before reflecting. (iii) Knowing. 3. Ethics: (i) Psychological contribution. Alternative views offer changes in understanding/ thoughts. (ii) Values: CPs' do not always match staff's. Open work relationships aided dvpt of shared goals. <b>Results:</b> 91.8% Ps had facilitated RPGs (80% in IPS). 41.1 % currently facilitating IPS RPGs. RPGs often at handover to maximize attendance. 9 Ps cited +ve/6Ps reported mixed staff feedback. +ve: feeling listened to/supported; ↑ understanding of own/colleagues' feelings; ↑ideas for changing practice; ↑capability - role management. -ve: worries re confidentiality/ being "psychoanalysed"/practical matters.

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12 Hockley (2014)	UK Two private "for profit" palliative nursing care homes (NCHs)	Part of action-research study: To ascertain problems staff encounter in caring for dying residents and how RPGs affect end-of-life care provision for OAs in NCHs. To explore what might support high-quality end-of-life care.	Mixed methods. Reflective debriefing groups to: "1. use the experience of caring for a resident who had died as a basis for learning about end-of-life care"; 2. safely and openly discuss death; 3. develop knowledge about end-of-life care of OAs dying in NCHs. 10 RPGs transcribed - used as data with broader study Q. Descriptive & thematic analysis.	RPGs: N=34 (nurse managers; nurses; HCAs; domestics; activity coordinators). Range: 3-7 staff/RPG.  Q administered to staff/owners: Total N=22/46. NCH1, n=7 (4 nurses, 3 HCAs); NCH2, n=15 (9 nurses, 6 HCAs).	<b>CASP: 6.5</b> EA not stated Self-selected Ps. RPGs led by nurse consultant-experienced in palliative care/facilitating experiential learning (i.e., highly skilled facilitation). Limited number of Ps. Transferability/generalizability limited due to specific context.	<b>Themes:</b> RPGs: 1. Educational. (i) "Being taught"-building knowledge/ learning (affecting practice/ interactions with residents' family); (ii) Shared understanding/building model of end-of-life care specific to population, learning together re residents'/families' needs; (iii) Developing critical awareness/"ability to challenge status quo"/culture 2. Emotionally supportive. 3. Communicative: facilitating open dialogue re death-team opportunity to share stories & "let go" of difficult feelings re loss/death/dying; developing staff communication <b>Q Results:</b> 45% (10/22) rated RPGs 8-10/10; 8 Ps rated 6/10; 4 nurses rated 4/10. 2 nurses said they did not need support; 1 declined attending. Conflict re time allocated for RPGs in 1 NCH, yet encouraged by owners. "Many" HCAs: legitimate time to "share feelings". One senior nurse: opportunity to show staff are valued; insight into others' feelings.
13 Lillemoen & Pedersen (2015)	Norway Publicly-funded community health services (two NCHs; two "home care districts"; residential home for people with learning disabilities (PWLD).	To "explore how ethical reflection in colleague groups was experienced and evaluated" by employees, facilitators, & service managers. Part of R&D project (community care services, Community Health Management, & Oslo University).	Mixed methods. 3 FG intvws; reflective notes/ documentation from RPGs; facilitators' biannual written reports; research fieldnotes. Content analysis.  Two years of 60-90 mins RPGs weekly or fortnightly, open to all staff.	N=17. FG1: n=7 (nurses; nurses' aides); FG2: n=5 (RPGs' facilitators representing 5 work sites involved); FG3: n= 5 (service managers of healthcare departments involved).	<b>CASP: 6</b> EA not stated. Unclear how Ps selected. Ltd number of Ps were RPG staff-represented all views or biased? HCPs/management views may not represent patient/family experiences of care. Authors' project involvement may have influenced findings.	<b>Themes:</b> 1. Better care quality:+ve questioning of practices/assumptions/ managers→ new perspectives/ solutions/practice shifts. ↑person-centred care. Improved staff-patient/family relationships/communication. ↑awareness non-verbal communication /patients' needs/rights re decisions. ↑self-awareness→↑staff confidence /better care. 2.↑"Collegial support". Shared learning →↑solidarity/stronger relationships. ↑appreciation of diffs-chance to learn. Unskilled Ps felt their views more valued. <b>Other:</b> shared focus on ethical challenges v "struggling alone". Managers believed RPGs would →↓absenteeism, ↑RNs to community services; FG Ps "doubtful". Cases from everyday practice more meaningful-applying changes. Double-loop learning. Management prioritizing resources imp for RPGs' success.

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14 Lown & Manning (2010)	USA 16 SCRs sites (SCRs described as "educational forum").  Based on SCCC-funded Goodman Research Group (GRG) independent evaluation of SCRs in 2006-2007.	To "assess the impact of [SCRs] on self-reported changes among attendees in their beliefs about patient care, their behavio[u]rs during health care interactions, their participation in teamwork, and their sense of stress and personal support."	Mixed methods: Retrospective surveys (RS) at 10 "experienced" sites (SCRS ≥ 3 years) and prospective surveys (PS) at 6 new sites (pre-implementation and post: ≥ 7 SCRs); 44 semi-structured interviews at 5 experienced sites. Qualitative analysis method=?	RS & PS Ps: SCRs attendees (nurses; physicians; social workers; clergy; "other"). RS: n=256/413 estimated (62%). Retention rate: 222/399 (52%). 43% RS & 51% PS respondents "experienced caregivers" >20 yrs' professional experience: Nurses, physicians, SWs, Clergy, other.  Average age: 46-49 yrs. Interviewees inc. SCRs leads/facilitators, and "hospital administrators".	<b>CASP: 2.5</b> <b>QAT: Weak</b> EA not stated RS & PS Ps "identified" by SCRs coordinators. SR changes.  PS: Most participants reported pre-existing high appreciation of emotional/ psychosocial factors of care.  Limited information re qualitative research.  SCCC-funded. One author - a SCCC Director.	<b>Intvws:</b> HCPs ↑knowledge of each other; sharing perspectives facilitated empathy; ↑ understanding of colleagues' challenges. ↑ respect; ↑connection/shared purpose; modelling humility/ learning from each other. Reported policy/practice changes: 1. "unique & profound contribution"; 2. "teamwork"; 3. "patient-centred approach"; 4. "specific institutional outcomes" (e.g., staff support progs). SCRs - space for dialogue not offered elsewhere - can influence org'l culture. <b>Survey Ps/intvw Ps:</b> SCRs +ve impact on teamwork/ communication; more holistic view of care across disciplines/departments. 51% <b>RS</b> , 40% <b>PS</b> Ps reported policy/practice affected. <b>PS</b> ↑patient-centred care. More SCRs attended → ↑scores: teamwork/ communication /appreciation of colleagues' contributions; ↑patient interaction. ↑insight into psychosocial factors/compassion. <b>RS:</b> High attendees ratings > low attendees for: 1. Heeding non-verbal cues; 2. ↑compassion-patients/ families; 3. ↑ease discussing "sensitive issues"; 4 new strategies for difficult situations; 5. ↑energy for work. ≥85% Ps ↑belief re imp. of empathy. <b>RS Indv:</b> ↓stress; ↑ability to deal with psychosocial challenges. <b>RS Teamwork</b> ↑team participation; ↑appreciation of MDT colleagues' roles; better communication re clinical/psychosocial matters
15 McVey & Jones (2012)	UK Acute hospital and specialist healthcare services trust (York Teaching Hospital	To "evaluate feedback from five clinical supervision groups"/ "RPGs" & explore their meaning for staff.	Qualitative service evaluation of 5 RPGs. Seven "intvws": 3x1-1; 2 x2 Ps; 2x3 Ps. Psychology set up RPGs (60-90 mins), every 4 weeks, each with 3-5 members,	N=13 (1m; 12 f). 12 nurse specialists; one occupational therapist. Participants in RPGs for min. of 6 months and currently active in	<b>CASP: 5</b> EA not stated Unclear how Ps selected. Ps possibly biased twds RPGs (regular attendees). Ps interviewed by	<b>Themes:</b> 1. Professional dvpt (psychological skills; wider focus v solution-oriented; building self-assurance). 2. Group structure key (varied prof perspectives; ltd numbers; skilful facilitation). 3. Other group members key (problem-sharing helpful/ ↓feelings of isolation). 4. Safety (no judgement/threat-able to show vulnerabilities). 5. "Subconscious processes" (not always sure what to bring but "burning



Reference	Country & Context	Aim/s	Design/Methods/ Analysis	Sample/ Participants (Ps)	Quality Rating (QR) <sup>11</sup> / Risk of Bias	Themes/Results/Other Findings
	NHS Foundation Trust). Renal, neurology and cancer services.		facilitated by a CP with clinical supervision training. Thematic analysis.	RPGs.	CP-possible social desirability (set up by Psychology). Consultant CP involved in analysis (risk of bias).	issues" arose v usually "keeping issues curled up" -repressed/avoided /denied). <b>Other:</b> RPGs valued by Ps: build/maintain psychological skills key to cancer care/communication skills. Authors advocated resource-efficient method of clinical supervision in oncology services. Group name: RPG v "supervision" (to avoid -ve connotations re appraisal).
16 Moore & Phillips (2009)	USA Veterans' affairs hospital	Review of SCRs (including SCCC-funded (2008) study findings), consideration of SCRs' value re support-provision for palliative care, & information re SCRs' implementation.	Anecdotal	N/A	<b>QR: N/A</b> Subjective views of two professionals (SW & palliative care doctor) involved in SCRs' implementation; risk of confirmatory bias.	<b>Results:</b> +ve SCRs feedback from evaluation forms/ authors' obs. SCRs aided: 1. Coordinated care-↑knowledge re hospital's services /programmes. ↑joined-up working. 2. ↑staff dialogue re palliative care. Space to reflect on practice /self-care. Support/validation. Hierarchy suspended. ↑empathy amongst professionals/ ↑insight into others' challenges; improved cross-disciplinary communication. <b>Other:</b> *Respected medical lead advanced interest in SCRs-staff & management support legitimized purpose. *Experienced MDs model/ validate SCRs to juniors. *Large SG reduced burden of SCRs admin/logistics on individual staff. *SCRs contribute to fulfilling Accreditation Council for Graduate Medical Education (ACGME) communication core competency criteria for residents/fellows. *Panellist guidelines aid SCR process for participants. ↑insight into roles/challenges of other profs beyond team. SCRs connect clinical-non/clinical staff. ↑"shared sense of purpose, empathy, and understanding amongst staff." 70.4% attendees rated SCRs "excellent"/"exceptional" 24% rated "good". 75.3% "completely agreed" ↑insight re how others think/feel about caring for patients. 44.6% "completely agreed" ↑knowledge to help patient care.
17 Mullick, Wright, Watmore-Eve, & Flatley (2013)	UK Hospice (first in UK to implement SCRs) - St. Joseph's Hospice	Brief review of SCRs in US, UK pilot, and brief evaluation following 8 SCRs at hospice since January 2012.	Autoethnographic/ evaluation	Total N=? Range=23-52/300 staff members per SCR. Repeat Ps: n=? Unique Ps: n=?	<b>QR: N/A</b> Self-selected Ps. Possible repeat Ps. Subjective views of staff involved in SCRs implementation; risk of confirmatory bias. SR.	

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18 Parish, C., Bradley, L., & Franks, V. (1997)	UK Intensive therapy unit (10 beds) in a large teaching hospital	RPGs established "to provide staff with a forum for discussion [of work- related professional/ personal issues]" and support "to manage the stress of caring."	Autoethnographic/ anecdotal evidence re weekly, 1-hour RPGs open to all ITU staff members, facilitated by external senior nursing lecturers supervised by qualified counsellor/ lecturer with systemic/group analytical work background.	Total N=? ITU Staff: 60 nurses, 40 consultants & medical teams; allied health professionals.	<b>QR: NA</b> Subjective views - Authors included two RPGs facilitators (invested in group); success of group attributed to "persistence" of regular, self- selecting attendees.  No evidence from staff who were non- attendees of the RPGs aside from indication RPGs were viewed positively.	*Skilled facilitation: linking experiences to ↓isolation; enabled discussion of underlying emotions/group processes to ↑staff self- awareness/responsibility/ empowerment; modelled openness re own fallibility→↑self- knowledge/ understanding colleagues. *RPGs "container" for staff anxiety. *Evolving aims: confidential forum-"helpful" discussion; reflect on theory-practice links (learning); ↑understanding of colleagues; better team work/atmosphere; collaboration. <b>Enablers:</b> *Management support (funding facilitators' supervision/permitting attendance); *Facilitators providing safe base for staff to explore/be challenged; *Attendees committed. <b>Results:</b> Difficult to measure RPGs' success; most staff found safe, supportive space –to share thoughts/feelings; ↑stress-management; RPGs continued 2.5 yrs post-commissioning; reviewed at 6-monthly meetings between facilitators and managers, latter believed +ve impact on morale/team-functioning. Survey at 1 year: RPG viewed +vely by non-attendees. Group name key; RPG v. "staff support". RPG => professional & personal issues.
19 Reed, Cullen, Gannon, Knight, & Todd, 2015	UK Hospice (300 employees)	To evaluate "the impact [of SCRs] on staff and the organization" having conducted 12 (starting in 2012).	Mixed methods: Post-SCR "exit survey" and 4 FGs. Descriptive statistics and thematic analysis.	Part 1, Survey: N=398/535 attendances. Repeat Ps: n=? Unique Ps: n=? Part 2: 4 x interprofessional FGs: N=33 (8 presenters; 19 attendees; 6 non- attendees) from different disciplines (not	<b>CASP: 2.5</b> EA not stated  Self-selected Ps. Unvalidated tool. SR.  Possibility of repeat survey participants - biased sample.	<b>Themes:</b> *↑feeling part of a larger team; listening to colleagues validated attendees' feelings; resonance with panellists→↑sense of connection/ shared purpose. *↑ understanding of how different roles fit together for org'l functioning. *Panellists seen as human through openness/ honesty/ vulnerability. People worried about social judgement/not being heard perceived as human/brave.↑+ve view of those colleagues/their roles. <b>Results:</b> 535 attendances/12 SCRs; M=44/SCR (range=31- 57). 78% rated 4 or 5 (excellent or exceptional) 87% ↑insight-how others think/feel re caring for

Reference	Country & Context	Aim/s	Design/Methods/ Analysis	Sample/ Participants (Ps)	Quality Rating (QR) <sup>11/</sup> Risk of Bias	Themes/Results/Other Findings
				identified).		patients. Not all valued SCRs; non-attendees felt contributed to team/ org'l running without listening to "stark reality" at SCRs.
<b>Non Peer-reviewed</b>						
20 Farr & Barker (2015)	UK Three community and mental health services sites	To understand how "Schwartz Rounds [are] implemented in mental health and community services [and whether] these contexts affect the model and process of Schwartz Rounds, and if so, how?"	Mixed methods at 3 case study sites: Obs of SCRs (N=5); intvws; post-SCR evaluation forms.	Intvws with staff (organizers/ attendees/ panellists): N=22. Intvws with TPoCF mentors: n=4. Evaluation forms: N=206.	QR: N/A	<b>Impact-self &amp; patient work:</b> ↑patience; ↑reflection; ↑awareness of work's emotional impact; better communication; ↑empathy/compassion; ↑ability to deal with difficult feelings re patients; ↑caring for staff supports patient care; ↑self-awareness→↑compassion/ability to meet others' needs. <b>Staff relationships:</b> ↑trust; ↑"human" connection; ↑empathy; appreciating shared experiences/values; learning from others; querying assumptions; ↑listening skills; ↑courage to discuss difficult subjects; ↑space/time to think; support RP/staff support mechanisms. SCRs valued; safe space to share experiences (not offered elsewhere). <b>Culture:</b> support staff & open/honest org'l culture; help stop splitting/scapegoating →↑quality indiv'l-team-org'l relationships; Trust recognition-emotional impact; advancing Trust values; staff feel valued.
21 Maben, Leamy, Reynolds, & Taylor (2016)	UK 10 UK SCRs provider sites (7 established; 3 new)	To explore how SCRs participation affects staff wellbeing at work, staff social support & staff-patient relationships & to explore the relationship between mechanisms & the effect context has on outcome.	Mixed methods. Longitudinal staff survey at 0 & 8 months. 10 case studies/ethnographic fieldwork involving obs & intvws. Framework analysis. EA = Realist: Context (C) + mechanism (M) = outcome (O).	Survey: n=800 attendees; n=2,500 non-attendees. 10 case studies: obs (SCRs; SG meetings; panel preparation); and intvws (attendees; non-attendees; panellists; senior stakeholders).	QR: N/A	<b>10 CMO themes (GROUP CRAFT):</b> "Group work Role-modelling vulnerability; Offering a counter-cultural 3 <sup>rd</sup> space; Uncovering/shining spotlight on hidden roles/stories; Participant self-disclosure; Contextualizing patients/staff; Reflection/resonance; A story; Fidelity; Trust & safety." <b>Themes across 4-stage SCR cycle:</b> 1. Source stories; 2. Craft stories; 3. Tell stories/create 3 <sup>rd</sup> /counter-cultural space in SCR; 4. Post-SCR effects, e.g., If (C) sources carefully prepared, (M) attendees put selves in panellists' shoes= (O) ↑empathy-colleagues/↑self-compassion/ better teamwork & communication. Post-SCR →shifting perceptions →transforming culture.



+ve=positive; -ve=negative; ↓= decreased; ↑= increased; → = to/led to/leads to; >=more than/greater than; => = implies; ACA=available case analysis/ses; AHPs=allied health professionals; CASP=*Critical Appraisal Skills Programme Qualitative Research Checklist*; CCs=Compassionate Conversations; ComPs=comparison ward participants; Com-ward=comparison ward; ConPs=consultation ward participants; Con-ward=consultation ward; CP/s=clinical psychologist/s; depts=departments; diff/s=difference/s; dvpt = development; EA=epistemological approach; EF/s=evaluation form/s; f=female; FG/s = focus group/s; HC=healthcare; HCAs= healthcare assistants; imp=important ; inc.=including ; indv'l=individual; intvw/s= interview/s; IPS=inpatient psychiatric services; Ldn=London; M=mean; m=male; MBI=Maslach Burnout Inventory; MD/s=medical doctor/s; min=minimum; mins=minutes; mths = months; multiprof=multiprofessional; N=total number; n=number; N/A=not applicable; NCH/s=nursing care home/s; NP/s=nurse practitioner/s; NS=non-significant; OAs=older adults; obs=observation/s; OH=occupational health; org'l = organizational; Ps=participants; prof/s=professional/s; prog/s=programme/s; PS=prospective survey; Pt/s=physiotherapist/s; PWLD=People with learning disabilities; Q/s= questionnaire/s; QAT=*Effective Public Health Practice Project Quality Assessment Tool*; QR: quality rating; ref=reference; re=regarding; RNs=registered nurses; RNM/s=registered nurse manager/s; RP=reflective practice; RPG/s=reflective practice group/s; RQ=research question; RS=retrospective survey; SCR/s=Schwartz Center Round/s; SD=standard deviation; SG=Steering Group; Sig=significant/significantly; Sig.↓=significantly lower; SigDiff = significant difference; SP=speech path; SR=self-report; SW/s=social worker/s; SWE=South West England; twds = towards; v=versus; WAS=Ward Atmosphere Scale; yrs=years

### **PICOS Criteria and Quality**

Most of the participants in the studies in this review were attendees of healthcare SCRs/RPGs or, in some way, had a vested interest in SCRs/RPGs, for example, as SG members or facilitators. The majority of papers were based on self-report evaluations of the interventions and only one paper included a control intervention, which then evolved into a comparison with contextual changes. Outcomes were often based on subjective perceptions and measured via an unvalidated questionnaire, with only one study utilizing questionnaires with established reliability and validity. Those study designs including ethnographic evidence without sufficient reflexivity and those of lower quality were more likely to be subject to confirmatory bias. Evidently, this has implications for the discussion (see below) and highlights gaps in the literature. Further research incorporating the views of organizational members who are non-/non-regular participants in the said interventions, and studies including control or comparison interventions with validated and independent measures are required.

### **Narrative Synthesis of Findings**

The majority of papers reported SCRs and RPGs were rated highly and valued by most participants across professions. SCRs/RPGs were rated moderately by medical students (9) and 55% of participants in two care homes (12). Only studies 19 and 21 included participants who were non-attendees; the former reported not all staff valued SCRs. Non-attendees felt they contributed organizationally without needing to attend. Study 12 referred to non-attendees reporting not needing support or new knowledge.

There were many related outcome themes across papers labelled and conceptualized in variable ways. A synthesis of four predominant themes is outlined below. The first three are explicated across the three abovementioned levels. The final theme incorporates enablers and barriers considered to affect SCRs/RPGs and their outcomes.

### **1. Reflection, learning and development.**

Nearly all the papers reported on the learning, educational, personal and/or professional developmental impact of SCRs/RPGs; study 16 stated SCRs' attendance helped fulfil the American Accreditation Council for Graduate Medical Education's communication core competency criteria for residents and fellows.

**Individual.** SCRs/RPGs offered space for greater personal and/or professional shared reflection and learning (8/9) which might not happen elsewhere (14/20/21), which was not assessed (1), and might lead to a shift in identity (21). SCRs/RPGs' informative (5), educational (12) and thought-provoking potential was appreciated (3). They stimulated greater self-awareness (6/13/20) and critical awareness via new knowledge, ideas, and strategies (12/15) to deal with challenging work situations (14) which could lead to transformed thinking (11) and practice (12/13) resulting in improved care quality (13) and/or increased staff confidence (13/15).

**Relational.** Many studies reported participants gaining insight into others' experiences of caregiving which could improve collaboration (10/18), collegial support, and staff relationships (2/12/13/14/18/20/21). Increased understanding of colleagues' roles was reported (10/14/16/17/18). Increased reflection led to cognitive, emotional, and behavioural changes resulting in improved quality, greater patient-centredness (13/14), and improved

communication amongst HCPs and/or between staff and patients/families (12/13/14/15/16/20/21). Paper 4 discussed SCRs attendees' increased awareness of the need to develop communication skills for difficult situations. Differences between staff previously perceived as negative came to be seen as opportunities (13) in the reflective space from which staff could learn (13/14/20).

**Organizational.** SCRs permitted broader thinking (14) and increased organizational understanding of how different departments and roles fit together. Study 19 outlined non-clinical staff's involvement in facilitating this; one participant described feeling like "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." This more holistic view of care across teams and departments (14), not reported in RPGs studies, could offer more coordinated patient-care across services (16), sometimes with policy and practice changes (14). Two RPGs studies described staff's strengthened critical awareness, enabling challenges to the "status quo" (12) and managers (13) which could transform practice. Study 15 underlined RPGs as a resource-efficient method of clinical supervision, required for supporting staff, patient care, and safety. Participants in study 8 reported supervision as non-existent in nursing.

## **2. Emotional and psychological impact: catharsis or a container for anxiety?**

SCRs/RPGs offering an emotionally supportive space in which staff could discuss difficult feelings and psychosocial work challenges (3/10/11/12/16/20) and be validated was valued (10/11). Participation in such forums could be emotive (9/11) and impacted by enablers/barriers (see below) including facilitation and safety. Two papers (11/18) discussed the way in which well-functioning RPGs/SCRs acted as an anxiety container. Study 11 reported

facilitators' views that some staff cited competing demands to avoid the thinking space and protect themselves from any emotional disturbance it might elicit.

Study 19 described non-attendees feeling they did not need to hear the "stark reality" of patients and professionals' experiences. Study 15 discussed "subconscious processes" whereby participants suppressed or repressed issues which would subsequently arise as "burning issues" in RPGs, proving cathartic, and preventing unconscious emotions from affecting working relationships.

**Individual.** Several studies discussed participants' reporting reduced stress, greater ability to cope with stress and emotional work challenges, with greater awareness of work's emotional impact and/or boosted resilience to protect against burnout through SCRs/RPGs (1/10/14/18/20). Study 2 showed no changes in staff-reported stress levels in an RPG on a forensic, high-security ward, although they displayed non-significantly lower levels of depersonalisation than the comparison group. This is arguably a unique, high-risk environment where violence towards staff is common (Lauvrud, Nonstad, & Palmstierna, 2009). Study 8 found a decrease in the reported emotional labour of work for new SCRs attendees, but not for those with prior SCRs experience.

**Relational.** Participants described reduced isolation (5/13/15/18) aided by skilful facilitators making connections between different people's experiences (18). The discussion of emotive topics could result in increased team-building and collaboration (9/13), greater empathy and compassion for colleagues and/or patients (9/10/14/16/17/20/21), and an increased awareness of, or ability to meet, others' needs (13/16/20).

**Organizational.** Study 14 reported that SCRs were leading to other staff support interventions.

### 3. **Storytelling: connecting humans through narrative communication.**

Ninety-two per cent of medical students valued storytelling at SCRs in reflecting medicine's human side (9). Study 12 identified RPGs as developing staff communication through the facilitation of open dialogue and storytelling/story-sharing. Study 20 found SCRs promoted better quality individual-team-organizational interaction, helping prevent "splitting" (between staff groups/hierarchical levels with an "us" and "them" whereby one group is blamed by the other for problems without recognition of their possible responsibility for, or contribution to, these (Parish, 1997)). Study 11 indicated splitting in teams was widespread between RPGs attendees versus non-attendees. Study 8 indicated attendees rated peers more favourably post-SCRs, yet rated line managers more negatively. It was unknown whether the latter attended. Study 21 addressed non-attendees' views but results are not yet available.

**Individual.** Attending to others' stories improved listening skills (20). Resonating emotionally or having feelings validated through the stories they heard (3/4/19/21) helped participants see others, especially doctors (6), as more human (9/6/19/20), which could encourage generosity and compassion towards colleagues and patients (8/9/10/14/16/20/21). Formally retelling stories about difficult feelings could enable catharsis (12).

**Relational.** Participants described feeling part of a larger team with increased feelings of connection (1/8/14/17/19/20), a shared purpose, and greater appreciation of shared experiences and values (5/6/10/14/17/19/20). SCRs/RPGs could engender greater trust amongst attendees (20) and

improved communication with colleagues and/or patients

(12/13/14/15/16/20/21)

**Organizational.** SCRs may support the embodiment of shared Trust values and a caring culture (10/20).

#### **4. Leadership and culture: Openness and honesty.**

Participants in SCRs/RPGS discussed their impact on developing transparency, honesty and openness (1/3/10/11/12/20/21). Aligned with the idea of a “counter-cultural” space (21), medical students reported on emotional suppression in medical culture (9), indicating senior medics modelling open communication about uncertainty and/or difficult emotions was powerful to witness and could normalize feelings and demonstrate the value of reflective forums (1/6/10/14/16/18/21). These were validated by senior physicians’ attendance (16).

Panellists worried about social judgement and exposing vulnerabilities were seen as brave (19) and human (1/9/19/21). Some studies reported staff feeling more valued in SCRs/RPGS and a suspension of the professional hierarchy (6/10/13/16). However, study 6 discussed the limits on safety at SCRs depending on who was present; one participant likened them to a company Christmas party, endorsing the need for self-monitoring as people were at work where the hierarchy persisted.

Study 11’s participants indicated hierarchical power imbalances amongst staff, or between staff and patients, could be mirrored in RPGs’ attendance and non-attendance. They discussed the challenge of protecting the reflective space in cultures in which thinking did not happen or was not prioritized and seen as “self-indulgence”.

***Enablers and barriers.***

Two enablers and barriers of SCRs/RPGs which could affect their success and outcomes were the same (resources and safety) and interrelated with leadership and culture. Leadership was key to providing strategic and symbolic support to enable success (providing resources/financial backing, permitting staff space and time to reflect, encouraging managers to support staff attendance) (7/11/13). Study 10 deemed board support, a TPoCF requirement, essential for SCRs' continued success.

Leadership was instrumental in rendering reflective spaces and the practices within acceptable (1/9/16/21). Staff felt valued and supported when the organization supported SCRs/RPGs (20). Inversely, restricted resources, busyness, and conflicts with other demands were cited as barriers (1/4/7/9/12). Although SCRs/RPGs were often described as safe, secure, and supportive, there were limits to how vulnerable or open participants trusted they could be in terms of who was present and larger group sizes, which could inhibit participation. Smaller groups could facilitate safety and discussion (1/9/6/15).

The language used to describe RPGs was important given how it might be interpreted by staff within different contexts. Study 11 considered different names attributed to RPGs; study 15 avoided "clinical supervision" with its notion of appraisal; reference 18 avoided "staff support", choosing RPGs to encompass discussion of personal and professional issues. Participants appreciated skilful facilitation when it enabled connection between their own and others' experiences, across disciplines, to reduce feelings of isolation (3/4/18).



Although study 15 highlighted the value of multiple professional perspectives, and study 10 described all SCR topics being perceived as valuable, two discussed the need to connect to the topic in some way (4/7).

### **Discussion**

This review sought to explore the impact of SCRs/RPGs on healthcare teams. The reflective log was important in maintaining a critical awareness of the gaps, and not succumbing to the confirmatory bias which appeared to be present in the existing literature. For example, there was a strong narrative that openly discussing emotions related to work events in SCRs was almost entirely positive, resulting in beneficial outcomes such as reduced staff stress, better relationships and communication, with positive implications for the development of a compassionate, transparent, honest, and non-hierarchical culture. The log provided space in which to reflect on the potential bias in my own assumptions as well as in this narrative, and to pose questions to challenge this (such as how adaptive is it for surgeons to compassionately connect with the human being they must cut open on the operating table). It also allowed me to compare my own observations of SCRs in different trusts with the current evidence (for example, that bearing witness to unprocessed raw emotions might increase stress; it could be distressing and draining rather than nurturing and energy-giving, and existing cultural patterns might be perpetuated in the space with particular senior professionals' voices dominating).

Reflecting on the evidence which ran counter to the dominant discourses (for example, that SCRs/RPGs offer a safe, supportive space for HCPs to discuss emotions and vulnerabilities) increased vigilance to ensure this was included when present (that open emotional disclosure may not always be safe and witnessing it might be upsetting). Reflecting on observations and questions

helped develop a more balanced view of the potential negative, as well as positive, repercussions of SCRs/RPGs, for example, possible splitting, tension, and strained relationships between attendees and non-attendees. Such potential negative outcomes were cited in one RPGs paper but, for SCRs, were generally not presented. To accurately and effectively determine the impact of SCRs/RPGs on healthcare teams, particularly at an organizational level, independent measures and the perspectives of non-attendees are also required but are, for the most part, currently lacking. This is important as SCRs may have detrimental implications for healthcare teams and organizations, which are currently not being identified as they are being portrayed as a unifying force.

There is a dearth of truly independent research in this area. The majority of papers included authors who were somehow invested in the said interventions, for example, as facilitators, SG members, or representatives of the organizations which promote and receive financial income from SCRs. This does colour the evidence, particularly in studies of lower quality and lacking reflexivity, in which authors did not sufficiently consider how their own position might influence findings.

Although there appeared to be evidence that SCRs/RPGs engendered beneficial outcomes at individual and relational levels, the participants were mostly self-selected, attendees of the interventions, and likely biased towards them. In the SCRs evaluations, an unvalidated, self-report measure was administered to participants immediately following the intervention, from which attendees may have experienced instant benefits, such as (unsurprisingly) increased understanding of how colleagues think and feel about work. Such changes may incite systemic changes. However, there was a lack of evidence for effects at the organizational level, or how individual and relational effects

might be sustained and translated to outcomes at a whole-system's level. This is striking given the considerable investment that has already, and continues to be, put into SCRs as an initiative to promote organizational and cultural change. With this in mind, the themes identified in the existing evidence for the impact of SCRs/interdisciplinary RPGs on healthcare teams are discussed below.

### **Reflection, Learning and Development**

Lillemoen and Pedersen (2015) posited the theory of double-loop learning in RPGs whereby professional development ensues from qualitatively changed thinking and questioning via shared reflection on practice. Not permitting time for reflection may adversely impact on organizational functioning. Being exposed to alternative viewpoints can offer new understandings to deepen and broaden people's self-awareness and range of potential actions (Lindberg, 2007). Double-loop learning involves questioning assumptions and may facilitate the dispensing of "possibly dysfunctional ways of thinking, feeling, and acting" (Cartwright, 2002, p.69) through accessing alternatives.

### **Emotional and Psychological Impact**

George (2016) theorized the sharing of stressful psychosocial challenges at SCRs might help foster more situational versus dispositional stress appraisals, reducing the threat to staff's identities, which can trigger anxiety and the threat response's narrowed focus which prioritizes self-preservation, limiting the capacity for empathy and compassion. SCRs might reduce staff anxiety as they realize they are not unusual in their struggles.

RPGs/SCRs may facilitate the development of psychological-mindedness and skills by offering space for the processing and release of emotions or "burning issues" (McVey & Jones, 2012), which might otherwise be,

unidentified, unacknowledged, misunderstood, avoided, or defended against.

Having an opportunity to reflect on what may be occurring in work relationships (such as with transference/counter-transference) may enhance understanding of both self and others and can aid the prevention of enactments or compulsions to act in a particular way (Lemma, 2003).

### **Storytelling: Connecting Humans through Narrative Communication**

Bruner (1986, p.11) delineated “two modes of cognitive functioning”: the logico-scientific and narrative, the former “[establishes] formal and empirical truth”, the latter “verisimilitude”. Much of modern healthcare and medicine is founded on the former, with “objective data” prioritized above subjective perspectives (Curtis, Tzannes, & Rudge, 2011) and narrative thinking.

Luetsch & Rowett (2015) specified successful interdisciplinary communication as fundamental for collaborative practice amongst HCPs. Corless et al. (2009) reported “medical jargon” at SCRs required clarification for other disciplines; SCRs may improve cross-disciplinary communication (Moore & Phillips, 2009), although left untranslated, logico-scientific speech could act as a barrier. Maben et al. (2016) suggested SCRs offer a third space where storytelling is privileged above the dominant cultural mode, which can help staff “put themselves in [others’] shoes”. Black (2008, p.93) wrote of stories inviting “dialogic moments” enabling identity-crafting as group members “take on others’ perspectives”.

SCRs/RPGs may facilitate the development of a shared social, or “collective identity” (George, 2016) amongst members as they see themselves in others and others in themselves. As well as helping to counter the fundamental/ultimate attribution errors (George, 2016; Maben et al., 2016), whereby staff may overrate the impact of dispositional factors and underrate

those of situational factors on others' behaviour. The organizational impact in this area needs investigation and could be informed by consideration of how the social identities of attendees and non-attendees compare and contrast.

### **Leadership and Culture: Openness and Honesty**

Open cultures require psychological safety (Wilde, 2014). Trust, not fear, is intrinsic to just, compassionate cultures (Tombs-Katz, 2014). Schein (2004, p.11) underlined the interconnection between culture and leadership, highlighting how leadership “creates and changes cultures, while management and administration work within a culture”. Clinical leaders who reflect on the emotional impact of their work at SCRs/RPGs may help address some of the cultural barriers to open and honest discussions in healthcare, establishing safety and normalizing emotional expression, thereby facilitating connection to their and their patients' human side. Haslam (2017) suggested when people engage in action which builds a perceived sense of social identity, it encourages individuals to view others as related to the self, offering a foundation to develop beyond “one's comfort zone”, with assurance to grow in a context that might otherwise be felt as “threatening”.

### **Conclusion and Future Directions**

This review considered the evidence regarding the impact of SCRs and RPGs on healthcare teams at individual, relational, and organizational levels, and enablers and barriers which may affect these. Although it may be easier to establish safety in smaller RPGs, it appeared SCRs involving non-clinical and clinical staff across organizations may hold greater potential for staff to develop more holistic perspectives with the possibility for transformative dialogue to effect changes at the organizational level.

The view presented of multidisciplinary reflective forums was positive. A caveat rests on the potential bias of both participants and numerous authors of papers in this review, indicating the findings should be treated with caution. The NIHR-study may go some way to redressing the stark dearth of SCRs non-attendees' voices in the literature. However, more studies need to investigate their perceptions of this intervention. Might SCRs truly offer an opportunity for sustained organizational changes and the development of a shared social identity, or might opposing groups become entrenched in their positions across the SCRs attendees/non-attendees divide?

Although challenging given their complexity, it would be informative to investigate whether and how SCRs may be impacting relationally on staff-patient/family interactions from the latter's perspective when cared for by staff who are SCRs participants compared with those who are not. Whether SCRs hold the power to transform healthcare cultures remains a more moot point than previous research has claimed. This review's findings nevertheless indicate SCRs and RPGs can elicit positive effects on healthcare teams at different levels.

## References

- Armijo-Olivo, S., Stiles, C.R., Hagen, N.A., Biondo, P.D., & Cummings, G. G. (2012). Assessment of study quality for systematic reviews: A comparison of the Cochrane Collaboration Risk of Bias Tool and the Effective Public Health Practice Project Quality Assessment tool: Methodological research. *Journal of Evaluation in Clinical Practice*, 18(1):12-8.
- Barker, R., Cornwell, J., & Gishen, F., (2016). Introducing compassion into the education of healthcare professionals, can Schwartz Rounds help? *Journal of Compassionate Health Care*, 3(3), 1-8. DOI: 10.1186/s40639-016-0020-0.
- Black, L. W. (2008), Deliberation, Storytelling, and Dialogic Moments. *Communication Theory*, 18: 93–116. DOI:10.1111/j.1468-2885.2007.00315.x.
- Blumenthal, S., Ruszczynski, S., Richards, R., & Brown, M. (2011). Evaluation of the impact of a consultation in a secure setting. *Criminal Behaviour and Mental Health*, 21, 233-244. DOI: 10.1002/cbm.798.
- Bruner, J. (1986). *Actual minds, possible worlds*. Cambridge, MA: Harvard University Press.
- Cartwright, S. (2002). What is double-loop learning? *Journal of Leadership Education*, 1, 68-71.  
[http://www.journalofleadershiped.org/attachments/article/18/JOLE\\_1\\_1\\_Cartright.pdf](http://www.journalofleadershiped.org/attachments/article/18/JOLE_1_1_Cartright.pdf).
- Chadwick, R., Muncer, S., Hannon, B., Goodrich, J., & Cornwell, J. (2016). Support for compassionate care: Quantitative and qualitative evaluation of Schwartz Center Rounds in an acute general hospital. *Journal of the Royal Society of Medicine*, 0(0), 1-8. DOI: 10.1177/2054270416648043.

- Cole-King, A. & Gilbert, P. (2011). Compassionate care: The theory and the reality. *Journal of Holistic Healthcare*, 8(3), 29-37.
- Corless, I. B., Michel, T. H., Nicholas, M., Jameson, D., Purtilo, R., & Dirkes, A. M. (2009). Educating health professions students about the issues involved in communicating effectively: a novel approach. *Journal of Nursing Education*, 48, 367-373. DOI: 10.3928/01484834-20090615-03.
- Cornwell, J., & Goodrich, J. (2010). Supporting staff to deliver compassionate care using Schwartz Center rounds – a UK pilot. *Nursing Times*, 106(5), 10-12.
- Critical Appraisal Skills Programme. (2013). *Qualitative Research Checklist*. Retrieved from [http://media.wix.com/ugd/dded87\\_25658615020e427da194a325e7773d42.pdf](http://media.wix.com/ugd/dded87_25658615020e427da194a325e7773d42.pdf).
- Curtis K., Tzannes A., & Rudge, T. (2011). How to talk to doctors: A guide for effective communication. *International Nursing Review*, 58, 13–20.
- Department of Health (2013, May 21). *Expansion of groundbreaking scheme to support staff*. London: Author. Retrieved from <https://www.gov.uk/government/news/expansion-of-groundbreaking-scheme-to-support-nhs-staff>.
- Deppoliti, D.I., Côté-Arsenault, D., Myers, G., Barry, J., Randolph, C., & Tanner, B (2015). Evaluating Schwartz Center Rounds® in an urban hospital center. *Journal of Health Organization and Management*, 29, 973-987. DOI: 10.1108/JHOM-09-2013-0189.
- Effective Public Health Practice Project Quality Assessment tool (2010). Retrieved from [http://www.ephpp.ca/PDF/Quality%20Assessment%20Tool\\_2010\\_2.pdf](http://www.ephpp.ca/PDF/Quality%20Assessment%20Tool_2010_2.pdf).



- Farr, M., & Barker, R. (2015). Implementing Schwartz rounds in community and mental health services: How can processes of group reflection support health and social care staff? Executive summary and guidance to sites. Bath: Author.
- Francis, R. (2013). *Report of the Mid Staffordshire NHS Foundation Trust public inquiry*. London: The Stationery Office. Retrieved from [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/279124/0947.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/279124/0947.pdf).
- Gardner, S., & Bray, D. (2014). Compassionate Conversations. *British Medical Journal Quality Improvement Report*, 3, 1-3.  
DOI:10.1136/bmjquality.u204059.w2102.
- George, M. (2016). Stress in NHS staff triggers defensive inward-focussing and an associated loss of connection with colleagues: This is reversed by Schwartz Rounds. *Journal of Compassionate Health Care*, 3(9), 1-17.  
DOI: 10.1186/s40639-016-0025-8.
- Gishen, F., Whitman, S., Gill, D., Barker, R., & Walker, S. (2016). Schwartz Centre Rounds: A new initiative in the undergraduate curriculum-what do medical students think? *BMC Medical Education*, 16(246) 1-7. DOI: 10.1186/s12909-016-0762-6.
- Goodrich, J. (2012). Supporting hospital staff to provide compassionate care: Do Schwartz Center Rounds work in English hospitals? *Journal of the Royal Society of Medicine*, 105, 117–122. DOI: 10.1258/jrsm.2011.11018.
- Haslam, A. (2017). The social identity approach to education and learning: Identification, ideation, interaction, influence and ideology in K. I. Mavor, M. J. Platow, and B. Bizumic (Eds.) *Self and social identity in learning and educational contexts* (pp. 19-52). Abingdon: Routledge.

- Heneghan, C., Wright, J., & Watson, G. (2014). Clinical psychologists' experiences of reflective staff groups in inpatient psychiatric settings: A mixed methods study. *Clinical Psychology & Psychotherapy, 21*, 324-40. DOI: 10.1002/cpp.1834.
- Hockley, J. (2014). Learning, support and communication for staff in care homes: outcomes of reflective debriefing groups in two care homes to enhance end-of-life care. *International Journal of Older People Nursing, 9*, 118-130. DOI: 10.1111/opn.12048.
- Holman, C., Meyer, J., & Davenhill, R. (2006). Psychoanalytically informed research in an NHS continuing care unit for older people: Exploring and developing staff's work with complex loss and grief. *Journal of Social Work Practice, 20*, 315-328. DOI: 10.1080/02650530600931872.
- Hopceck, P. (2016). Conflict management in healthcare organizations: Navigating the intersections of patients, families, and healthcare workers in T. R. Harrison and E. A. Williams (Eds.) *Organizations, communication, and health* (pp. 134-150). New York: Routledge.
- Kakunje, A. (2011). Stress among health care professionals: The need for resiliency. *Online Journal of Health and Allied Sciences, 10*(1):1-2.
- Lauvrud, C., Nonstad, K., & Palmstierna, T. (2009). Occurrence of post-traumatic stress symptoms and their relationship to professional quality of life (ProQoL) in nursing staff at a forensic psychiatric security unit: A cross-sectional study. *Health and Quality of Life Outcomes, 16*, 31. DOI: 10.1186/1477-7525-7-31.
- Leamy, M., & Maben, J. (2016). *Schwartz Rounds: Origins, early development, and implementation in the US and UK*. Presented at The Point of Care Schwartz Community Conference, London, UK.

Lemma, A. (2003). *Introduction to the practice of psychoanalytic psychotherapy*. Chichester: Wiley.

Lillemoen, L., & Pedersen, R. (2015). Ethics reflection groups in community health services: An evaluation study. *BMC Medical Education*, 16(25), 1-10. DOI: 10.1186/s12910-015-0017-9.

Lindberg, E. (2007). Increased Job Satisfaction After Small Group Reflection on an Intensive Care Unit. *Dimensions of Critical Care Nursing*, 26(4), 163-167.

Lown, B. A., & Manning, C. F. (2010). The Schwartz Center Rounds: Evaluation of an interdisciplinary approach to enhancing patient-centered communication, teamwork, and provider support. *Academic Medicine*, 85, 1073-1081. Retrieved from <http://www.pointofcarefoundation.org.uk/Downloads/Schwartz-Center-Rounds-Evaluation-Study-2010.pdf>.

Luetsch, K., & Rowett, D. (2015). Interprofessional communication training: benefits to practicing pharmacists. *International Journal of Clinical Pharmacy*, 37(5), 857-864. DOI: 10.1007/s11096-015-0130-3.

Maben, J. (2014, June 6). Take staff support seriously with Schwartz Rounds. *Health Service Journal*. Retrieved from <https://www.hsj.co.uk/comment/take-staff-support-seriously-with-schwartz-rounds/5071380.article>.

Maben, J., Leamy, M., Reynolds, E., & Taylor, K. (2016, October). *Schwartz Rounds: Realist evaluation draft findings from national research study*. Presented at The Point of Care Schwartz Center Round Conference, Manchester, UK.

- Maben, J., Peccei, R., Adams, M., Robert, G., Richardson, A., Murrells, T., & Morrow, E. (2012). *Patients' experiences of care and the influence of staff motivation, affect, and wellbeing. Final report.* NIHR Service Delivery Organization Programme.
- McVey, J., & Jones, T. (2012). Assessing the value of facilitated reflective practice groups. *Cancer Nursing Practice, 11*(8), 32-37.  
DOI:10.7748/cnp2012.10.11.8.32.c9357.
- Moher, D., Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). *Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement.* PLoS Med 6(7): e1000097.  
DOI:10.1371/journal.pmed1000097.
- Moore, C., & Phillips, J. M. (2009). In these rounds, health care professionals heal themselves. *Journal of Social Work in End-of-Life & Palliative Care, 5*, 116-125. DOI:10.1080/15524250903555064.
- Mullick, A., Wright, A., Watmore-Eve, J., & Flatley, M. (2013). Supporting hospice staff: the introduction of Schwartz Center Rounds to a UK hospice setting. *European Journal of Palliative Care, 20*, 62–65.
- Newcastle Hospitals (2014). *Post Francis work progress report appendix C.*  
Retrieved from [http://www.newcastle-hospitals.org.uk/downloads/Board%20of%20directors/June\\_14\\_A5vi\\_Post\\_Francis\\_Work\\_Progress\\_Report\\_Appendix\\_C.pdf](http://www.newcastle-hospitals.org.uk/downloads/Board%20of%20directors/June_14_A5vi_Post_Francis_Work_Progress_Report_Appendix_C.pdf).
- Parish, C., Bradley, L., & Franks, V. (1997). Managing the stress of caring in ITU: A reflective practice group. *British Journal of Nursing, 6*, 1192-6. DOI: 10.12968/bjon.1997.6.20.1192.
- Penson, R. T., Shapira, L., Mack, S., Stanzler, M., & Lynch, T. J. (2010). Connection: Schwartz Center Rounds at Massachusetts General Hospital

Cancer Center. *Oncologist*, 15, 760-764. DOI:

10.1634/theoncologist.2009-0329.

Reed, E., Cullen, A., Gannon, C., Knight, A., & Todd, J. (2015). Use of Schwartz

Centre Rounds in a UK hospice: Findings from a longitudinal evaluation.

*Journal of Interprofessional Care*, 29, 365-366. DOI:

10.3109/13561820.2014.983594.

Robert, G., Philippou, J., Leamy, M., Reynolds, E., Ross, S., Bennett, L., Maben,

J. (2017). Exploring the adoption of Schwartz Center Rounds as an

organizational innovation to improve staff well-being in England, 2009-

2015. *BMJ Open*, 7(1), 1-10. DOI: 10.1136/bmjopen-2016-014326.

Salinsky, J. (2009). *A very short introduction to Balint Groups*. Retrieved from

<https://balint.co.uk/about/introduction/>.

Shamseer, L., Moher, D., Clarke, M., Gherzi, D., Liberati, A., Petticrew, M.,

Shekelle, P., & Stewart, L., A. The PRISMA-P Group (2015). Preferred

reporting items for systematic review and meta-analysis protocols

(PRISMA-P) 2015: Elaboration and explanation. *BMJ*, 349, g7647. DOI:

10.1136/bmj.g7647.

The King's Fund (2017). *About us*. Retrieved from

<https://www.kingsfund.org.uk/about-us>.

The Point of Care Foundation (2017a). *List of sites*. Retrieved from

<https://www.pointofcarefoundation.org.uk/our-work/schwartz-rounds/list-of-sites/>.

The Point of Care Foundation (2017b). *About us*. Retrieved from

<https://www.pointofcarefoundation.org.uk/about-us/>.

Tombs-Katz, M. (2014). Fostering a continuous learning culture in the NHS: The

role of leadership. *Occupational Psychology in Public Policy (OPIPP)*

*group report: Implementing culture change within the NHS: Contributions from occupational psychology*, pp. 45-51. London: BPS. Retrieved from: [https://www.bps.org.uk/system/files/user-files/Division%20of%20Occupational%20Psychology/public/17689\\_cat-1658.pdf](https://www.bps.org.uk/system/files/user-files/Division%20of%20Occupational%20Psychology/public/17689_cat-1658.pdf).

Van Roy, K., Vanheule, S., & Inslegers, R. (2015). Research on Balint Groups: A literature review. *Patient Education and Counseling*, 98, 685-694.

Wicks (2007). *The resilient clinician*. Oxford: Oxford University Press.

Wilde, J. (2014). *Cultures of transparency and openness in the NHS: The Francis imperative*. Retrieved from <http://foundersnetwork.uk/wp-content/uploads/2014/11/Joanna-Wilde-Article.pdf>.

Willig, C. (2001). *Introducing qualitative research in psychology: Adventures in theory and method*. Buckingham, Philadelphia: Open University Press. Retrieved from <http://www.mheducation.co.uk/openup/chapters/0335205356.pdf>.

Wren, B. (2014). Schwartz Rounds: An intervention with potential to simultaneously improve staff experience and organizational culture. *Clinical Psychology Forum*, 263, 22-25.

Zwarenstein, M., Goldman, J., & Reeves, S. (2009). Interprofessional collaboration: Effects of practice-based interventions on professional practice and healthcare outcomes (review). *Cochrane Database of Systematic Reviews*, 8(3). DOI: 10.1002/14651858.CD000072.pub2. Retrieved from <http://caipe.org.uk/silo/files/cochrane-review--ipe-2009.pdf>.

## **Appendices**

- A. *The Critical Appraisal Skills Programme (CASP) Qualitative Research Checklist (2013)*
- B. *The Effective Public Health Practice Project (EPHPP) Quality Assessment Tool (QAT)*
- C. *CASP and QAT Quality Ratings*

**Appendix A: The *Critical Appraisal Skills Programme (CASP)***

***Qualitative Research Checklist (2013)***

**10 questions to help you make sense of qualitative research**

**This assessment tool has been developed for those unfamiliar with qualitative research and its theoretical perspectives. This tool presents a number of questions that deal very broadly with some of the principles or assumptions that characterise qualitative research. It is *not a definitive guide* and extensive further reading is recommended.**

**How to use this appraisal tool**

Three broad issues need to be considered when appraising the report of qualitative research:

- **Rigour: has a thorough and appropriate approach been applied to key research methods in the study?**
- **Credibility: are the findings well presented and meaningful?**
- **Relevance: how useful are the findings to you and your organization?**

The 10 questions on the following pages are designed to help you think about these issues systematically.

The first two questions are screening questions and can be answered quickly. If the answer to both is “yes”, it is worth proceeding with the remaining questions.

A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

**Screening Questions**

**1. Was there a clear statement of the aims  Yes  No**

**of the research?**

*Consider:*

- *what the goal of the research was*
- *why it is important*
- *its relevance*



**2. Is a qualitative methodology appropriate?**  Yes  No

*Consider:*

- *if the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants*

**Is it worth continuing?**

Detailed questions

***Appropriate research design***

**3. Was the research design appropriate to address the aims of the research?** Write comments here

*Consider:*

- *if the researcher has justified the research design (e.g. have they discussed how they decided which methods to use?)*

*Sampling*

**4. Was the recruitment strategy appropriate to the aims of the research?** Write comments here

*Consider:*

- *if the researcher has explained how the participants were selected*
- *if they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study*
- *if there are any discussions around recruitment*

*(e.g. why some people chose not to take part)*

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*Data collection*

**5. Were the data collected in a way that** Write comments here  
**addressed the research issue?**

*Consider:*

- if the setting for data collection was justified*
- if it is clear how data were collected (e.g. focus group, semi-structured interview etc)*
- if the researcher has justified the methods chosen*
- if the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews were conducted, did they used a topic guide?)*
- if methods were modified during the study. If so, has the researcher explained how and why?*
- if the form of data is clear (e.g. tape recordings, video material, notes etc)*
- if the researcher has discussed saturation of data*

*Reflexivity (research partnership relations/recognition of researcher bias)*

**6. Has the relationship between researcher and** Write comments here  
**participants been adequately considered?**

*Consider whether it is clear:*

- *if the researcher critically examined their own role, potential bias and influence during:*
  - *formulation of research questions*
  - *data collection, including sample recruitment and choice of location*
- *how the researcher responded to events during the study and whether they considered the implications of any changes in the research design*

### ***Ethical Issues***

**7. Have ethical issues been taken into consideration?** Write comments here

*Consider:*

- *if there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained*
- *if the researcher has discussed issues raised by the study (e. g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)*
- *if approval has been sought from the ethics*

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### *Data Analysis*

#### **8. Was the data analysis sufficiently rigorous?** Write comments here

*Consider:*

*– if there is an in-depth description of the analysis*

*process*

*– if thematic analysis is used. If so, is it clear how*

*the categories/themes were derived from the*

*data?*

*– whether the researcher explains how the data*

*presented were selected from the original*

*sample to demonstrate the analysis process*

*– if sufficient data are presented to support the*

*findings*

*– to what extent contradictory data are taken*

*into account*

*– whether the researcher critically examined their*

*own role, potential bias and influence during*

*analysis and selection of data for presentation*

### **Findings**

#### **9. Is there a clear statement of findings?** Write comments here

*Consider:*

*– if the findings are explicit*

*– if there is adequate discussion of the evidence*

*both for and against the researcher's arguments*

*– if the researcher has discussed the credibility of*

*their findings (e.g. triangulation, respondent*

*validation, more than one analyst.)*

*– if the findings are discussed in relation to the*

*original research questions*

### **Value of the research**

#### **10. How valuable is the research? Write comments here**

*Consider:*

*– if the researcher discusses the contribution the*

*study makes to existing knowledge or*

*understanding (e.g. do they consider the*

*findings in relation to current practice or policy,*

*or relevant research-based literature?)*

*– if they identify new areas where research is*

*necessary*

*– if the researchers have discussed whether or*

*how the findings can be transferred to other*

*populations or considered other ways the*

*research may be used*

**Appendix B: The *Effective Public Health Practice Project (EPHPP)***

***Quality Assessment Tool (QAT)***

**QUALITY ASSESSMENT TOOL FOR QUANTITATIVE STUDIES**

**COMPONENT RATINGS**

**A) SELECTION BIAS**

(Q1) Are the individuals selected to participate in the study likely to be representative of the target population? 1 Very likely 2 Somewhat likely 3 Not likely 4 Can't tell

(Q2) What percentage of selected individuals agreed to participate? 1 80 - 100% agreement 2 60 – 79% agreement 3 less than 60% agreement 4 Not applicable 5 Can't tell

RATE THIS SECTION STRONG MODERATE WEAK See dictionary 1 2 3

**B) STUDY DESIGN**

Indicate the study design 1 Randomized controlled trial 2 Controlled clinical trial 3 Cohort analytic (two group pre + post) 4 Case-control 5 Cohort (one group pre + post (before and after)) 6 Interrupted time series 7 Other specify \_\_\_\_\_ 8 Can't tell

Was the study described as randomized? If NO, go to Component C. No Yes

If Yes, was the method of randomization described? (See dictionary) No Yes

If Yes, was the method appropriate? (See dictionary) No Yes

RATE THIS SECTION STRONG MODERATE WEAK See dictionary 1 2 3

**C) CONFOUNDERS**

(Q1) Were there important differences between groups prior to the intervention?

1 Yes 2 No 3 Can't tell

The following are examples of confounders: 1 Race 2 Sex 3 Marital status/family 4 Age 5 SES (income or class) 6 Education 7 Health status 8 Pre-intervention score on outcome measure

(Q2) If yes, indicate the percentage of relevant confounders that were controlled

(either in the design (e.g. stratification, matching) or analysis)? 1 80 – 100%

(most) 2 60 – 79% (some) 3 Less than 60% (few or none) 4 Can't Tell

RATE THIS SECTION STRONG MODERATE WEAK See dictionary 1 2 3

**D) BLINDING**

(Q1) Was (were) the outcome assessor(s) aware of the intervention or exposure status of participants? 1 Yes 2 No 3 Can't tell

(Q2) Were the study participants aware of the research question? 1 Yes 2 No 3

Can't tell

RATE THIS SECTION STRONG MODERATE WEAK See dictionary 1 2 3

**E) DATA COLLECTION METHODS**

(Q1) Were data collection tools shown to be valid? 1 Yes 2 No 3 Can't tell

(Q2) Were data collection tools shown to be reliable? 1 Yes 2 No 3 Can't tell

RATE THIS SECTION STRONG MODERATE WEAK See dictionary 1 2 3

**F) WITHDRAWALS AND DROP-OUTS**

(Q1) Were withdrawals and drop-outs reported in terms of numbers and/or reasons per group? 1 Yes 2 No 3 Can't tell 4 Not Applicable (i.e. one time surveys or interviews)

(Q2) Indicate the percentage of participants completing the study. (If the percentage differs by groups, record the lowest). 1 80 -100% 2 60 - 79% 3 less than 60% 4 Can't tell 5 Not Applicable (i.e. Retrospective case-control)

RATE THIS SECTION STRONG MODERATE WEAK See dictionary 1 2 3 Not Applicable

### **G) INTERVENTION INTEGRITY**

(Q1) What percentage of participants received the allocated intervention or exposure of interest? 1 80 -100% 2 60 - 79% 3 less than 60% 4 Can't tell

(Q2) Was the consistency of the intervention measured? 1 Yes 2 No 3 Can't tell

(Q3) Is it likely that subjects received an unintended intervention (contamination or co-intervention) that may influence the results? 4 Yes 5 No 6 Can't tell H)

### **ANALYSES**

(Q1) Indicate the unit of allocation (circle one) community organization/institution practice/office individual

(Q2) Indicate the unit of analysis (circle one) community organization/institution practice/office individual

(Q3) Are the statistical methods appropriate for the study design? 1 Yes 2 No 3 Can't tell

(Q4) Is the analysis performed by intervention allocation status (i.e. intention to treat) rather than the actual intervention received? 1 Yes 2 No 3 Can't tell



**GLOBAL RATING**

COMPONENT RATINGS Please transcribe the information from the gray boxes on pages 1-4 onto this page. See dictionary on how to rate this section.

A SELECTION BIAS STRONG MODERATE WEAK 1 2 3 B STUDY

DESIGN STRONG MODERATE WEAK 1 2 3 C CONFOUNDERS

STRONG MODERATE WEAK 1 2 3 D BLINDING STRONG MODERATE

WEAK 1 2 3 E DATA COLLECTION METHOD STRONG MODERATE

WEAK 1 2 3 F WITHDRAWALS AND DROPOUTS STRONG MODERATE

WEAK 1 2 3 Not Applicable

GLOBAL RATING FOR THIS PAPER (circle one):

1 STRONG (no WEAK ratings) 2 MODERATE (one WEAK rating) 3 WEAK  
(two or more WEAK ratings)

With both reviewers discussing the ratings:

Is there a discrepancy between the two reviewers with respect to the component (A-F) ratings? No Yes

If yes, indicate the reason for the discrepancy 1 Oversight 2 Differences in interpretation of criteria 3 Differences in interpretation of study

Final decision of both reviewers (circle one):

1 STRONG 2 MODERATE 3 WEAK

## Appendix C: CASP and QAT Ratings

Reference	CASP Ratings								CASP Score
	Design	Recruitment Strategy	Data Collection	Researcher Bias/ Reflection/ Reflexivity	Ethical Issues	Data Analysis	Findings	Research Value	
1 Barker, Cornwell, & Gishen (2016) Based on data from reference 9	0.5	1	0.5	0	1	0.5	1	1	5.5
3 Chadwick, Muncer, Hannon, Goodrich, & Cornwell (2016)	0.5	0.5	0.5	0	0.5	0.5	1	1	4.5
6 Deppoliti, Côté- Arsenault, Myers, Barry, Randolph, & Tanner (2015)	0.5	0.5	1	0.5	0	1	1	1	5.5
8 George (2016)	1	0.5	1	1	1	1	1	1	7.5
9 Gishen, Whitman, Gill, Barker, & Walker (2016)	0.5	1	0.5	0	1	0.5	1	1	5.5
10	0.5	0.5	0.5	0	0.5	0.5	0.5	0.5	3.5

Goodrich (2012)										
11 Heneghan, Wright, & Watson (2014)	1	1	1	1	1	1	1	1	1	8
12 Hockley (2014)	1	1	1	0.5	1	0.5	0.5	1	1	6.5
13 Lillemoen & Pedersen (2013)	1	0	1	0.5	1	0.5	1	1	1	6
14 Lown & Manning (2010)	0.5	0	0	0	0.5	0	0.5	1	1	2.5
15 Mcvey & Jones (2012)	0.5	0.5	0.5	0	1	0.5	1	1	1	5
19 Reed, Cullen, Gannon, Knight, & Todd, 2015	0.5	0	0.5	0	0.5	0	0.5	0.5	0.5	2.5

## QAT Ratings

Reference	A	B	C	D	E	F	Global
2 Blumenthal et al. (2015)	Weak	Moderate	Weak	Moderate	Strong	Weak	Weak
8 Lown & Manning (2010)	Moderate	Moderate	Moderate	Weak	Moderate	Weak	Weak
14 George (2016)	Moderate	N/A	Weak	Weak	Weak	N/A	Weak

CASP Ratings: Criteria not met = 0; criteria partially (≥50%) met = 0.5; criteria fully (≥ 75%) met =1.



**SCHOOL OF PSYCHOLOGY  
DOCTORATE IN CLINICAL PSYCHOLOGY**

**EMPIRICAL PAPER**

**Do Schwartz Center Rounds® Hold Transformational Power? An  
Investigation into the Subjective Experiences of Panellists in Devon.**

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**Submitted in partial fulfilment of requirements for the Doctorate Degree in  
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## Abstract

**Objective.** To investigate the subjective experiences of NHS Schwartz Center® Rounds (SCRs) panellists in Devon. To explore whether SCRs hold transformational power on three levels: individual, (group/self-other) relational, and organizational, within an overarching systemic approach.

**Data sources/study setting.** Twelve panellists who had presented at the Royal Devon and Exeter NHS Foundation Trust-Devon Partnership NHS Trust (RD&E-DPT) SCRs in South West England, the first joint SCRs initiative between an acute NHS trust (RD&E) and a mental health NHS trust (DPT). Six RD&E and six DPT panellists took part between May and November 2016, who were also regular attendees (N=4), non-regular attendees (N=5), and non-attendees (N=3) of SCRs.

**Study design.** Twelve individual semi-structured qualitative interviews.

**Data analysis.** Thematic analysis from a social constructionist position was employed to identify patterns across the data set.

**Key findings.** The analysis identified three overarching themes: 1. Psychological safety, culture/s, and leadership; 2. Reflection, learning, and development; 3. Storytelling, connection, and compassion. Reciprocal relationships appeared mutually reinforcing amongst these interacting themes. SCRs in this context appeared to effect transformation at individual and relational levels, with limited impact at the organizational level. For most participants, relational changes were around increased human connection, compassion, and empathy towards colleagues rather than patients.

**Conclusions.** SCRs' transformational power may be constrained if organizations are solely focused on achieving external goals and if

barriers, particularly related to psychological safety, cultural assumptions, norms, and values, are not addressed. Possible SCRs' mechanisms cited by previous research were supported and a new theoretical model proposed.

**Key words.** Schwartz Center Rounds, compassion, empathy, staff support, human.

## Introduction

### **Schwartz Center Rounds® Background**

In 1994, Ken Schwartz, a 40-year-old American lawyer, was diagnosed with advanced-stage lung cancer. During his “patient” journey, he reflected on barriers clinicians faced in providing compassionate care, including enduring emotional difficulties (Cole-King & Gilbert, 2011) and working in frenetic environments (Schwartz, 1995). He questioned how the increased focus on efficiency, resource management, and budget cuts in the American healthcare system might impact on clinician-patient relationships and their potential for human connection. He described this connection as “more healing” than technically-advanced treatments, appeasing his distress and sense of isolation, rendering “the unbearable bearable” (Schwartz, 1995). He established the Boston Schwartz Center for Compassionate Care (SCCC) which developed Schwartz Center Rounds® (SCRs). Its mission involves advancing compassionate healthcare, engendering human connection in clinician and patient relationships, supporting caregivers, and nourishing healing (SCCC, 2017).

### **SCRs in the UK: Sociopolitical and Cultural Context**

The etymology of compassion derives from the concept of “cosuffering”; in sharing another’s suffering, both the co-sufferer and the distress of the other can be transformed (Barnard, 2013) resulting in healing (Gilbert, 2005). The ability to connect with and feel compassion for colleagues and patients requires psychological presence (Worline & Dutton, 2017) - constituted of connection, attentiveness, self-integration, and focus (Kahn, 1992) - and “psychological



availability”, believing one holds the emotional, cognitive, and physical wherewithal for engaging the self at work (May, Gilson, & Harter, 2004). This may be challenging for staff faced with significant pressures and competing work demands (Perrin & Griffiths, 2008) in busy National Health Service (NHS) cultures where thinking and rest time are not valued but deemed inefficient or weak (Ghaye, 2005). Optimum interdisciplinary team functioning and effectiveness necessitate a “nurturing” organizational culture (Opie, 1997) where social reflexivity and task reflexivity exist, meaning social relationships and staff wellbeing, alongside task objectives and working strategies, are reflected upon and supported (West, 2003).

Francis (2013) and Berwick (2013) urged for systemic changes in NHS organizations towards open cultures of learning and collective leadership to displace fear-based cultures. SCRs transferred to the UK in the context of austerity which caused NHS spending per capita to decline in real terms with negative effects on patient care (Dykes, 2015) and NHS job losses (Johnson, 2013).

As the NHS England *Putting Patients First Business Plan 2014/15-2016/2017* described SCRs as an “evidence-based” intervention which could be implemented to support staff to improve patient experience, forty per cent of mental health trusts underwent budget cuts. Mental health provider cost-reduction transformation programmes resulted in insufficient staff and skill mixes (Gilburt, 2015). Austerity measures and continual NHS transformation generated increased organizational anxiety (Wren, 2014). Preliminary reports indicated SCRs might hold transformational power to positively influence NHS organizational cultures (Goodrich, 2011; Wren, 2014).

SCRs theoretically offer an organization-wide “counter-cultural space” (Maben, Leamy, Reynolds, & Taylor, 2016) where clinical and non-clinical staff may reflect together monthly. Shared reflection can incite double-loop learning (Lillemoen & Pedersen, 2015), group and individual transformation (Burnard, 2002). Ghaye (2005) described the development of reflective healthcare teams as a transformational process on three levels, individual, team, and organizational, with the power to change relationships, work practices, and organizational infrastructures. Research is needed, incorporating the perspectives of organizational members who are not regular SCR attendees or heavily invested in SCR, to investigate whether they may elicit sustained organizational change. The mechanisms which might be operating in SCR also require further exploration.

### **Extant Theories on SCR**

A fully-constructed theory of SCR has not yet been developed (Barker & Flanagan, 2015; George, 2016), perhaps related to its complexity as an intervention in dynamic social systems. Barker & Flanagan (2015) outlined six hypotheses regarding how SCR may operate: 1. emotions normalization; sharing experiences and difficulties validates individual experiences, assuaging feelings of inadequacy. 2. Transforming narratives; sharing stories can validate identities. 3. Supporting connection; hierarchies may be attenuated through understanding colleagues. 4. Developing open cultures; different ways of interacting may be exported beyond SCR. 5. Inability to “cure”; SCR allow open communication, recognizing empathy is key to good care. 6. Role-modelling; junior staff learn from senior staff about reflecting on work’s impact.

George (2016) proposed a stress-appeasement model of SCRs. Patient care may benefit indirectly from SCRs through attenuating staff's threat response. Triggered by stress, it leads to focus-narrowing and reduced capacity to mentalize (envisaging others' thinking and feeling states), thereby diminishing empathy and compassion. Hearing others' self-disclosures provides disconfirmatory evidence challenging assumptions and the ultimate attribution error, whereby any behaviour deemed negative in "outgroup" members is attributed to dispositional deficiencies. George suggested SCRs provide a protective sense of connection with colleagues, reinforcing a collective identity and organizational attachment, with stress recognized as shared across teams, preventing psychological withdrawal.

An NIHR-funded SCRs evaluation led by Maben (2014-2017)<sup>12</sup> investigated the relationship between SCRs' causal mechanisms and the impact of context on their operationalization and effects. Results are not yet available.

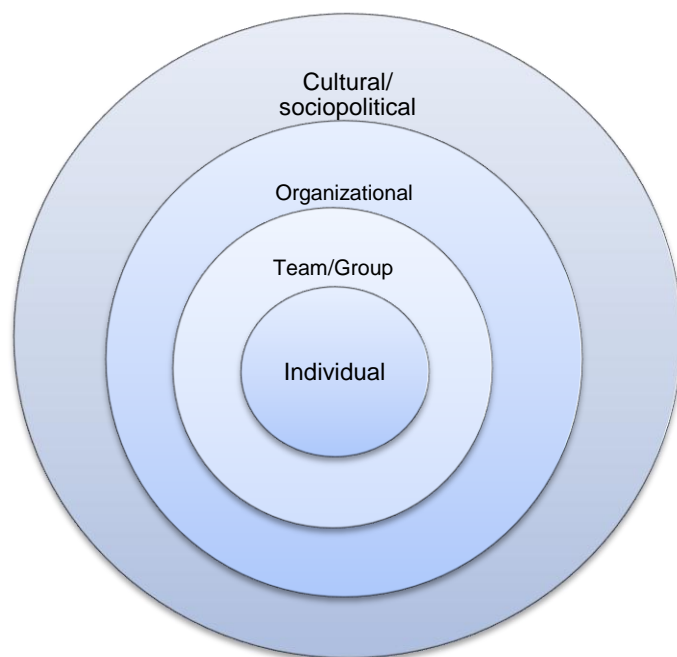
The present study will consider possible psychological mechanisms of SCRs, drawing on multiple theories specifically considering a systemic approach.

## **Systems Theory**

Systems theory is a transdisciplinary, holistic "field of enquiry" which can aid understanding of the "complex dynamics of human bio-psycho-socio-cultural change" (Lazslo & Krippner, 1998, p. 30). A system may be defined as

---

<sup>12</sup> A full description of the study can be found at the following URL: <https://njl-admin.nihr.ac.uk/document/download/2007777>.



“a complex of interacting components together with the relationships among them that permit the identification of a boundary-maintaining entity or process” (Lazslo & Krippner, 1998, p. 7).

*Figure 1. Systemic view of NHS organizations.*

Open systems exchange energy with other systems and their environment. Human-beings, teams/groups, and NHS organizations are open systems embedded within a broader cultural and sociopolitical system. Considering each level as simultaneously part and whole, with each subsystem constituting part of each larger system (Figure 1), acknowledges the mutual, if unequal, forces and feedback loops acting within and between the different systems (Carr, 2000). Changes at any level may influence changes or transformation at the other levels. Communication between individuals in a social system may stimulate change for themselves and for the overarching system (Greene, 2008).

### **Research Rationale and Context**

Although Maben and colleagues' study findings are imminent, little independent research has been conducted into NHS-run SCRs, notwithstanding the Department of Health's investment into the scheme and the UK SCRs training contracts' recent increased cost<sup>13</sup>. Besides financial outlay, lunch

<sup>13</sup> The cost for large trusts (1,000+ employees) currently stands at £15,960 for the initial two year “training” contract, with the cost of subsequent two-year membership at £3,780 (Robert et al., 2017).

provision, and facilitator training, SCRs require staff's commitment, effort, and time (Gishen & Wood, 2015). If SCRs hold the power to transform NHS organizational cultures, place people at the centre of care, and ameliorate staff wellbeing, patient experience, and safety, their return on investment may be immeasurable. Therefore, their potential impact requires further research.

Wren (2014) described SCRs panellists discussing how preparing for SCRs presentations increasingly raised their awareness of how they were affecting peers, namely, their social reflexivity, which might enable discussions on team relationships. Panellists may be considered as experiencing SCRs as a more indepth reflective process; they construct narratives with facilitators, and often fellow panellists, in pre-SCR preparation, possibly akin to reflective group practice. No published research to date has focused solely on SCRs panellists' experiences, with much previous research centred on attendees' evaluations. Qualitative research is indicated to better understand what the impact of being a SCRs panellist might be and whether any perceived changes are sustained, particularly from the perspectives of non-regular/non-attendees as well as those who regularly attend.

The Royal Devon and Exeter NHS Foundation Trust-Devon Partnership NHS Trust (RD&E-DPT) joint SCRs initiative commenced SCRs in September 2013. It is the first in the UK across an acute medical trust and a mental health trust. No previous psychological research had been conducted into this joint venture between two highly diverse trusts and its impact on panellists' experiences. It was important to investigate panellists' perspectives on discussing the emotional and psychosocial aspects of their work (and exposing vulnerabilities) with employees from a different organization and diverse healthcare settings, in terms of focus and geography. DPT employees work in

diffuse locations, many distant from the RD&E Hospital site where SCRs take place.

Given the dearth of research exploring panellists and non-attendees perceptions, it was imperative to investigate these groups' views on the RD&E-DPT SCRs, especially given this intervention's unique cross-trust nature, whether they deem them to be effective, and what barriers and enablers exist in accessing this forum. This information may help shape the future of SCRs within these Trusts. The research sought to investigate panellists' subjective experiences and whether they perceived SCRs as holding transformational power on the three levels outlined by Ghaye (2005).

In the context of this research, transformational power may be interpreted in two ways. On a basic level, it may be equated with the capacity to effect change of any kind. On a higher level, it aligns with concepts from transformational leadership and transpersonal psychology. Specifically, it relates to the capacity to incite beneficial change/s in social systems – including social relations, work practices, and systemic infrastructures (Ghaye, 2005) - as well as in individuals through human and organizational connectedness in terms of identity and values (Langston University, 2017). It is also linked with that which is beyond the individual or personal and related to the greatest potential of human-beings (Lajoie & Shapiro, 1992) and human organizations. In contrast, impact may be defined as any effects which may equally be negative or positive.

## **Aims**

1. To explore panellists' subjective experiences of SCRs;

2. To investigate whether SCRs have any perceived impact on individual, relational, and/or organizational levels.

### **Research questions.**

1. What is the impact of preparing for, and presenting at, SCRs on panellists' sense of identity/ies, and on their thoughts and feelings towards and about themselves?
2. What is the impact on panellists' sense of social connection, and on their thoughts, feelings and behaviour towards others (including the ways in which they provide care)?
3. How does their experience as panellists affect their view of the organizations within which they work and the practices and care delivery in those settings? Do they perceive any changes, or the need for any?

## **Methodology**

### **Philosophical Assumptions and Reflexivity**

The methods (of data collection/data analysis) a researcher employs and their epistemological, ontological, methodological, and axiological assumptions (Creswell, 2012) constitute a qualitative research project's methodology (Duberly, Johnson, & Cassell, 2012). Haynes (2012) outlined interpretation and reflection as the principle factors comprising reflexivity. The former acknowledges how researchers' assumptions, sociopolitical position, values, and language influence the research. Appendix A contains a reflexivity statement. Confirmatory bias was guarded against by reflecting both through reflexive notes and in supervision.

The philosophical approach of this study is social constructionist, with the view knowledge about “reality/ies” is constructed socially and influenced by culture (Yardley & Marks, 2004). Language is the tool through which knowledge production is actively negotiated through social processes, and influenced by the systemic and historical context in which it is embedded (Duberly et al., 2012). My background aligns me with Gergen’s (2001, p.7) view that humans are “fundamentally interdependent beings” and “[doing] science is not to hold a mirror to nature, but to participate actively in the interpretive actions and practices of a particular culture.”

### **Ethics**

The University of Exeter School of Psychology Research Ethics Committee granted ethical approval (Appendix B) for this project, which was registered with University Research Governance. Consultation with the RD&E and DPT Research and Development (R&D) Departments indicated NHS ethical approval via IRAS was not required. R&D approval from both Trusts was sufficient and awarded (Appendices C and D) with the University of Exeter acting as sponsor (Appendix E). All participants provided informed consent. Participants’ details and possible identifying factors have been avoided. “They” is used to refer to participants instead of gender pronouns.

### **Design**

Qualitative methods offer a rich and profound enquiry (George, 2016) for exploring subjective experiences. Qualitative interviews can provide insight into participants’ perspectives on a topic and how they ascribe meaning to, and make sense of, experiences (King, 2004). They are appropriate for examining



layers of meaning and social identities in organizations, given the various organizational and professional allegiances which may co-exist (King, 2004).

Although focus groups may have been employed to investigate participants' views towards SCRs, it would have been challenging logistically to coordinate clinicians' availability. The issue of psychological safety could also have impacted on participants' ability to honestly share opinions. It may have risked dominant organizational and cultural discourses being perpetuated. Interviews permitted individual voices to be heard irrespective of role, seniority, gender, or confidence level.

### **Participants**

Of approximately 63 panellists, 15 (24%) expressed interest in participating.

**Final sample.** Twelve (19%) panellists (eight female; four male) participated, consistent with the University of Auckland School of Psychology's (2017) recommendations<sup>14</sup> for a UK professional doctorate. Participants' ages ranged between 27 and 62 (M=46.6) years. Six RD&E employees and six DPT employees participated. They worked across a range of professions including specialist and psychiatric nursing, specialist and psychiatric medicine (including three consultants), arts and occupational therapies, and psychology. The sample included one junior doctor and one unqualified staff member. The remaining participants held between nine and 40 years' qualified clinical experience; eight had over 20 years' experience. Most held senior, leadership, or management positions.

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<sup>14</sup> Ten to 20 participants for a UK professional doctorate.

Table 1 outlines participants' SCRs involvement.<sup>15</sup> They presented at SCRs between 2014 and 2016. The research interviews occurred in 2016. Participants' range of time post-panel was between one and 22 months.

Table 1

*Participants' SCRs Involvement*

Panellists' Attendance	Only as panellist	1 SCR	2SCRs	3SCRs	4 SCRs	>4 SCRs
"Regular" <sup>16</sup> and on SG						4
Non-regular" <sup>17</sup>		2	1	1	1	
Non-attendees	3					

**Materials**

The information and consent form provided to participants (Appendix G) included details of support resources given the potentially emotive subject matter. The semi-structured interview schedule (Appendix H) offered a flexible outline. Exact interview content depended on what participants brought to discussions and on their time availability. Following the first interview, the topic exploring participants' thoughts regarding the Trusts' collaboration in SCRs was added.

**Procedure**

Previous RD&E-DPT SCRs panellists had not provided consent to being contacted for research but were contactable via the SG. In June 2016, a SCRs facilitator emailed previous panellists for whom they held details informing them of the study. Ten people expressed interest contacting me directly (N=6) or via

<sup>15</sup> Appendix F contains a figure outlining the different SCRs roles and how people may hold multiple roles within an organization.

<sup>16</sup> Attendance at four or more SCRs in the previous year.

<sup>17</sup> Attendance at one or two SCRs in the previous year.

the facilitator (N=4). Three were no longer RD&E or DPT employees. Lack of R&D approval from their new trusts precluded their participation. The SG provided information to panellists when I did not attend SCRs. I attended five SG meetings and four SCRs to speak with new panellists. Seven expressed interest. Five responded to emails and took part.

Participants read the information and consent form and were encouraged to ask questions. I sought verbal consent, reminding participants of the research aims, nature of the interview, and confidentiality. I discussed disseminating the findings to participants and the timescale for this. Four interviews took place face-to-face on RD&E or DPT premises, seven were phone interviews, and one was via Skype. Their duration ranged from 38 to 66 minutes. All were recorded, fully transcribed, and checked for accuracy.

Although face-to-face interviews may be deemed the “gold standard” above telephone interviews for qualitative enquiry (Novick, 2008), the research which exists comparing these modalities in terms of data quality does not substantiate this view (Novick, 2008; Vogl, 2013). Although it may be argued that it is easier to build connection, rapport, and to perceive non-verbal communication when physically opposite another human-being, or that telephone interviews may result in contextual or verbal data being distorted or lost, existing evidence does not support these assumptions (Novick, 2008).

In this study, it may have been easier for one telephone interviewee to have terminated the call sooner (possibly due to contextual demands), yet they may have equally felt able to do so in person. Although a few words were unintelligible on a couple of recordings, these factors did not seem to adversely affect data quality. Non-verbal information was still perceptible on the phone/recordings (for example, intonation, sighs). In some cases, it may even

have been easier for some participants to disclose information on the telephone, and it may have dispensed with some potential power dynamics, such as when one face-to-face interviewee asked the interviewer to sit in the “patient’s seat”. The data quality appeared equitable across the different modes (telephone/Skype/ in-person).

### **Data Analysis**

Thematic analysis (TA) was chosen to enable identification of broader patterns (both commonalities and differences) across the data set in relation to the specified research aims and questions. Its adaptability in terms of allowing the possibility of inductive as well as deductive analysis featured in the rationale for its selection. Another reason for its use was its epistemological flexibility, so that the researcher was able to incorporate her preferred theoretical position. It can be used from a social constructionist position to provide insight into the sociocultural and organizational contexts in which narratives are mediated and embedded (Braun & Clarke, 2006). Analysis began during transcription with brief notes made following each transcription/transcription-check. Braun & Clarke’s (2006) TA checklist (Appendix I) was consulted to aid good practice.

Transcripts were printed and read twice. Notes were made on each. Transcripts were then coded in relation to the research questions at individual, relational, and organizational levels. Commonalities, differences, and patterns across transcripts were identified. After mapping out some of the themes I was noticing (Appendix J), I returned to code the transcripts in relation to these. I then ordered sub-themes across three levels and identified three overarching themes and collated the quotes for these into different word documents, with another for enablers and barriers. I again read through the transcripts, checking

the codes/themes, reordering these if necessary and identifying all instances of these in each transcript.

Appendix K contains tables showing which codes featured in which transcripts with examples of quotes to aid transparency. Two other researchers analysed one transcript. Identified codes/themes were discussed. Data saturation (Fusch & Ness, 2015) was reached before the final transcript. Quotes included were chosen for being compelling, if they covered more than one theme, and to incorporate different participants' voices.

## Findings

The analysis identified three main interacting themes, represented in Figure 2:

1. Psychological safety, culture/s, and leadership;
2. Reflection, learning, and development;
3. Storytelling, connection, and compassion.

Table 2 outlines the subthemes within each overarching theme at the individual, (self-other) relational, and organizational levels. Changes at any of these levels may exert influence at other levels. Appendix L offers interpretations, based on the metanarrative constructed from participants' voices, of how the themes may interact when SCRs operate in adaptive/less adaptive contexts.

Table 2

### *Thematic Structure*

<b>Theme</b>	<b>Individual Level Subthemes</b>	<b>Relational Level Subthemes</b>	<b>Organizational Level Subthemes</b>
<b>1. Psychological Safety, Culture/s and Leadership</b>	*Anxiety/nervousness *Fear of exposing "real" self/vulnerability	*Psychological safety versus risk of social judgement/stigma/shame/rejection/critical attack	*Culture clash/conflict *Sociocultural norms and values clash/conflict

Theme	Individual Level Subthemes	Relational Level Subthemes	Organizational Level Subthemes
	<ul style="list-style-type: none"> <li>*Professional mask</li> <li>*Courage/bravery</li> <li>*Respect/appreciated/valued</li> <li>*Relevance/worth (of story)</li> </ul>	<ul style="list-style-type: none"> <li>*Seeing others as brave/respecting others</li> <li>*Leaders modelling</li> </ul>	<ul style="list-style-type: none"> <li>*Normalizing emotional expression and discussion/saying the “unsayable”</li> </ul>
<b>2. Reflection, Learning, and Development</b>	<ul style="list-style-type: none"> <li>*Self-awareness/self-understanding</li> <li>*Personal/professional growth/development</li> <li>*Increased confidence</li> <li>*Pride</li> <li>*Increased understanding of others, their roles, needs, challenges and/or the organizations</li> <li>*SCRS as thinking/learning/ sharing space valued/shifted perception of value</li> </ul>	<ul style="list-style-type: none"> <li>*Teaching others/communicating a message</li> <li>*Learning from/about others</li> <li>*Sharing perspectives (cognitive empathy), strategies/challenging insular thinking</li> <li>*Team development</li> <li>*Opening discussions on difficult/ethically-challenging/subjects</li> </ul>	<ul style="list-style-type: none"> <li>*Permission, time and, space to stop, think, share – not available elsewhere</li> <li>*Cross-service/cross-organizational learning/development</li> <li>*Broader organizational and beyond healthcare conversations</li> <li>*More holistic thinking – mental health and physical health</li> </ul>
<b>3. Storytelling, Connection, and Compassion</b>	<ul style="list-style-type: none"> <li>*Power and value of space to construct/tell/ share story</li> <li>*Feeling listened to, seen, and heard</li> <li>*Validation/acceptance</li> <li>*Catharsis – processing emotion</li> <li>*Self-compassion/self-care/ self-forgiveness/ difficulties with</li> <li>*Feeling supported/ compassion/ empathized with</li> </ul>	<ul style="list-style-type: none"> <li>*Sharing stories</li> <li>*Empathic resonance (emotional empathy)/shared emotion/ Non-verbal feedback)</li> <li>*Common ground/ shared human experiences/less alone</li> <li>*Compassion/empathy/ caring for others</li> <li>*Time and space to connect with others</li> <li>*Forgiving/ understanding/ supporting others/ challenges</li> <li>*Improved relationships/ connections</li> <li>*Camaraderie</li> <li>*Common social identity- no “us”/“them”</li> </ul>	<ul style="list-style-type: none"> <li>*Power of stories (to transform) / Levelling hierarchy- “just people”/</li> <li>*Compassionate, caring culture versus target-driven business culture (theory versus practice)</li> <li>*Disconnect frontline staff/management - “us”/“them”</li> <li>*Systemic/ sociopolitical pressures/ resource constraints affecting connection/empathy</li> <li>*Lack of patient voice/stories</li> <li>*Organizational responsibility to care for staff</li> </ul>

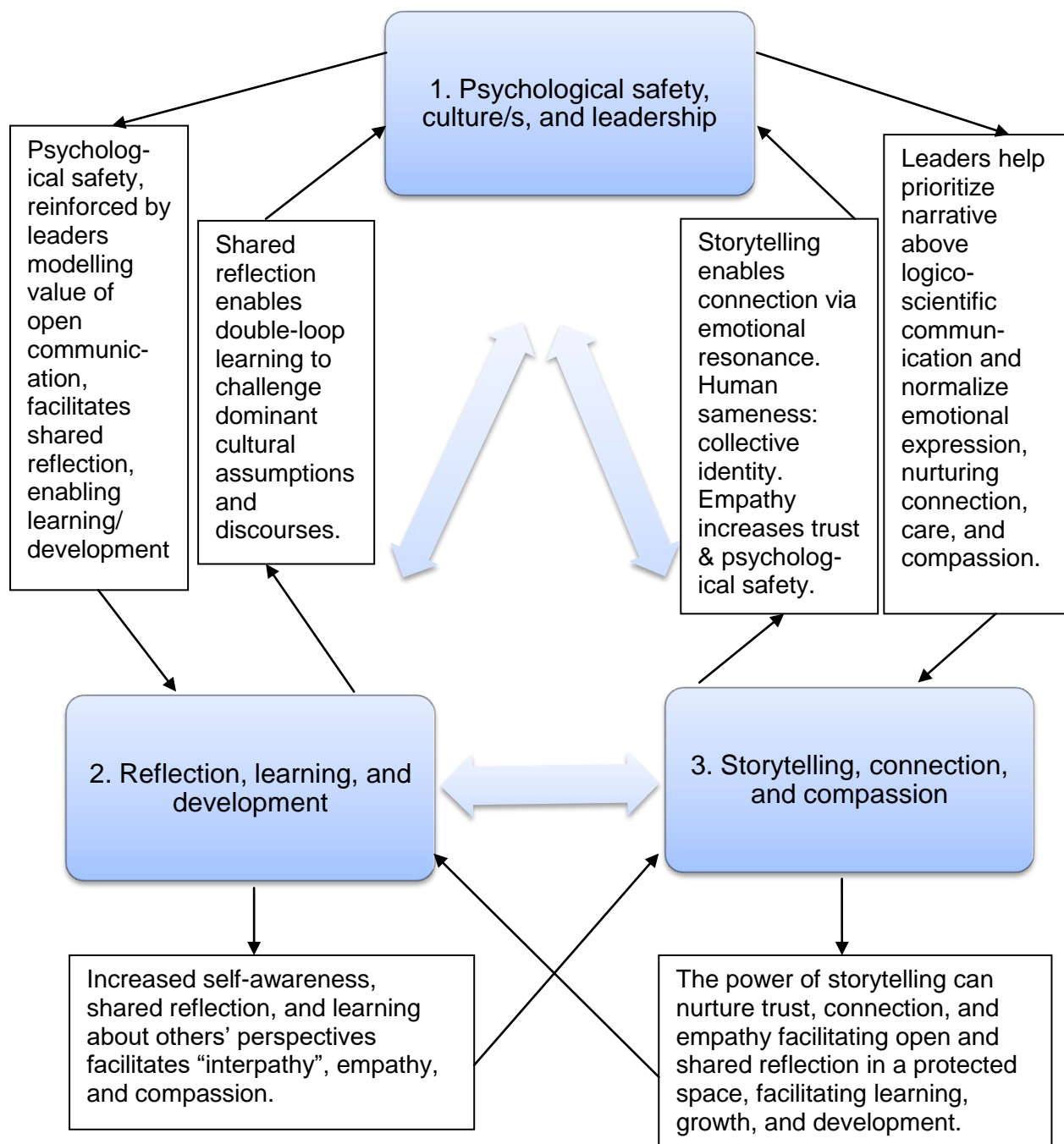


Figure 2. Model of interacting SCRs themes.

## 1. Psychological Safety, Culture/s, and Leadership

Psychological safety has been defined as “a shared belief held by members of a team that the team is safe for interpersonal risk taking” (Edmondson, 1999, p.350). It is instrumental for developing openness and transparency within cultures. It may be enhanced through interventions which nurture belongingness (shared identity), “meaning-making” (of experiences), and “contribution” (Wilde, 2014). Although most participants had extensive clinical and/or teaching experience and held senior positions, there was a common anxiety regarding exposing their vulnerable, human side.

Some questioned their story’s worth or relevance. Others had questioned how safe the space and its boundaries were and whether “opening up”, removing their professional mask, might elicit negative social judgement, stigma, shame, or critical attack. The fear of exposure was shared across disciplines and seniority levels Emotional expression may be considered “unprofessional” in medical cultures (Kerasidou & Horn, 2016):

[My] sort of overall approach, it’s one of professionalism[↑], my expectations for colleagues are high and junior colleagues particularly [...] in a *workplace* where, I’ve got quite a senior role, in terms of leadership [laughs], I wasn’t too sure I actually wanted to, erm, open up[↑] quite like that. I’ll do that with *patients*, on a one-to-one. (P7)

Participant 7’s suggestion it might be safer to show one’s human side to patients in a one-to-one relationship than with other professionals in the large, reflective forum of SCRs was echoed by participant 3. They saw the space’s size and formality as constraining its safety, therefore limiting what they would share. Participant 9 discussed the limits on safety and topic choice, taking a



case in which clinical decision-making could be “defended” in what theoretically “should” be a safe, non-judgemental, and confidential space.

Participants generally viewed SCRs as “safe” post-hoc, an environment where people “are not judging you” (P1). At one SCR I attended, some attendees appeared critical of panellists’ decisions in the presented case in which they had grappled with ethical issues. Participant 8, although having generally experienced empathy from attendees, seemed to confirm this:

[Lots] of the other members of the audience were very encouraging, or they nodded alot. [...] someone came at the end and spoke to me and had a slightly different perspective, and *asked me*, she was a doctor [inhalation] did I not think a relationship was fifty-fifty, I thought, *absolutely*, but I felt like I gave 90%, and the lady gave *nil* [laughs]! Luckily, somebody else came and that ended.

Some participants indicated attendees considered panellists “brave” for being honest. Others saw themselves as “courageous” for “raising [their heads] above the parapet” as participants 2 and 10, both doctors, described themselves. Participant 12’s description of being a panellist was akin to facing a firing squad in which they were “about to be shot” by attendees. Besides emphasizing the sense of exposure panellists felt, these linguistic terms posited SCRs as a potential space for a confrontation of cultures.

Participant 2 initially feared medical colleagues would view their participation in SCRs as a “weakness” given norms specifying emotional detachment from technically competent doctors (Kerasidou & Horn, 2016):

[From] the start of medical school, potentially even before, there's an attitude of, sort of, having a stiff upper lip and not really letting things affect you, and, *it's a culture*, I think, that's always been there.

Reflecting and discussing how you feel about things is *not* inbuilt into the culture at all.

Participant 7, a senior medical consultant likened their first SCR to “group therapy”, initially feeling “borderline horrified” people were “exposing themselves” emotionally at work. Norms delimiting emotional expression were seen as more entrenched in “male-dominated” medical specialities (surgery) and in “macho cultures” such as “inpatient units” where they might operate as social defences against emotional distress.

People described inner conflicts in feeling able to voice “taboo” feelings of “hating” patients when in a caring profession. Participants generally described openness at SCRs resulting in positive outcomes, feeling respected and/or validated. They saw it as helping normalize emotional responses, especially when modelled by senior colleagues, offering junior staff social learning opportunities (theme 2) “through observation, imitation, sharing” (Bandura, 1977).

Some participants felt SCRs “normalizing” the healthy discussion of emotions may be having a limited “impact” on hospital culture, as attendees could connect with colleagues’ “human” side (linked to theme 3) Participant 11 warned social defences against emotions may be replicated within SCRs through facilitators over-protecting panellists, indicating patterns in one part of a system may reappear in another part (Carr, 2000).

This participant mentioned the RD&E and DPT's cultures possibly conflicting, suggesting the latter's employees may be less ready "to show vulnerability in a public setting", perhaps linked to a "double-bind" or conflicted message (Carr, 2000) in the organization regarding openness. Although SCRs promote "speaking up" (Francis, 2015), one participant suggested silence, which is "collective and cultural", (Mannion & Davies, 2015), and the antithesis to learning and just cultures, was endorsed:

We have these "Our Journey" events. We're meant to go on these days out to Exeter racecourse or something, they get a motivational speaker, to motivate us about the NHS, to tell us to, "keep on going" [whispered]. So, it's all very positive and we're encouraged to not make any complaints<sup>18</sup>.

This participant felt these events' expenditure was "a colossal waste" which could be better invested in more staff.

A final conflict was present between the cultures of caring and business/economy, described by both organizations' participants, discussed in theme 3.

## **2. Reflection, Learning, and Development**

Although participants thought being a panellist had not triggered significant identity changes, they all considered the experience positive post-hoc. For some, it led to cognitive and behavioural changes, such as engaging in increased self-care (theme 3), and greater appreciation of reflective practice's benefits. This was related to the value attributed to SCRs in offering learning,

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<sup>18</sup> Participant numbers have occasionally been purposefully omitted.

creating space and time for personal and shared reflection, not otherwise available.

Reflection could lead to increased self-awareness and understanding the self and/or others' needs and work challenges, facilitating cognitive empathy, challenging attributional errors (George, 2016; Maben & Leamy, 2016), as organizational and sociopolitical factors impacting others' behaviour became visible. Greater learning, through sharing experiences and strategies, incited deeper respect and appreciation amongst staff. Presenting at SCRs resulted in personal or professional growth for some, and team, service, or organizational developments.

Participant 4 described encouraging their team's participation in SCRs to aid reflection and team development:

I think it's a really valuable tool for people. I promote people, even in my team, just to go to the Rounds, even if they don't think they're immediately valuable, because sometimes, just that space, and that time, and *opportunity* for some self-reflection is really, really important, is really, really valuable. I think it's given me another tool to provide, like some additional pastoral care to my team. It's a tool to help them reflect and develop. (P4)

Some participants described increased confidence, a sense of achievement, fulfilling a moral obligation, doing the "right [albeit uncomfortable] thing", challenging themselves, or taking a risk professionally eliciting pride. This was linked to theme 1, risk-taking in a potentially hostile or unsafe cultural environment:

I felt afterwards quite proud I'd done it, that it was a bit of a risk, but, I'd grown a bit through doing it. There was a sense of professional pride, a bit of risk-taking, I'd stepped out of my comfort zone a little bit and I'd done the right thing by doing it. (P10)

Some participants discussed modified perceptions and ascribing increased value to SCRs after attending their first SCR and recognizing their benefits, akin to George's (2016) description of new attendees' "epiphany" moment.

Experiencing SCRs challenged Participant 1's assumption SCRs were akin to the "routine business" of reflective practice, acknowledging qualitative differences: The former was "just about expressing emotions", "feeling OK to hold that emotion", whereas the latter might involve problem-solving. For others, emotional expression/processing was not sufficient; the value of presenting at SCRs resided in the opportunity to teach or convey a message. Participant 6 wanted to elicit empathy from medical staff for nurses and the emotional labour of nursing:

I don't really like talking about things for the sake of talking about things, *but* I think making people think about how it feels and how difficult it can be, certainly for the nurses. Sometimes I think sharing how the nurses feel about things to medical staff is useful, 'cos of the different ways people work. (P6)

Participants discussed the benefits of sharing perspectives within and across services and organizations which could help dispel pre-existing assumptions, as occurs in double-loop learning (Cartwright, 2002), encourage

more holistic thinking, incorporating both physical and mental health, challenge insular thinking, and offer additional positive ways of working.

Perspectives differed on how well RD&E and DPT staff communicated and collaborated. Most participants observed DPT's much lower level of SCRs engagement than RD&E. All participants thought the organizations' collaboration was important for "building bridges" (P12) between mental and physical health and for cross-organizational relationships. Participant 3 suggested more could be done to develop cross-organizational learning such as developing cross-trust peer supervision networks. Participant 10 thought time sharing perspectives was "really well-invested" as "you learn alot" and "are *often* surprised" because people often "come up with stuff you weren't anticipating, and what you thought was an agenda, is often, something quite different", which can "[make] you kinder towards" others as insight regarding what is influencing their behaviour increases.

Some participants reported their SCRs experience had triggered broader conversations beyond the healthcare context, such as applying SCRs in the police. One participant entered into a new organizational initiative through SCRs' participation. Another participant described service changes directly linked to their experience.

### **3. Storytelling, Connection, and Compassion**

Almost all participants referred to the "story", "script", or "narrative" they constructed for SCRs. Some described the "power" of sharing their stories and receiving others' non-verbal and verbal feedback. Mehl-Madrona and Mainguy (2015) illustrated stories' power in transformation, highlighting the brain regions and networks implicated in story creation, story memory, and hearing stories, engage the "default mode of the brain" (DMB). They reported the DMB's

involvement in self-reflection and mentalizing and its overlap with the “social brain”, underpinning the hypothesis humans’ innate resting mode is associated with social affiliation.

Supporting the notion healthcare is catching up with indigenous cultures in recognizing stories’ power (Mehl-Madrona & Mainguy, 2015) to connect, participant 11 said SCRs reminded them “storytelling is “a fundamental part of human existence”, which changed their practice; they tried to tell more stories when lecturing.

Some participants valued sharing their stories, being respectfully attended to, feeling resonated with, facilitating catharsis or a sense of validation. Others described SCR preparation as the most beneficial and emotive component. This was variably associated with emotional-processing, deeper social connection, or through revised meanings of past events which reflection enabled (theme 2).

Participant 1 revealed preparing a script enabled them to connect with and release emotions they were unaware remained within:

I wouldn’t be able to tell you exactly what it was but I do think I had one of those lightbulb moments during this conversation, and, once I’d started writing it up, the script, I just couldn’t stop, it flew, it poured out of me, I think there was something quite cathartic about it [...] you don’t know what is staying with you, tucked away somewhere.

Others felt SCRs were powerful and effective without understanding why. Several participants thought sharing stories within SCRs helped develop a sense of connection, “camaraderie”, and common ground with colleagues. This could positively influence professional relationships, reducing feelings of isolation.

A manager and an unqualified staff member recounted feeling reassured their struggles were not due to personal failings. The latter felt heard and appreciated by senior colleagues, perhaps “counter-cultural” (Maben & Leamy, 2016) to common ward experiences. Instead of being seen by their bandings and associated power differentials, attending to stories as “just people in a room” (P5) helped appreciation of individuals’ experiences. The “dominant cultural voices” (Mehl-Madrona & Mainguy, 2015), temporarily silent, provided space for subordinated voices to speak up and new narratives to be heard:

[It] was nice to hear they have similar experiences, when you hear the social workers and the doctors saying there’s patients they dreaded seeing and they would find really difficult to work with. That’s really validating [laughs] it’s not just you as a support worker, it’s everybody [...] the audience said thank you, which is really kind of, odd, but again validates it, you don’t necessarily hear that ... rightly or wrongly from a band 3’s perspective listening to, kind of band 7s and 8s saying, “Thank you for that information,” when you’re so used to, on the ward, really having to fight for that information to get across and often it doesn’t. In one small space, it was like, “That was really interesting, thank you.”

The SCRs space may hold transformational power in helping people appreciate other professionals “are also people” (P4). Contrary to the “driven” hospital environment “where everyone is so professional” and emotional expression restricted, having opportunities to “*show emotion* [...] is very strong, it’s very powerful” (P4). Participant 1 recounted the



hierarchy dissipated as their Medical Director “burst into tears”, “there was no them and us”.

Sharing stories and affective sharing, one of the proposed components of empathy alongside self-awareness (theme 2), mental flexibility, and emotional regulation (Decety & Moriguchi, 2007), may help SCRs participants perceive a common social identity at the most fundamental level, that of human kin. Coborn (2001) highlighted, irrespective of difference, it is “our human sameness” that facilitates emotional resonance with the emotional experience of another.

Resonance, seeing others visibly resonate and emotionally connect with their stories made some panellists feel “glad” (P8) they had participated and feel psychologically safer (theme 1), more trusting in revealing their human side, stronger, and more connected with others (P11). Resonance was often conveyed non-verbally, with eye contact perhaps the most potent form of communication (Burnard, 2002).

The trust, support for emotional storytelling, and sense of connection felt in SCRs may not necessarily extend beyond this space. Participant 9 highlighted SCRs participants may share particular characteristics or personality types and be a skewed group not necessarily representative of the organizations’ wider populations.

Some participants felt their experience with SCRs (as attendees, steering group members, and panellists) directly impacted on their ability to maintain compassionate awareness. Four felt SCRs participation affected behaviour with patients, for participant 2, specifically around the importance of relational aspects of care and the need to put people “at ease” and “not make them feel like *another* job on [their] list”.

Most participants reported not feeling SCR participation had significantly impacted on the patient care they provided. More noticed changes in how they viewed colleagues; hearing their stories helped them understand their pressures and challenges (linked to theme 2), increasing empathy, compassion, a sense of forgiveness, encouragement, or support towards other staff. Sharing stories at SCRs might restore systems' energy and enable what Swinton (2001) termed "interpathy", the ability to traverse into another's experience, and convey empathy, compassion, and a type of understanding which can initiate "healing".

Two participants indicated storytelling enabled self-compassion. One recognized the need for better self-care. They implemented changes to better care for themselves and others in pressured cultures which did not support this. Once, this involved stopping to reflect with a previously unknown colleague with whom they had shared a traumatic clinical encounter. Another recounted appreciating "space to look back, to make sense of things in retrospect that had probably been difficult to make sense of at the time". Reconstruction of their narrative transformed understandings of past events allowing forgiveness of others and of their younger self given the systemic pressures all were under, made visible through re-storying.

SCRs' transformational potential to unite people through sharing stories, emotions, and common experiences, engender compassion, and challenge dominant organizational and cultural narratives appeared to be delimited by who held knowledge of and attended SCRs. Related to this were the conflicted values present within systems, belonging to opposing cultures, a target-driven business culture versus a caring, compassionate

culture, which one participant suggested the UK organization which licenses SCRs epitomized:

[It] *has to survive economically*, so they have to charge for the whole provision of the service, that's conflicted values, really, one set of values is about doing the work, its intrinsic value, whereas they have to *sell* it, so that's a sort of extrinsic motivation as an organization they've got two conflicting values. I think that value crunch or clash is present in everything we're doing in the NHS right now.

Some participants felt SCRs made them feel their organization was more compassionate, whether through feeling nourished by SCRs via emotional and physical sustenance at work, or by witnessing colleagues' compassion. Several participants thought even if the RD&E-DPT SCRs might encourage change, they were not sufficient to transform cultures and offer staff the requisite support because of their formality, work pressures, and the values clash/policy-practice gaps. Participants discussed staff needing to support each other in smaller groups for it to become part of daily culture, and saw the organization held responsibility for enabling this and addressing barriers to accessing SCRs.

[There's] a lot of talk about, supporting each other, but actually [laughs] it's almost shocking to me that we're a healthcare provider yet we don't really look after ourselves very well, and we don't look after each other very well. I think that comes back to [inhales] us caring for each other, the organization caring for its employees. (P7)

Several participants discussed this gap between "talk"/policy and practice, related to reduced resources and increased staff burden,

reflective of the sociopolitical suprasystem directives adversely impacting on subsystems. One participant said staff felt “exploited, that we are *undervalued* politically”. Some thought, despite the organization appearing (to the CQC) to support staff through SCRs, this was not translating into practice as so few attended. One participant reflected, “You can’t be compassionate or *feel* if you’re not in an environment that is making you feel you are cared for”. They discussed patient care being adversely affected, possibly because with “so many cuts”, people “are so stressed, trying to do so much [they] are becoming less resilient and more detached”, echoing Menzies Lyth (1960) and Francis’s (2013) accounts of social defences developing in overwhelming, uncaring contexts.

One participant positively evaluated the RD&E’s previous Chief Executive’s engagement as a panellist. Yet the disconnect between purported aims to support staff in providing compassionate care, and their experience of pressured working environments with demands from above, appeared through use of the “us-them” dichotomy, suggesting splitting, whereby senior management were referred to as “they”:

It's all very well and good on paper they want you to be there for the people, they want you to spend time with people and talk, and all that. You see it all over the press releases [...] When it boils out with it, if you were to do that, they would be kicking off and wanting you just getting this person ready to go home tomorrow. (P4)

Finally, on organizational compassion, one participant depicted how the former DPT space where SCRs had taken place had been converted into a hotdesking area:

[RD&E colleague] came over to one of our venues, we had [...] which used to be a big meeting place, and now changed it to hotdesking, you know, [they] said it looked like battery hens, they said, “Your organization isn’t very compassionate letting people work like this” [laughs].

The removal of the physical space where staff reflected via SCRs, or rather, filling that space with intense activity, may be a powerful metaphor for the value attributed towards “thinking” space, over which perhaps “doing” had been prioritized.

### **Enablers and Barriers**

Appendix M outlines a full list of the enablers and barriers to accessing SCRs identified in participants’ narratives. Besides logistical issues and work demands, factors related to theme 1 featured prominently. Barriers included sociocultural norms and values regarding acceptable behaviour and emotional expressiveness in medical, “macho”, and hospital cultures, psychological and social threat, and preconceptions of reflection and SCRs. Enablers included respected leaders encouraging and facilitating attendance, modelling (theme 2) the value of new ways of communicating (theme 3), and showing it was safe to do so, reflecting how “leadership “creates and changes cultures” Schein (2004, p.11).

### **Discussion**

This study explored the subjective experiences of RD&E-DPT SCRs panellists who were also regular and non-regular/non-attendees. The principle question of whether SCRs hold transformational power was addressed by investigating whether SCRs had any perceived impact on individual, (group/self-

other) relational, and/or organizational levels within an overarching systemic framework, as changes at any of these might trigger transformation at other levels.

### **Individual**

Participants generally perceived no significant effects on their personal or professional identities. Some experienced increased confidence, pride, and personal growth through professional risk-taking. Most described greater self-awareness which helps delineate self-other boundaries required for empathy (Decety & Moriguchi, 2007). Half the participants who described catharsis, which may be transformative and restorative within a safe context, were one-off attendees. Participants described feeling respected or validated.

Deeper reflection, storytelling's power in connecting participants' to themselves (and others), and (re-)constructing narratives enabled reframing of past events and new insights, contributing to some participants experiencing self-forgiveness or self-compassion cognitively and/or behaviourally. Others acknowledged difficulties with self-compassion which organizational pressures could exacerbate.

Learning about other professionals' roles and challenges through storytelling affected participants' views of, and increased empathy for, colleagues, which facilitated enhanced compassion towards them, as discussed below. It could be claimed that the SCRs were not succeeding in promoting compassionate care as few participants discussed changed perspectives of, and interactions, with patients. The participants who took part generally considered and presented themselves as already holding empathy and compassion for patients. However, this could arguably be a self-serving bias to enhance or maintain self-esteem or the image of the self (Hoorens, 1993) as a

“good” and compassionate HCP, which underplays the impact contextual factors may have on HCPs’ behaviour and the ability to compassionately connect with patients.

The changed views of, increased empathy, and compassion for colleagues is aligned with the SCCC and SCRs’ mission of facilitating compassionate healthcare through affecting interpersonal interactions amongst caregivers (as well as between caregivers and patients). However, the organizational contexts in which participants were operating and the pressures within and weighing on those organizations, including limited resources, appeared to be delimiting the capacity for curiosity and reflection. When participants were able to overcome the barrier of restricted time to be present in SCRs, to hear and reflect on others’ stories, this could facilitate understanding and empathy. However, transferring this curious, compassionate mindset to the everyday work environment, confronted with its busyness and challenges, seemed more difficult for participants. They might then be more susceptible to reverting to making assumptions about colleagues’ behaviour due to limited time to think about what colleagues’ “stories” and the factors influencing their behaviour might be.

### **Relational**

Participants discussed initial anxieties about presenting, fearing judgement or being stigmatized, reflecting the evolutionary significance of the individual staying within the group system for survival. This reverberates with Foucault’s (1979) writings on Bentham’s Panopticon; any observer might exercise power through surveillance or the “normalizing gaze” (Harper & Spellman, 2014) which sees sociocultural norms become internalized, constraining behaviour. This seemed pertinent for medics and those operating

in cultures which valued emotional detachment. Most participants felt relatively safe within SCRs facilitated by emotional resonance. There were limits to what participants felt safe to share.

Most participants did not feel SCRs affected the patient care they provided. Regarding social connection, almost all described emotional resonance and the value of sharing stories with colleagues which could inspire respect, empathy, and compassion towards them through transformed understandings of pressures affecting them, including from the sociopolitical suprasystem. Shared experiences could encourage a perceived common social identity even for non-regular attendees. Some recognized work demands could delimit the reflective space required to uncover stories and put oneself “in another’s shoes”.

### **Organizational**

Apropos of views on their organizations and care delivery, participants discussed resource constraints and systemic pressures. One participant voiced concern about staff lacking curiosity, adversely impacting care quality, attributed to staff feeling uncared for and defensively protecting themselves. Several discussed the policy-practice gap representative of conflict between target-driven and caring cultures. The former may be considered “oppression” by the sociopolitical suprasystem exerting a “disorganizing” force on the organizational system, the latter lacking adequate energy to meet the demands placed upon it. Some thought managers protected them from this. Others saw it negatively impacting staff’s ability to offer compassionate care encompassing human connection.

Some participants saw SCRs (temporarily) transforming habitual sociocultural norms and behaviour. Two mentioned an attenuated hierarchy



within SCRs. Some felt their organization was more compassionate through witnessing colleagues' compassion or from the organization and chief executive investing in SCRs. Some thought engaging in SCRs had contributed to more holistic thinking, new service and cross-organization initiatives, and to cross-service/cross-organizational learning. Participants thought SCRs might be having limited effects on cultures through normalizing emotions, and that acknowledging the psychological impact of professional caring was required to nurture staff resilience and prevent burnout. Participants saw the organization and its leaders had a responsibility to care for staff, address barriers, enable staff to attend SCRs, and support interventions that might be built into organizational culture.

### **SCRs Mechanisms: A Systemic Attachment Narrative Theory**

A theory of SCRs based on attachment narrative therapy (encompassing systemic, attachment/psychodynamic, and narrative theory) and psychological safety is outlined below, which may operate in conjunction with the aforementioned psychological mechanisms.

Energy, the “power to effect change”, is the primary “stuff” of systems which must perform four energy functions for continued survival: securing energy internally and externally and accomplishing goals internally and externally (Carter, 2011). When one function predominates and others are neglected, system/s fragmentation can result (Carter, 2011). If an NHS organization continually aims to achieve the suprasystem's financial targets, yet fails to secure sufficient external resources and internal energy, this may be detrimental to the organization and its employees.

SCRs may enable organizations to secure internal energy and, when organizations join forces, external energy. SCRs provide opportunities for exchanging information thereby enabling energy to be imported and exported by individuals, teams, and organizations. Greater communication amongst sub- and suprasystems can trigger synergy, amplified energy within those systems (Greene, 2008), protecting against energy bankruptcy, supporting survival through ever-evolving conditions as staff may reflect and adjust for continued effectiveness (Finestone, 2003).

Synergy has also been described as the alignment of individual and cultural goals (Carter, 2011). SCRs may allow goal alignment across systems/cultures through sharing stories, and human connection. Narrative and systemic therapies emphasize communication's role in the process of change and the importance of meaning-making in human experience; meanings attributed to events influence cognitive, emotional, and behavioural responses. If meanings are transformed, thoughts, emotions, and behaviour can change (Dallos & Stedmon, 2014).

SCRs may offer space for "the difference that makes a difference" (Bateson, 1972) as dominant cultural discourses may be challenged, individual and organizational narratives may be re-constructed, encompassing the complexity of human experience. The ability to consciously reflect on inner emotions, experiencing the discomfort this may evoke, can offer greater awareness, more integrated systems, new ways of dealing with internal conflicts (Leiper, 2014), reducing the possibility of enactments, and boosting resilience. Open reflection and exploration requires a "secure base" and psychological safety which SCRs may help to provide.

Bowlby (1973) proposed humans are best able to employ their skills when they know there are trusted people ready to help them through any problems, providing a secure base for exploration. Vetere and Dallos (2007, p.7) cited “responsiveness” and “accessibility” as key to attachment security and trusting connections, with members of a system listening to others, providing reassurance when recollecting is “difficult and painful”. SCRs may hold potential for nurturing a secure/safer base and organizational attachment security for regular participants through the emotional resonance, including reassuring feedback, storytelling can evoke. SCRs may encourage feelings of belongingness, contribution, human sameness, which can increase psychological safety (Wilde, 2014), enabling further risk-taking and learning. However, multiple factors can undermine psychological safety, a minimum degree of which is required for SCRs to function and for the potential of transformational power to be present.

## **Recommendations for Practice**

### **General.**

- SCRs can exert additional stress on facilitators. Organizations could consider specifically allocating time for staff to research, organize, and promote staff support interventions, including SCRs.
- Staff need to be enabled to attend SCRs. The extant research, humanistic and business cases could be delivered to executive boards, leaders, and managers clarifying the need to invest in wellbeing interventions for strategic plans to be developed to increase staff understanding around benefits, enabling

engagement/helping normalize support across cultures. Leaders could be directly invited to pertinent SCRs.

- Consideration should be given to whether SCRs are the most appropriate/adaptive method of support or whether interventions could be developed for smaller groups where relationships and trust can be built and consolidated so positive effects within local cultures may be sustained. This might include cross-trust consultation or peer supervision (across seniority levels/disciplines).

#### **RD&E-DPT.**

- RD&E-DPT SCRs are not reaching staff who may most need reflective space. Awareness/knowledge of SCRs could be progressed through various means: Regular E-shots to previous panellists/attendees with encouragement to share with teams/colleagues; using non-electronic methods; systematic presentations to staff groups covering the benefits/outcomes of participating, which would need support from credible leaders. They might distribute supporting information/leaflets to staff teams/services.
- CPD events could be scheduled hosting debates between two respected figures arguing for/against SCRs to raise awareness and open a dialogue with the wider system, considering what would enable and encourage attendance across groups.
- Flexibility in SCRs' timing could be trialled in liaison with communication with clinical leads to enable broader staff attendance,

with rotations facilitating different staff members' attendance each month.

- The SG may consider whether patients could present at specially selected SCRs (as in America).
- The SG might consider developing a SCRs panellists' guidelines pamphlet outlining what is involved, encouraging prior attendance and information-seeking so prospective panellists provide fully-informed consent.

### **Limitations**

This study has several limitations. Although eight participants were non-regular/non-attendees, all had participated in at least one as a panellist. They were arguably positively biased towards SCRs, which may have influenced their decision to volunteer, although some had initially been sceptical of SCRs. Most participants had holistic ways of thinking, appearing interested in the psychosocial and human aspects of care, concordant with their specialities/disciplines. The sample was female-dominated, perhaps representative of SCRs audiences and indicative of wider sociocultural norms which place the discussion of emotions in the realm of women. Most participants were over 40 and in senior positions, possibly representative of the SCRs audience, yet maybe providing a skewed perspective. Time and resources have not permitted participant validation, although this will be sought. Finally, this research could have benefited from having non-clinical participants who are instrumental in patient care and experience patient-related distress and systemic pressures.

## **Future Directions**

Further exploration of panellists' and non-attendees subjective experiences in different healthcare contexts is indicated. Longitudinal research may investigate the stress, sickness, wellbeing, empathy, self-compassion, and psychological engagement levels of attendees compared with non-attendees and staff involved with other staff support interventions, such as reflective practice groups. Exploration of team cohesion and performance, and patient experience studies could help understanding of any potential wider impact of SCRs.

## **Conclusion**

The present investigation into SCRs' transformational power in a unique cross-NHS trusts context in South West England indicated SCRs appeared to effect transformation at individual and relational levels, with limited impact at the organizational level. For most participants, relational changes were around increased human compassion and empathy towards colleagues rather than patients.

Small changes in perception and interpersonal communication amongst colleagues have the potential to trigger great differences in a system and its outputs, such as care delivery, as Ghaye (2005) highlighted when citing the "butterfly effect" in chaos theory, and are intrinsic to developing compassionate healthcare cultures. However, as evidenced in this study, SCRs' power may be constrained if organizations (are induced to) predominantly focus on achieving external goals and if barriers, particularly around psychological safety, cultural assumptions, norms, values, and access, are not addressed.

As one participant noted, SCRs in and of themselves are unlikely to hold the power required to transform the organizational culture, especially given the

limited reach of SCRs, pressures on the systems, and the current perceived conflicted values and gaps which seem to exist between policy and practice. Nonetheless SCRs seem to be having an impact on those who participate, especially if they hold multiple SCRs roles, and relationally on those with whom they interact. A new theoretical model was also proposed.

## References

- Bandura, A. (1977). *Social learning theory*. New Jersey: Prentice Hall.
- Barker, R., & Flanagan, E. (2016). Schwartz Rounds: What are they and how do they support all staff groups working in healthcare? In L. Bostock (Ed.) *Interprofessional staff supervision in adult health and social care services, Volume I* (pp. 67-72). Hove: Pavilion.
- Barnard, P. (2013). Schwartz Rounds: Librarian roles and opportunities, *Journal of Hospital Librarianship*, 13(1), 71-78. DOI: 10.1080/15323269.2013.743368.
- Bateson, G. (1972). *Steps to an ecology of mind*. New York: Ballantine.
- Berwick (2013). *A promise to learn, a commitment to act: Improving patient safety in England*. National Advisory Group on the Safety of Patients in England. London: Department of Health.
- Bowlby, J. (1973). *Attachment and loss, volume 2: Separation, anxiety, and anger*. London: Hogarth.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77-101. DOI: 10.1191/1478088706qp063oa.
- Burnard, P. (2002). *Learning human skills: An experiential and reflective guide for nurses and health care professionals*. Oxford: Butterworth-Heineman.
- Carr, A. (2000). *Family therapy: Concepts, process, and Practice*. Chichester: Wiley.
- Carter, I. (2011). *Human behaviour in the social environment: A social systems approach* (6<sup>th</sup> ed.). New Brunswick: Aldine Transaction.
- Cartwright, S. (2002). What is double-loop learning? *Journal of Leadership Education*, 1, 68-71.



[http://www.journalofleadershiped.org/attachments/article/18/JOLE\\_1\\_1\\_Cartright.pdf](http://www.journalofleadershiped.org/attachments/article/18/JOLE_1_1_Cartright.pdf)

- Coborn, W. J. (2001). Subjectivity, emotional resonance and the sense of the real. *Psychoanalytic Psychology, 18*, 303-319.
- Cole-King, A. & Gilbert, P. (2011). Compassionate care: The theory and the reality. *Journal of Holistic Healthcare, 8*(3), 29-37.
- Creswell, J. W. (2012). *Qualitative inquiry and research design: Choosing among five approaches*. Thousand Oaks, CA: Sage.
- Dallos, R., & Stedmon, J. (2014). Integrative formulation in practice: A dynamic multi-level approach in L. Johnstone & R. Dallos (Eds.) *Formulation in psychology and psychotherapy* (pp. 191-215). London: Routledge.
- Decety, J., & Moriguchi, Y. (2007). The empathic brain and its dysfunction in psychiatric populations: Implications for intervention across different clinical conditions. *BioPsychoSocial Medicine, 1*(22), 1-21. Retrieved from <http://bpsmedicine.biomedcentral.com/articles/10.1186/1751-0759-1-22>.
- Duberley, J, Johnson, P. Cassell, C.M. (2012). Philosophies underpinning qualitative research in G. Symon & C. M. Cassell (Eds.) *Qualitative organizational research: Core methods and current challenges* (pp. 15-34). London: Sage.
- Dykes, M. (2015, November 16). 11 ways Cameron's cuts are hurting our NHS – #FullyFundOurNHS [blog post]. Retrieved from <http://touchstoneblog.org.uk/2015/11/11-ways-camerons-cuts-are-hurting-the-nhs-fullyfundournhs>.
- Edmondson, A. (1999). Psychological safety and learning behavior in work teams. *Administrative Science Quarterly, 44*, 350-383. DOI: 10.2307/2666999.

- Finestone, S. (2003). *Understanding emotion at work*. London: Sage.
- Foucault, M. (1979). *Discipline and Punish: The Birth of the Prison*. New York: Vintage Books.
- Francis, R. (2013). *Report of the Mid Staffordshire NHS Foundation Trust public inquiry*. London: The Stationery Office. Retrieved from [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/279124/0947.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/279124/0947.pdf).
- Francis, R. (2015). *Freedom to speak up*. London: Monitor. Retrieved from [http://webarchive.nationalarchives.gov.uk/20150218150343/https://freedomtospeakup.org.uk/wp-content/uploads/2014/07/F2SU\\_web.pdf](http://webarchive.nationalarchives.gov.uk/20150218150343/https://freedomtospeakup.org.uk/wp-content/uploads/2014/07/F2SU_web.pdf).
- Fusch, P. I., & Ness, L. R. (2015). Are We There Yet? Data Saturation in Qualitative Research. *The Qualitative Report*, 20, 1408-1416. Retrieved from <http://nsuworks.nova.edu/tqr/vol20/iss9/3>.
- George, M. (2016). Stress in NHS staff triggers defensive inward-focussing and an associated loss of connection with colleagues: This is reversed by Schwartz Rounds. *Journal of Compassionate Health Care*, 3(9), 1-17. DOI: 10.1186/s40639-016-0025-8.
- Gergen, K. (2001). Psychological science in a postmodern context. *The American Psychologist*, 56, 803-813. Pre-publication draft. Retrieved from [http://www.swarthmore.edu/Documents/faculty/gergen/Psychological\\_Science\\_in\\_a\\_Postmodern\\_Context.pdf](http://www.swarthmore.edu/Documents/faculty/gergen/Psychological_Science_in_a_Postmodern_Context.pdf).
- Ghaye, T. (2005). *Developing the reflective healthcare team*. London: Blackwell.
- Gilbert, P. (2005). *Compassion: Conceptualisations, research and use in psychotherapy*. London: Routledge.
- Gilbert, H. (2015). *King's Fund briefing: Mental health under pressure*. London: Author.

- Gishen, F. & Wood, M. (2015). Using Schwartz Centre Rounds to change hospice culture: Does it work? *BMJ Supportive & Palliative Care*, 5, 108. DOI: 10.1136/bmjspcare-2014-000838.17.
- Greene, R. (2008). *Human behavior theory and social work practice*. New Jersey: Aldine Transaction.
- Harper, D., & Spellman, D. (2014). Formulation and narrative therapy: Telling a different story in L. Johnstone & R. Dallos (Eds.) *Formulation in psychology and psychotherapy* (pp. 96-120). London: Routledge.
- Haynes, K. (2012). Reflexivity in qualitative research in G. Symon & C. Cassell (Eds.) *Qualitative organizational research* (pp. 72-79). London: Sage.
- Hoorens, V. (1993). Self-enhancement and superiority biases in social comparison. *European Review of Social Psychology*, 4, 113-139. DOI: 10.1080/14792779343000040.
- Johnson, P. (2013). Opening remarks Institute for Fiscal Studies Spending Review 27/06/2013. Retrieved from [http://www.ifs.org.uk/budgets/sr2013/paul\\_johnson.pdf](http://www.ifs.org.uk/budgets/sr2013/paul_johnson.pdf).
- Kahn, W. A. (1992). To be fully there: Psychological presence at work. *Human Relations*, 45, 321-349.
- Kandola, B. (2012). Focus groups in G. Symon & C. M. Cassell (Eds.) *Qualitative organizational research: Core methods and current challenges* (pp. 258-274). London: Sage.
- Kerasidou, A. & Horn, R. (2016). Making space for empathy: Supporting doctors in the emotional labour of clinical care. *BMC Medical Ethics*, 17(8), 1-5. DOI: 10.1186/s12910-016-0091-7.

- King, N. (2004). Using interviews in qualitative research in C. Cassell & G. Symon (Eds.), *Essential guide to qualitative methods in organizational research* (pp. 11-22). London: Sage.
- Lajoie, D. H. & Shapiro, S. I. (1992). Definitions of transpersonal psychology: The first twenty-three years. *Journal of Transpersonal Psychology, 24*, 79-98.
- Langston University (2017). *Transformational leadership*. Retrieved from <https://www.langston.edu/sites/default/files/basic-content-files/TransformationalLeadership.pdf>.
- Lazslo, A., & Krippner, K. (1998). Systems theories: Their origins, foundations, and development in S. Jordan (Ed.) *Systems theories and a priori aspects of perception* (pp. 47-74). Amsterdam: Elsevier.
- Leiper, R. (2014). Psychodynamic formulation: Looking beneath the surface in L. Johnstone & R. Dallos (Eds.) *Formulation in psychology and psychotherapy* (pp. 44-56). London: Routledge.
- Lillemoen, L., & Pedersen, R. (2015). Ethics reflection groups in community health services: An evaluation study. *BMC Medical Ethics, 16*(25), 1-10. DOI: 10.1186/s12910-015-0017-9.
- Maben, J., & Leamy, M. (2016, November). *Schwartz Rounds: Realist evaluation draft findings from national research study*. Presented at The Point of Care Schwartz Center Round Conference, Manchester, UK.
- Mannion, R. & Davies, H. T. (2015). Cultures of silence and cultures of voice: The role of whistleblowing in healthcare organizations. *International Journal of Health Policy and Management, 4*, 503-505. DOI: 10.15171/ijhpm.2015.120.
- May, D. R., Gilson, R. L., & Harter, L. M. (2004). The psychological conditions of meaningfulness, safety and availability and the engagement of the human

spirit at work. *Journal of Occupational and Organizational Psychology*, 77, 11-37.

Mehl-Madrona, L., & Mainguy, B. (2015). *Remapping your mind: The neuroscience of self-transformation through story*. Rochester: Inner Traditions.

Menzies Lyth, I. (1960). Social systems as a defence against anxiety: An empirical study of the nursing service of a general hospital. *Human Relations*, 13, 95-121.

NHS England (2014). *Putting patients first business plan 2014/15-2016/2017*. London: Author. Retrieved from <https://www.england.nhs.uk/wp-content/uploads/2015/11/nhse-bus-plan-1415-1617.pdf>.

Novick, G. (2008). Is There a bias against telephone interviews in qualitative research? *Research in Nursing & Health*, 31, 391–398. DOI: 10.1002/nur.20259.

Opie, A. (1997). Thinking teams thinking clients: issues of discourse and representation in the work of health care teams. *Sociology of Health and Illness*, 19, 259–80. Retrieved from <http://onlinelibrary.wiley.com/doi/10.1111/j.1467-9566.1997.tb00019.x/pdf>.

Perrin, A., & Griffiths, T. (2008). Clashing cultures: Managing conflicting demands while engaged in psychotherapy training for junior doctors. *Clinical Psychology Forum*, 186, 42-45.

Robert, G., Philippou, J., Leamy, M., Reynolds, E., Ross, S., Bennett, L., Maben, J. (2017). Exploring the adoption of Schwartz Center Rounds as an organizational innovation to improve staff well-being in England, 2009-2015. *BMJ Open*, 7(1), 1-10. DOI: 10.1136/bmjopen-2016-014326.

- Schein, E. H. (2004). *Organizational culture and leadership* (3<sup>th</sup> ed.). San Francisco: Jossey-Bass.
- Schwartz Center for Compassionate Care (SCCC) (2015). *Our mission*. Retrieved from <https://www.theschwartzcenter.org/about-us/schwartz-center-glance/>.
- Schwartz, K.B. (1995, July 16). A patient's story. *The Boston Globe Magazine*. Retrieved from [http://www.theschwartzcenter.org/media/patient\\_story.pdf](http://www.theschwartzcenter.org/media/patient_story.pdf).
- Swinton, J. (2001). *Spirituality and mental health care: Rediscovering a forgotten dimension*. London: Jessica Kingsley Publishers.
- University of Auckland School of Psychology (2017). *Frequently asked questions: I've collected 5 interviews – is that enough for a TA?* Retrieved from <https://www.psych.auckland.ac.nz/en/about/our-research/research-groups/thematic-analysis/frequently-asked-questions-8.html#c83c77d6d1c625135085e489bd66e765>.
- Vetere and Dallos (2007, p.7). Attachment narratives and systemic therapy. *Context*, 90, 5-9. Retrieved from <http://www.surrey.ac.uk/psychology/projects/ANT/publications/Attachment-narratives-systemic-therapy-Context-90-5-9.pdf>.
- Vogl, S. (2013). Telephone versus face-to-face interviews: Mode effect on semistructured interviews with children. *Sociological Methodology*, 42, 133-177. DOI: 10.1177/0081175012465967.
- West, M. A. (2003). *Effective teamwork: Practical lessons from organizational research*. Oxford: BPS Blackwell.
- Wilde, J. (2014). *Cultures of transparency and openness in the NHS: The Francis imperative*. Retrieved from <http://foundersnetwork.uk/wp-content/uploads/2014/11/Joanna-Wilde-Article.pdf>.

Worline, M., & Dutton, J. E. (2017). *Awakening compassion at work: The quiet power that elevates people and organizations*. Oakland: Berrett-Koehler.

Wren, B. (2014). Schwartz Rounds: An intervention with potential to simultaneously improve staff experience and organizational culture. *Clinical Psychology Forum*, 263, 22-25.

Yardley, L. & Marks, D. (2004). Introduction to research methods in clinical and health psychology in L. Yardley & D. Marks (Eds.) *Research methods in clinical and health psychology* (pp. 1-20). London: Sage.

## Appendices

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- M. Table of Enablers and Barriers to Accessing RD&E-DPT Schwartz Center Rounds
- N. Notes on Transcription
- O. Dissemination Statement
- P. Journal of Health Services Research and Policy Instructions for Authors



### **Appendix A: Reflexivity Statement**

My values around caring, compassion, and social justice and my interest in staff wellbeing and patient experience influenced my decision to conduct research into SCRs. I was aware that I was positively biased towards SCRs and the cultural changes they had been purported to encourage in healthcare, especially given the current sociopolitical and economic pressures on the NHS and its staff. I was nonetheless surprised when I found myself originally framing the systematic literature review question in the positive, considering only SCRs' benefits. I heeded the need to be wary of succumbing to confirmatory bias and to be attentive to any negative outcomes of SCRs, which was aided by reflexive and reflective journal writing and discussion in supervision.

I was also conscious of what expectations the RD&E-DPT Steering Group might hold of the research and the implications its findings might have for the Trusts. I am cognizant of the tremendous effort and commitment the Steering Group, and particularly the facilitators, exert to conduct well-functioning SCRs. My hope is to contribute to a culture of openness in a manner that can inform and aid the Steering Group such that SCRs/reflective forums may develop in a way that is accessible for staff of both organizations.

My second supervisor, Dr. Phil Yates, is a member of the RD&E-DPT Steering Group. However, he was not involved in the analysis of any data and the supervisory relationship did not affect the research findings.

**Appendix B: University of Exeter School of Psychology Research Ethics**

**Committee Ethical Approval**

**To:** Morris, Lisa

**Subject:** Your application for ethical approval (2016/1195) has been conditionally accepted

## Ethical Approval system

---

Your application (2016/1195) entitled Do Schwartz Center Rounds® Hold Transformational Power? An Investigation into the Subjective Experiences of NHS Panellists in Devon. has been conditionally accepted

Please visit <http://www.exeter.ac.uk/staff/ethicalapproval/>

---

University of Exeter, UK


[www.exeter.ac.uk](http://www.exeter.ac.uk)

The University of Exeter in Exeter, Devon, and Falmouth, Cornwall, UK, offers research and study in sciences, social sciences, business, humanities and arts.

Please click on the link above and select the relevant application from the list. The conditions are as follows:

Please can you add contact details for Chair of Ethics on the consent/information form - Dr. Lisa Leaver, [l.a.leaver@ex.ac.uk](mailto:l.a.leaver@ex.ac.uk)

**Appendix C: Devon Partnership NHS Trust R&D Approval and Letter of  
Access for Research**

**Devon Partnership**   
NHS Trust

Lisa Morris  
Trainee Clinical Researcher  
[Redacted]

Research and Development Directorate  
Wonford House Hospital  
Dryden Road  
EXETER  
EX2 5AF  
[Redacted]

16 March 2016

Dear Lisa

**Study Title:** Do Schwartz Center Rounds® Hold Transformational Power? An Investigation into the Subjective Experiences of NHS Panellists in Devon

**R&D Number:** DPT0325

I have reviewed the Trust R&D file for the above named study, which has received approval from the appropriate regulatory bodies, and I am happy to give approval on behalf of the Devon Partnership NHS Trust (DPT).

The documents approved for use in this study are those approved by ethics, these are detailed on a separate sheet.

As named Investigator for the research that is being undertaken at this Trust, it is your responsibility to manage and conduct this study in accordance with;

- The requirements of the **Research Governance Framework for Health and Social Care (2005)** and **Medicines for Human Use (Clinical Trials) Regulations 2004** (if applicable).
- **ICH-GCP** (Good Clinical Practice) – It is mandatory for those staff who will be consenting participants into this study to have undertaken GCP and to ensure it is updated every 2 years.
- The **Human Tissue Act 2004** and the **EU Tissue and Cells Directive (2006)** for research involving human tissue.
- The **Data Protection Act 1998** which details the eight principles of 'good information handling'.
- **R&D Standard Operating Procedures (SOPs)** and **Trust policies** which are available on the Trust intranet site

As Lead Investigator for this research, you are required to ensure study specific duties are appropriately delegated and clearly documented on the study Delegation Log. This guarantees clarity of roles and must be signed and dated by each individual on the study and yourself as Lead Investigator.

**Safety Reporting**  
Guidance on the classification of Adverse Events/Reactions (AEs/ARs) / Serious Adverse Events/Reactions (SAEs/SARs) and Suspected Unexpected Serious Adverse Reactions (SUSARs) and the requirements for reporting to the sponsor can be found in the study protocol. For Devon

R&D Trust Approval Letter (excluding No Ethics and Tissue Bank)  
V1.1 07/05/2014

Partnership NHS Trust sponsored studies this is also detailed in the sponsorship letter. All safety events that involve DPT patients, that require reporting to the Sponsor, must also be reported by fax marked for the attention of Sarah Laidler and sent to the R&D Office within 24 hours of becoming aware of the event (01392 6744929) alternatively via email to [sarahlaidler@nhs.net](mailto:sarahlaidler@nhs.net).

**Progress Reporting**

You are required to submit regular recruitment updates to the R&D Office, as well as annual progress reports to Ethics, MHRA (where applicable) and R&D. Please note that new government and Trust targets require you to have recruited your **first patient within 30 days of the date of Trust Approval** and to have recruited your target number of participants within the time frame stipulated on your SSI form (Time to Target).

**Monitoring and Audit**

Your study may be monitored by the Sponsor and selected for audit by the R&D Office (where DPT is not the Sponsor) and Regulatory Authorities at any time. The team involved in conducting this research must ensure full co-operation with any requests from any of these bodies. Action may be taken to suspend research if it is found to not be conducted in accordance with the protocol and all applicable regulations.

**Archiving**

Upon completion of this Research an **End of Study Report** must be submitted to the Regulatory Authorities (this will be done by the CI) and a copy submitted to the R&D Office. All studies must be archived appropriately and in accordance with the applicable Law. Where DPT is the Sponsor or where the Sponsor has delegated archiving to the Investigator team, it is your responsibility to contact the R&D Office to discuss appropriate archiving arrangements.

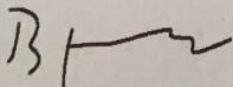
Any publications arising from the Research conducted at this site must be sent to the R&D Office as part of the on-going Research Governance Process.

You should be aware that the Trust accepts no responsibility for the provision of any study drug outside of Clinical Trials and specifically would not fund the continuing prescription of any therapy once the trial has concluded unless there is a written agreement.

Trust Approval is for the duration of the study, as specified in your SSI form. Research must **commence** within **6 months** of Trust Approval. If you have received an Honorary Contract or Letter of Access in order to conduct the above research at this Trust, it is important that you check the termination date on these documents and if applicable contact the R&D Office to extend the document end date.

We wish you every success with your study.

Yours sincerely



Tobit Emmens  
**Directorate of Research and Development**



Devon Partnership   
NHS Trust

Research and Development Directorate  
Wonford House Hospital  
Dryden Road  
EXETER EX2 5AF

Tel: 01392 675689  
Fax: 01392 403445

Email: sarahlaidler@nhs.net

Lisa Morris  
Trainee Clinical Psychologist



Dear Lisa

**Letter of access for research**

**RE: Do Schwartz Center Rounds® Hold Transformational Power? An Investigation into the Subjective Experiences of NHS Panellists in Devon**  
**Devon Partnership NHS Trust reference: DPT0325**

This letter of access enables you to work on the above mentioned project to conduct research through Devon Partnership NHS Trust on the terms and conditions as set out below. This right of access commences on **23 March 2016** and terminates on conclusion of the study.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation and defined in your Research Passport application.

You are considered to be a legal visitor to Devon Partnership NHS Trust premises. You are not entitled to any form of payment or access to other benefits provided by this NHS organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

While undertaking research through Devon Partnership NHS Trust you will remain accountable to your employer, but you are required to follow the reasonable instructions of the Research & Development Director in this NHS organisation or those given on his behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with Devon Partnership NHS Trust policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with Devon Partnership NHS Trust in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on Devon Partnership NHS Trust premises. You must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of

any other contract holder and you must act appropriately, responsibly and professionally at all time.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (<http://www.dh.gov/assetRoot/04/06/92/54/04069254.pdf>) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

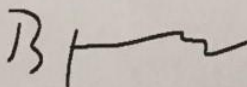
You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that this NHS organisation accepts no responsibility for damage to or loss of personal property.

We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted during this research project and may in the circumstances described above instigate disciplinary action against you.

Devon Partnership NHS Trust will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

If your current role or involvement in research changes, or any of the information provided in your Research Passport changes, you must inform your employer through their normal procedures. You must also inform your nominated manager in this NHS organisation.


Yours sincerely



**Tobit Emmens**  
Managing Partner, Research & Innovation

**Appendix D: Royal Devon and Exeter NHS Foundation Trust R&D**

**Approval and Letter of Access for Research**

**Royal Devon and Exeter**   
NHS Foundation Trust

Lisa Morris  
Trainee Clinical Psychologist  
University of Exeter  
Psychology  
College of Life and Environmental Services  
Washington Singer Building  
Perry Road  
EXETER  
EX4 4QG

Royal Devon and Exeter  
Hospital (Wonford)  
Barrack Road  
Exeter  
EX2 5DW  
Tel: 01392 411611

**GENERAL MANAGEMENT**  
Direct dial: 01392 406936  
Direct Fax: 01392 403012  
Email: [rde-tr.Research@nhs.net](mailto:rde-tr.Research@nhs.net)

20 April 2016 Ref: CB/R&D/CG

Dear Lisa

**Study Title:** Do Schwartz Center Rounds® Hold Transformational Power? An Investigation into the Subjective Experiences of Panellists in Devon

**R&D Ref:** 1612354

I have reviewed the Trust R&D file for your study and I note that this study does not require ethics approval. I am happy to give approval on behalf of the Trust.

**Research Governance**

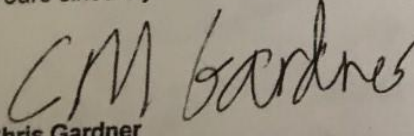
The Director of Research & Development has asked me to remind you of your responsibilities as an NHS researcher, which are:

1. Work must be carried out in line with the new Research Governance Framework for Health and Social Services, which details the responsibilities for everyone involved in research.
2. The Data Protection Act 1998 requires you to follow the eight principles of 'good information handling'.

More information about all these responsibilities can be obtained from the Research & Development Office, Royal Devon and Exeter Foundation Trust, 3<sup>rd</sup> Floor Noy Scott House, Barrack Road, Exeter EX2 5DW.

With best wishes for a successful study

Yours sincerely

  
**Chris Gardner**  
R&D Directorate Manager

Cc R&D Study File  
Dr Janet Smithson, University of Exeter  
Dr Phil Yates, Royal Devon & Exeter NHS Foundation Trust



Royal Devon and Exeter   
NHS Foundation Trust

Lisa Morris  
Trainee Clinical Psychologist  
University of Exeter  
Psychology  
College of Life and Environmental Services  
Washington Singer Building  
Perry Road  
EXETER  
EX4 4QG

Royal Devon and Exeter  
Hospital (Wonford)  
Barrack Road  
Exeter  
EX2 5DW

Tel: 01392 411611

**GENERAL MANAGEMENT**

**Direct dial:** 01392 406936

**Direct Fax:** 01392 403012

**Email:** [rde-tr.research@nhs.net](mailto:rde-tr.research@nhs.net)

20 April 2016

Dear Lisa

**Letter of access for research**

As an existing NHS employee you do not require an additional honorary research contract with this NHS organisation. We are satisfied that the research activities that you will undertake in this NHS organisation are commensurate with the activities you undertake for your employer. Your employer is fully responsible for ensuring such checks as are necessary have been carried out. This letter confirms your right of access to conduct research through Royal Devon & Exeter NHS Foundation Trust for the purpose and on the terms and conditions set out below. This right of access commences on **20 April 2016** and ends on **20 September 2017** unless terminated earlier in accordance with the clauses below.

You are considered to be a legal visitor to Royal Devon & Exeter NHS Foundation Trust premises. You are not entitled to any form of payment or access to other benefits provided by this organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

While undertaking research through Royal Devon & Exeter NHS Foundation Trust, you will remain accountable to your employer **Taunton & Somerset NHS Foundation Trust** but you are required to follow the reasonable instructions of your nominated manager, Dr Phil Yates, in this NHS organisation or those given on his behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with Royal Devon & Exeter NHS Foundation Trust policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with Royal Devon & Exeter NHS Foundation Trust in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of



## Royal Devon and Exeter

NHS Foundation Trust

yourself and others while on Royal Devon & Exeter NHS Trust premises. Although you are not a contract holder, you must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of a contract holder and you must act appropriately, responsibly and professionally at all times.

If you have a physical or mental health condition or disability which may affect your research role and which might require special adjustments to your role, if you have not already done so, you must notify your employer and the Trust prior to commencing your research role at the Trust.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (<http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf>) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

Royal Devon & Exeter NHS Foundation Trust will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that this NHS organisation accepts no responsibility for damage to or loss of personal property.

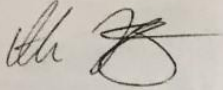
We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. You must not undertake regulated activity if you are barred from such work. If you are barred from working with adults or children this letter of access is immediately terminated. Your employer will immediately withdraw you from undertaking this or any other regulated activity and you **MUST** stop undertaking any regulated activity immediately.

Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

Royal Devon and Exeter   
NHS Foundation Trust

If your circumstances change in relation to your health, criminal record, professional registration or suitability to work with adults or children, or any other aspect that may impact on your suitability to conduct research, or your role in research changes, you must inform the NHS organisation that employs you through its normal procedures. You must also inform your nominated manager in this NHS organisation.

Yours sincerely



*pp*  
**Chris Gardner**  
Directorate Manager  
Research and Development

cc: HR department of the substantive employer  
R&D Study file

**Appendix E: University of Exeter Sponsorship Letter**



**RESEARCH & KNOWLEDGE  
TRANSFER**

The Innovation Centre  
Rennes Drive  
University of Exeter  
Exeter EX4 4RN

Telephone +44 (0)1392 262393  
Fax +44 (0)1392 263686  
Email [res@ex.ac.uk](mailto:res@ex.ac.uk)  
Web [www.exeter.ac.uk](http://www.exeter.ac.uk)

15<sup>th</sup> April 2016

**Project title:** 'Do Schwartz Center Rounds® Hold Transformational Power? An Investigation into the Subjective Experiences of NHS Panellists in Devon'

**Chief Investigator:** Lisa Morris, College of Life & Environmental Sciences, University of Exeter

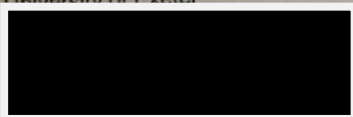
Dear Sir/Madam,

The University of Exeter will act as sponsor for the proposed study and will undertake its responsibilities in this role as outlined in the Department of Health's Research Governance Framework for Health and Social Care (second Edition, 2005). In addition, the University will ensure that the necessary approvals and insurance cover for professional indemnity and public liability are in place before the study commences.

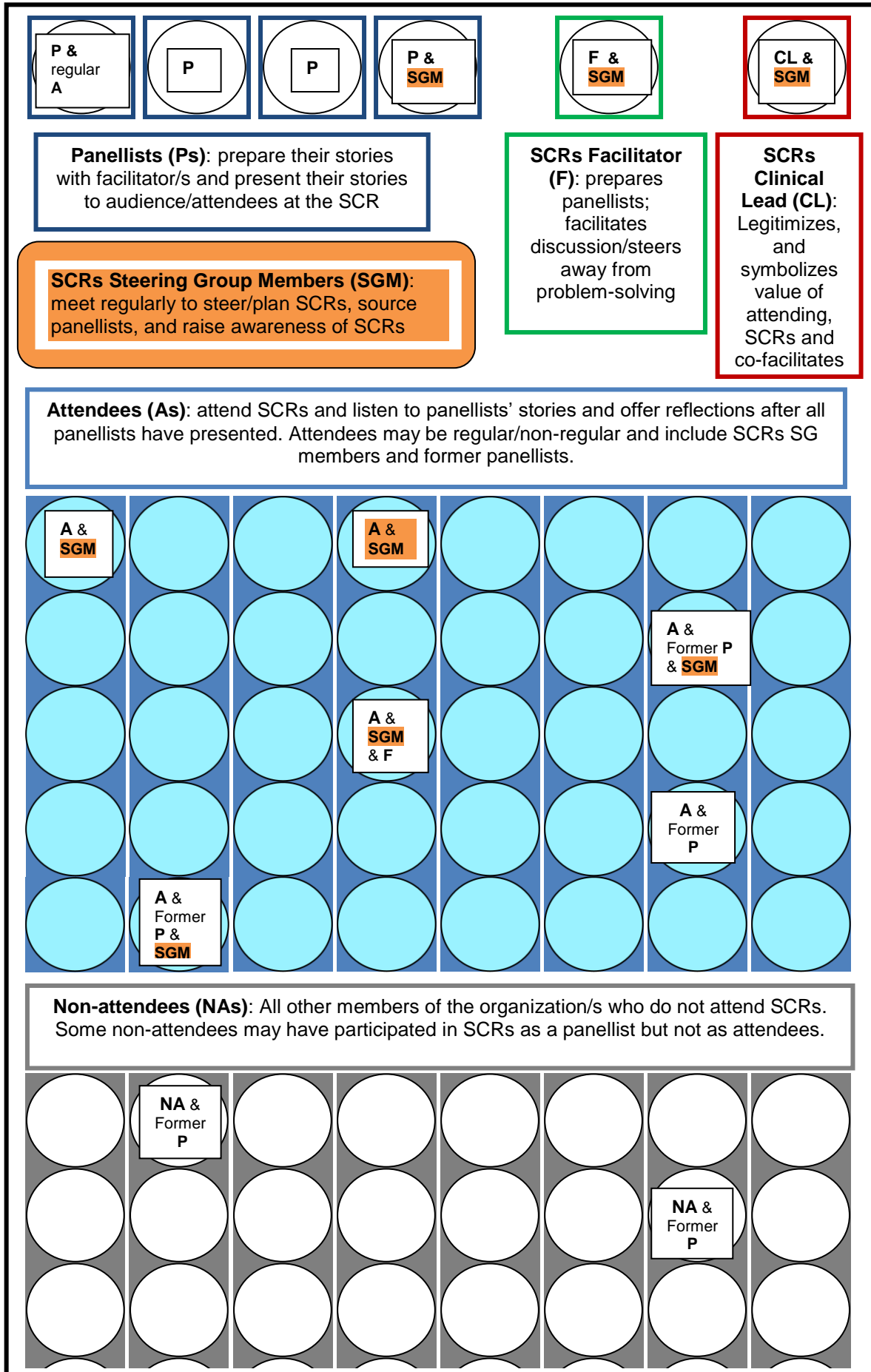
Yours faithfully,

Gail Seymour  
Research & Knowledge Transfer

University of Exeter



### Appendix F: Figure Outlining SCRs Roles and How People May Hold Multiple Roles within an Organization





## Appendix G: Participant Information and Consent Form

Information and Consent Form V2 23 March 2016



### Do Schwartz Center Rounds® Hold Transformational Power? An Investigation into the Subjective Experiences of Panellists in Devon.

**My name is Lisa Marie Morris. I am a Trainee Clinical Psychologist at the University of Exeter. I would like to invite you to take part in a research project investigating the subjective experiences of panellists in the Joint Royal Devon & Exeter-Devon Partnership Trust Schwartz Center Rounds.**

**I am carrying out this project in partial fulfilment of requirements for the Doctorate in Clinical Psychology (DclinPsy) at the University of Exeter. The project is being supervised by Dr. Janet Smithson, Senior Lecturer in Psychology at the University of Exeter, and Dr. Phil Yates, Research Tutor on the Exeter University DclinPsy Programme and NHS Lead Consultant Clinical Psychologist in Clinical Health Psychology and Neuropsychology. Dr. Yates is also a member of the Joint RD&E-DPT Schwartz Rounds Steering Group.**

**This is an opportunity for you to share your thoughts and feelings on, and insights into, your experience of participating in an RD&E-DPT Schwartz Center Round as a panellist. This might help us to understand what impact participating in the Rounds may, or may not, have on individual, relational, and organizational levels from your perspective. This is important to find out as little research has yet been carried out to explore the experiences of Schwartz Center Round panellists and what participating as a panellist might mean to people, healthcare teams, and healthcare delivery. Also, the RD&E-DPT Joint Schwartz Center Rounds initiative is the first in the UK to work across an acute medical trust and a mental health trust. It is therefore important to gather information on how this joint venture between two highly diverse Trusts may impact on the experience of panellists and on healthcare teams.**

**Participating in this project is completely voluntary. All data collected as part of the project will be treated with confidentiality. No identifiable information will be used in the dissemination of results and reported data will be anonymized. You can choose to withdraw from the study, without providing a reason, by requesting for your data to be withdrawn up to a month after taking part.**

**Before deciding whether you would like to take part, please take some time to read through this information sheet. It outlines why the study is being conducted, and what it would entail for you as a participant. If you have any questions, if there is anything you would like to clarify, and/or if you would like to take part, please contact me by email or telephone. My details are at the end of this information sheet.**

**[Thank you for taking the time to read this.](#)**

## **What are the Aims of the Project?**

The **aims** of the project are

- To explore the experiences of SCRs from panellists' viewpoints;
- To investigate whether SCRs have any perceived impact on individual, relational, and/or organizational levels.

## **Research Questions**

1. What is the impact of preparing for, and presenting at, SCRs on panellists' sense of identity/ies, and on their thoughts and feelings towards and about themselves?
2. What is the impact on panellists' sense of social connection, and on their thoughts, feelings and behaviour towards others (including the ways in which they provide care)?
3. How does their experience as panellists affect their view of the organizations within which they work and the practices and care delivery in those settings: Do they perceive any changes, or the need for any?

## **Procedures**

Participating in the study will involve taking part in an interview with me either at a designated Trust site or over the phone. The interview will last around 60 minutes and will be audiotaped using a Dictaphone. Audiotapes will be heard by me, and possibly by my primary supervisor and/or a second researcher for the purpose of analysing information for the project described. All identifying information will be deleted. The recordings will be used solely for the purposes above in accordance with the ethical standards of confidentiality that govern psychologists. The tapes will be destroyed within two years of completion of the project. Should you wish, you can ask for your recording to be destroyed at any time.

## **Potential Risks and Ethical Considerations**

By the time of implementation, ethical approval and permission for this project will have been sought from the National Research Ethics Service (NRES), the RD&E and DPT NHS Research and Development Offices, and Exeter University School of Psychology Research Ethics Committee.

As a clinician employed by the RD&E or DPT, and a previous Schwartz Center Round panellist, you are under no obligation to take part in this project.

Participation in this study is voluntary and the information you provide will be treated as confidential. Limits to confidentiality would apply only if unsafe care were identified, or if it emerged that there was a serious risk of harm to yourself or others.

Given that the interview will focus on your experience as a Schwartz Center Round panellist which involves thinking about the emotional and psychosocial aspects of a theme or case pertinent to you, it is possible that during the course of, or after, the interview, issues might arise for you which you find uncomfortable, difficult, or distressing. If this happens, you can tell me, or simply ask me to stop the interview at any time. Should you experience any distress as a result of the interview, you may wish to contact your GP or Occupational Health Team via your Trust. Other sources of support include:

Samaritans (24 hours a day)

[www.samaritans.org](http://www.samaritans.org)

Tel: 116 123

Email: [jo@samaritans.org](mailto:jo@samaritans.org)

DPT “Looking After Yourself” Information:

<http://www.devonpartnership.nhs.uk/Looking-after-yourself.342.0.html>

Mindful Employer: <http://www.mindfulemployer.net/>; Tel: 01392 677064. For information on looking after yourself, keeping well at work, mental health awareness, and links to information and support.

### **Benefits**

This is an opportunity for you to discuss your thoughts, feelings, and opinions about the RD&E-DPT Schwartz Center Rounds and, specifically, your experience of preparing for and participating in the Rounds as a panellist. You may find that you enjoy talking about and sharing your experience as a panellist which may (or may not) encourage others to take part in Schwartz Rounds. Your participation will be valuable to all stakeholders of both Trusts, from individual clinicians to healthcare teams and patients.

Gathering information about your experiences, and the possible impact of Schwartz Center Rounds may contribute to the research-evidence base in exploring whether or not there is something about the process of Schwartz Center Rounds within particular local cultural contexts which holds transformational power at the individual, relational, and organization levels of healthcare teams and whether continued and further investment in the Rounds may be desirable and justified. It might help inform wider policy discussions about whether the staff commitment, time and engagement required to make Schwartz Center Rounds work is worthwhile, or whether they might be equally well-employed in adaptations of the Schwartz model.

### **Confidentiality and Use of Data**

The information which you give, which is recorded, will be kept strictly confidential, except as may be required by the law or professional guidelines for psychologists. All information will be identified by an identification code, not your name. Any form that requires your name (e.g., this consent form) will be stored separately from the other material. Your name, or other identifying information, will not be associated with the resulting thesis, any reports, publications, or presentations which use the information from your interview.

### **Withdrawal/Premature Completion**

Your participation in the study is voluntary. You may discontinue, without giving a reason and without prejudice. If, after consenting to participate, you decide you want to withdraw your consent, you are free to do this, and can request for your data to be withdrawn from the study up to a month after participating.

### **Invitation to ask further questions**

If you have any questions concerning this project, please let me know. Please make sure you are happy you have all the information that you need before you sign this consent form.

**If you would like to speak to me about the project, you can contact me by email or phone. I shall, of course, be able to call you back at a convenient time.**

**Lisa Marie Morris:** email [LM468@exeter.ac.uk](mailto:LM468@exeter.ac.uk); phone: [REDACTED].

My supervisors may be contacted at:

**Dr. Janet Smithson**

Email: [J.Smithson@exeter.ac.uk](mailto:J.Smithson@exeter.ac.uk)

**Dr. Phil Yates**

Email: [P.J.Yates@exeter.ac.uk](mailto:P.J.Yates@exeter.ac.uk)

University of Exeter, Psychology, College of Life and Environmental Sciences

Washington Singer Building, Perry Road, Exeter EX4 4QG

**Tel:** +44 (0) 1392 724626

### **Consent**

**I give my informed consent to participate in this project.**

**I have read and understand the consent form. Upon signing below, I will receive a copy of the consent form from the project investigator.**

**Participant Name: (Printed)** \_\_\_\_\_

**(Date)** \_\_\_\_\_

**(Signature)** \_\_\_\_\_

**(Date)** \_\_\_\_\_

**Investigator Name: (Printed)** \_\_\_\_\_

**(Date)** \_\_\_\_\_

**(Signature)** \_\_\_\_\_

**(Date)** \_\_\_\_\_

Questions or concerns about the study can be addressed to the Chair of the Ethics Committee, School of Psychology, University of Exeter:

**Dr. Lisa Leaver**

**Chair of the Ethics Committee**

School of Psychology

University of Exeter

Email: [l.a.leaver@ex.ac.uk](mailto:l.a.leaver@ex.ac.uk)



## **Appendix H: Semi-structured Interview Schedule for Panellists**

Intro. Discussion of information sheet/informed consent/any questions. Verbal and signed consent.

As you know, this study is being conducted to explore and better understand the experience of SCRs from panellists' perspectives (and whether such practice has any perceived impact on individual, relational, and/or organizational levels or not).

**1. Tell me about yourself and your clinical role/your work.**

Clinical role/professional discipline; worksite/practice area (which Trust); level of responsibility; development/training; values/what first drew them to healthcare; age/gender;?

**2. Tell me about your understanding of SCRs (from when you first learnt about them to the point where you are now).**

How first heard about/introduced to; understanding of what SCRs are/aims/origin; any change in understanding/perception?

**3. Tell me about your own experience of becoming involved in SCRs.**

Regular attendee or not? – How often? How and why became involved as a panellist? – Internally or externally motivated? When took part as panellist? Subject/date of the SCR. How they felt presentation/SCR was received by audience? Who in the audience?

**4. Were there any factors that facilitated or hindered the experience of being an SCR panellist? Whether during the preparation/presentation/post SCR phase? Felt supported through or pressured, or neither?**

**5. Describe the process of preparing for/participating as an SCR panellist.**

Who else on panel with them? Any observations re self/others/workplace/org. What did they notice, if anything?– thoughts/feelings/actions/practice. If also SCR attendee, any differences (or similarities) to being on the panel?

**6. How, if at all, did the experience of being a panellist (at any point or throughout the process) influence how you see or feel about yourself as an individual or professional? (Whether positive or negative)? Any effect on personal/professional/social identity? Any effect on sense of values/ethics/responsibility or not?**

**7. How, if at all, has the experience of being a panellist (at any point throughout the process) affected how you view, feel about, or interact with your colleagues or other professionals in the NHS?**

8. **How, if at all, has the experience of being a panellist (at any point throughout the process) affected how you view, feel about, or interact with patients or anyone to whom you provide care?**

9. **What were the thoughts and feelings you had, and now have, around your experience as a panellist?**

Record or discuss them in any way (aside from at SCR, e.g., in journal, with family etc.)? How, where, who with? Have these changed or developed in any way throughout the process? If so, how?

10. **What does your experience as an SCR panellist mean to you? Any change between now and at time of presentation?**

11. **How did those close to you view your experience as an SCR panellist? What did it mean to them (if anything)? What did that mean for you? How did you respond? How, if at all, has your experience affected your personal relationships?**

12. **How did (immediate/wider) colleagues view your experience/participation on an SCR panel? Immediate colleagues were present at SCR? Any outside of panel? Similarities/differences between peers/managers/senior or junior colleagues.**

13. **How are SCRs seen and understood in your workplace/organization? Any differences/similarities between frontline staff/leaders/managers.**

14. **What were your thoughts/feelings towards work throughout the process and now? In terms of: patients? Colleagues? Own clinical practice? General clinical/caregiving practices in your workplace/s?**

15. **How, if at all, has your experience as a panellist affected how you view or feel about your organization and the care provided in your service?**

16. **Was there anything you particularly appreciated or found difficult about the experience/process?**

17. **Would you recommend SCRs to others -to be a panellist/attend - or not? Reasons.**

18. **Motivation for participating in the study.**

19. **Is there anything else you would like to add that we have not covered?**

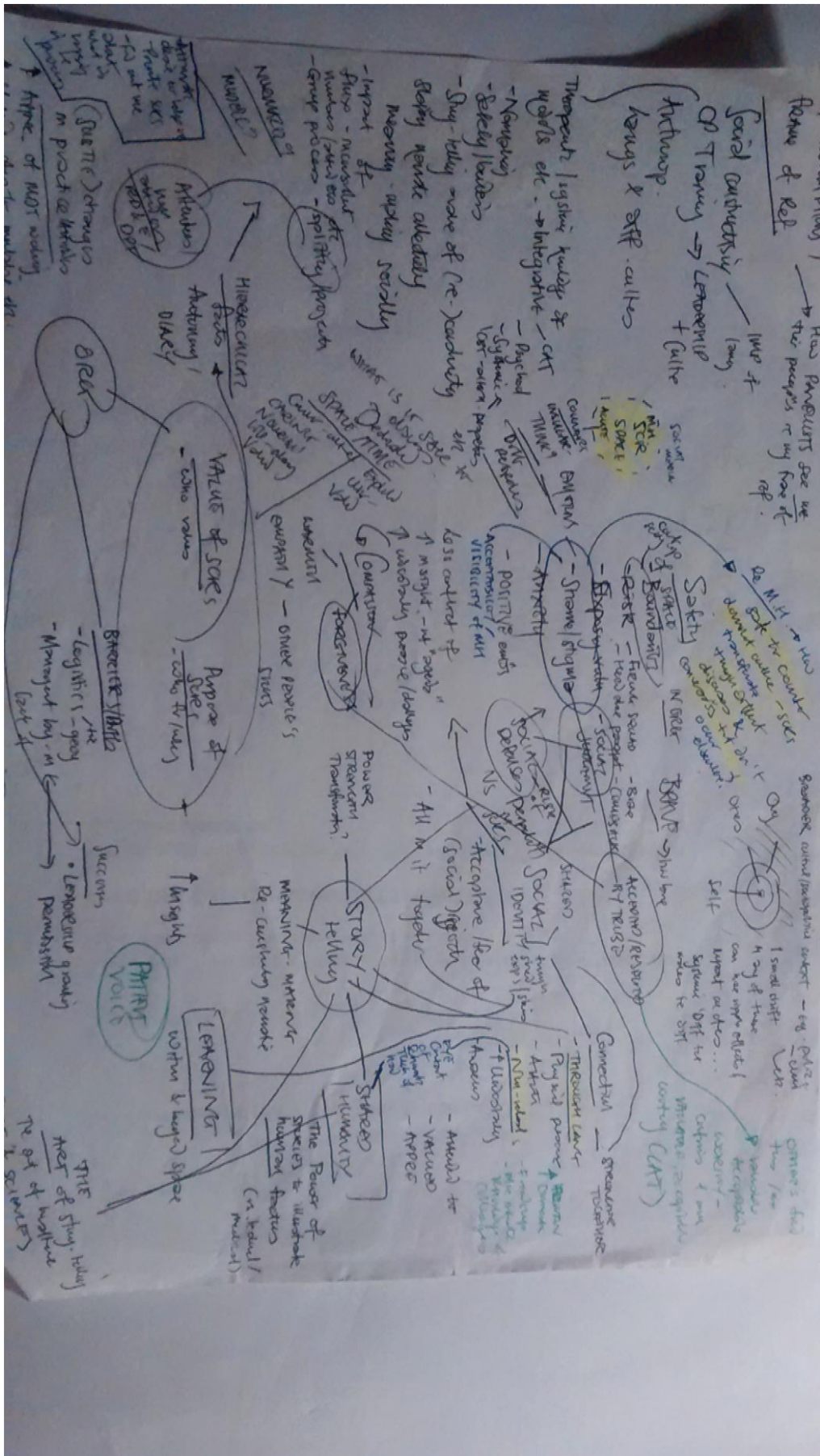
20. **Do you have any questions?**

**Thank you for your participation.**

**Appendix I: Braun and Clarke's (2006) Thematic Analysis Checklist**

<b>Process</b>	<b>No.</b>	<b>Criteria</b>
<b>Transcription</b>	1	The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for 'accuracy'.
<b>Coding</b>	2	Each data item has been given equal attention in the coding process.
	3	Themes have not been generated from a few vivid examples (an anecdotal approach), but instead the coding process has been thorough, inclusive and comprehensive.
	4	All relevant extracts for all each theme have been collated.
	5	Themes have been checked against each other and back to the original data set.
	6	Themes are internally coherent, consistent, and distinctive.
<b>Analysis</b>	7	Data have been analysed / interpreted, made sense of / rather than just paraphrased or described.
	8	Analysis and data match each other / the extracts illustrate the analytic claims.
	9	Analysis tells a convincing and well-organized story about the data and topic.
	10	A good balance between analytic narrative and illustrative extracts is provided.
<b>Overall</b>	11	Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly.
<b>Written report</b>	12	The assumptions about, and specific approach to, thematic analysis are clearly explicated.
	13	There is a good fit between what you claim you do, and what you show you have done / ie, described method and reported analysis are consistent.
	14	The language and concepts used in the report are consistent with the epistemological position of the analysis.
	15	The researcher is positioned as active in the research process; themes do not just 'emerge'.

Appendix J: Initial Thematic Mapping



## Appendix K: Tables Outlining Codes in Transcripts with Examples

Table K1

Theme: Psychological Safety, Culture/s and Leadership

### Individual Level Subthemes and Examples

#### Anxiety/nervousness: 1, 2, 4, 5, 9, 10, 12

\* "I was quite *nervous*, erm, I didn't worry too much leading up because everything was a bit [inhalation], but, yeah, a day or two *before*, I felt quite nervous, erm, just sort of apprehensive, size of audience, erm, how would they react, erm, how would I feel, you know." (P8)

\* "I think it was just walking into a situation where suddenly, you're in the front of this *big* room, and you're in the panel, which I wasn't expecting. I don't think I was told, "Oh you're going to be in a long line of people" [laughing]. It was a bit like, "I'm about to be shot." [...] That was like the trepidation. Suddenly there's an audience in front of you, and I thought, you know, I've done, of course I'm used to presenting, standing up in front of people, but that's different because you know what you're doing, and I suppose it was... It was a bit about, I thought I knew what I was doing, but I didn't, if you know what I mean." (P12)

\* "As I kind of mentioned, it, kind of, you know, your emotional response to different situations is not something that junior doctors, erm, *talk about*, particularly often [swallows], so I did feel *a bit*, I don't know, I don't know what the word is, erm, I guess I was slightly nervous about, erm, about talking about it in front of them all, but actually, it was, it was fine."

#### Fear of exposing "real" self/vulnerability: 1, 2, 3, 5, 7, 11, 12

\* "It *does feel*, it does feel quite exposing [...] I think in a profession that's not used to, that sort of forum. I think we're much, definitely, doctors are much more used to problem-solving, and, um, presentations, and discussions about facts, and the way we've resolved certain clinical situations, and actually, a Schwartz Round is very different to that sort of thing, so it does feel quite exposing and it does feel like something you're not used to doing." (P2)

\* "Am I, am I exposing myself as an, as an idiot, or, erm, you know, it's very exposing and there's risk of shame." (P3)

\* "I think some people had said to me, "Oh I would never go on the panel because I'd feel like I'm too exposed [...] I was thinking, "Gosh, it's quite exposing," because, you know, when you start to reflect and think about difficult things that have happened, you know, people react differently, don't they? But don't get me wrong, it was positive." (P12)

#### Professional mask (managing identity/others' perceptions): 1, 2, 3, 4, 7

\* "It's a five minute presentation that I decided to make in that way, decide what to say and what not to say. To be *more* [emphasized] revealing about myself, it has to be within a relationship, and one-to-one, or in a small group."

\* "I think that *outwardly*, lots of people, well over half, yeah, well over half would outwardly portray this, tough, and "nothing affects me and it shouldn't affect me", kind of attitude, but actually *deep down*, I think that people are quite, I think things do affect people, you just have to know people quite well before they [laughs] would divulge that." (P2)

\* "We all come across people, including patients, that we don't necessarily like, but it's important to maintain that professional veneer." (P4)

#### Courage/bravery: 2, 10

\* "I think that I, I felt that I, had put my head above the parapet slightly [...] I felt pleased that I'd done that. I felt like it was, um, kind of, a, a vaguely, um, [laughing] courageous

thing to do. I was, I was pleased that I had, erm, so I guess I, I guess I see myself as a bit of an *advocate* amongst the [medical] population.” (P2)

\* “I took part in it, I put my head above the parapet, I tried to understand, er, what was, what was going.” (P10)

**Respect/appreciated/valued:** 1, 2, 4, 5, 6, 8, 10

\* “[It] just reinforced, you know, good working relationships, professional respect, and that I felt very respected by them.” (P8)

\* “I did get the sense that people were attending to what I was saying [...] I got some nice comments back on the feedback sheets afterwards, and that was nice to have. Um, it felt, respectful, I think, you know, it was mostly a room full of medics who, perhaps, they might experience that patient group in an emergency department setting.” (P1)

\* I got positive feedback from my immediate professional peers, of my same profession. [...] they said, “You did great,” and, “What you were saying was really valuable,”

**Relevance/worth (of story):** 1, 5, 11

\* “[There] is something potentially shameful, isn’t there about telling a story, is it an important enough story?” (P11)

\* “I did feel, you know, is this, because we have these two organizations here, is, is this not so relevant? But then, I guess, feeling is feeling, isn’t it, regardless of the content.” (P1)

**Relational Level Subthemes and Examples**

**Psychological safety of space and support vs. risk of social judgement/ stigma/ shame/rejection/critical attack:** 1, 2, 3, 4, 5, 7, 10, 11, 12

\*\* I felt very safe in the environment, and I didn’t feel attacked. I didn’t feel like I was getting *glares* or anything at all like that. What I was worried about at that moment in time, and, I didn’t worry about it afterwards, was that I kind of had that moment within me, when I was thinking ... I was thinking, “Ohhh, if I say this, are there going to be repercussions?” (P4)

\* “I know they wouldn’t because it’s not in the spirit of it, and you are not there to look at the medical management but if, um, anybody’d been critical, I would have felt confident of being able to defend what had been done.” (P9)

\* “[Since presenting] I probably wouldn’t be so worried about being judged, you know, it’s clearly an environment where people, you know, aren’t judging you.” (P1)

\* “I think I wanted to just think, “Well, what are these all about? What is it that we’re actually talking about?” You know, “What sort of subjects are coming up? How hard-hitting are they?” You know, “How safe are they, really?” Because I’m always interested in, you know, when you have events like this, how safe people feel in a room.” (P12)

**Seeing others as brave/respecting others:** 4, 8, 9

\* “I think they thought, some of them thought we were brave.” (P8)

\* “I think [my colleagues] thought I was very brave.” (P3)

\* “The, the Schwartz Rounds [...] some of the others that I’ve listened to on areas, you know, not my own area, you know, I’ve come out, you come out very much in awe of people who work in different specialities who are dealing with equally challenging situations and you just think, ‘Gosh, I’m glad I’m not dealing with that day-to-day’ [laughs].” (P9)

**Leaders modelling:** 2, 4, 10

\* “I think a lot of the time, it feels like something you *shouldn’t* say, but, coming from your colleagues, and especially, kind of, colleagues that you respect, or senior colleagues, it’s quite useful to think that then, erm, yeah, it more allows you to, talk about those things.”



\*“I think it was received well. I think there was ... I think, I, I ... It was pretty *raw* and pretty *honest* and the feedback I seemed to get was that people appreciated that, particularly junior doctors seeing a senior doctor being pretty honest about their own experiences.” (P10)

### Organizational level Subthemes and Examples

**Culture clash/conflict** (disciplines/specialities/organizations): 1, 2, 6, 7, 9, 11

\* “I *know* that the organization has got a lot of stresses, erm, so I imagine that the issues are quite complex really, you know, about people’s readiness to show their vulnerability in a public setting, all that sort of thing, I think the dynamics in the two cultures (of the RD&E and DPT) might be quite different and I think there’s something really strong and healthy in bringing them together in this way.” (P11)

\* “This would just be so good for inpatient nurses-, you know, people who are *really* face to face with distress *all* the time, and tried, where you get those macho cultures sometimes in inpatient units because, you know, they have to [laughs].” (P1)

**Sociocultural norms and values clash/conflict**: 1, 2, 3, 7

\* “[As] a junior doctor, you will be attending all these fairly difficult things and there’s very, very rarely a debrief, and everyone just carries on, with whatever they were doing, before [laughing] that thing happened, and I think that, I guess there’s that pressure of you not wanting to be seen as the weak one that needs to take [inhales] a few minutes out to have a cup of tea, when everybody else is managing to get on with it. Erm, and I think that that attitude is probably what carries on into the Schwartz Rounds[↑]. I think that people potentially see it as [inhales], erm, a sign of a weakness [said with uncertainty], I guess having to discuss certain issues that come up, um, which I think is, obviously, quite [laughs], quite an unhealthy attitude [laughs].” (P2)

\* “[It] was like [specific specialism doctors] are quite good at hugging trees and being very, you know, team-orientated but you can imagine that that doesn’t suit all specialities. Erm, and, er [laughs], it felt actually to *me* that, erm, er, you know, potentially this sort of approach wouldn’t be .. favoured, or accepted, or, [sighs] erm, sort of people wouldn’t buy into the concept because .. it’s a bit woolly. I’m not saying it is. It could be seen as being a bit woolly [...] I was a bit sceptical for myself, erm, because, erm, well, just because I think it was, sort of, very new, and I was quite sceptical from, erm, looking at a sort of divisional level, an organizational level, to the sort of people who would actually buy into it and go. Erm, so that was, sort of, my initial reaction.” (P7)

**Normalizing emotional expression and discussion/saying the “unsayable”:**

1, 2, 4, 5, 11

\* “[They] said, ‘You did great,’ and, ‘What you were saying was really valuable,’ and things like that. But, how I was feeling is just human, I think, especially when you work in a caring profession. I guess you expect to always... It’s a difficult thing to say, isn’t it, when you verbally express, especially to others... It’s difficult just to think that you dislike somebody, and that actually, it’s probably a good thing that they’re not able to hurt anyone anymore. And then, it is a bit harder to even take that next step and verbalize it to other people.”

\* “It’s quite *taboo* to say that you have any negative feelings towards a patient, I mean, obviously, you wouldn’t *act* on them, and you’d treat them as you’d treat anybody else, but sometimes it’s quite healthy to say, actually, “That, that quite irritated me, and I needed to, erm, I needed to discuss *that* with someone rather than just continue to remain irritated.” Erm, and to, kind of, hear a consultant say that they felt that way, to, to, junior colleagues, is, is quite, erm, is quite, nice, to hear that everybody’s actually human, and are going to feel those emotions sometimes too.”

Table K2

*Theme: Reflection, Learning, and Development*

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### Individual Level Subthemes and (Further) Examples

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#### **Self-awareness/ self-understanding:** 1, 2, 4, 7, 9, 10, 12

\* “With reflection comes self-awareness, so for me that’s the learning, so what have I learnt as an individual about what I’ve just been talking about [...] my experience has been generally very positive because I think you learn alot, but you also have the opportunity to share.” (P12)

\* “It was good for my own self-reflection, my own self-learning, if you will. I hope it continues to gather momentum and strength, really.” (P4)

#### **Personal/professional growth/development:** 2, 3, 6, 7, 10

\* “I think I achieved something personal, got something out of it personally.” (P10)

\* “I think it’s given me a, a *greater* awareness of the *importance of being*, um, kind of, a kind and compassionate doctor [which] makes me feel more satisfied in the job I’ve done, um, with people, and I think, yeah, it makes me feel more positive about my professional role.” (P2)

“I suppose I was challenging myself actually, erm, because it felt like the right thing to do, er, to be involved in, and, erm, er, you know, it would be easier not to, wouldn’t it? It would be easier not to go .. but it felt like it was, you know, actually, it, it was the right thing, and, erm, just to sort of work out how [inhales], er, you know, how one responds to it.” (P7)

\* “I think I might have mentioned that, from an achievement’s perspective, when I did my PDR.” (P6)

#### **Increased confidence:** 1, 4, 5

\* “I certainly felt a little bit more confident coming out of it. I kind of had this moment, thinking, well, every time you do a little bit of public speaking, you get better at it, and a little bit more confident. But, I also felt, actually, it’s kind of like saying something uncomfortable out loud, you just get a little bit better and a little bit more confident in saying it. It’s kind of like practising breaking bad news to people.” (P4)

\* “I don’t feel quite so inferior as I did then prior to that, and it probably boosted my confidence to be able to... my opinion and my experiences are just as valid as, as theirs, and I think it does highlight that just because you are a band 3 or a band 8 it doesn’t mean you have any different subjective experiences and that mine isn’t any less valid than theirs and theirs isn’t any less valid than mine.”

#### **Pride:** 2, 10

\* “I was really *pleased* that I’d done it [...] I felt like it was, um, kind of, a, a vaguely, um, [laughing] courageous thing to do. I was, I was pleased that I had.” (P2)

\* “[There] was a sense of professional, erm .. professional pride, er, a bit of risk-taking, and that I’d stepped out of my comfort zone a little bit and that I’d done the right thing by doing it.” (P10)

#### **Increased understanding of others, their roles, needs, challenges and/or the organizations:** 1, 2, 6, 7, 9, 10, 11

\* “I think I learnt an awful lot. I learnt an awful lot about how the acute hospital works [...] and the organizational political demands that were being made, putting particularly medical staffing, you know, under alot of pressure.” (P10)

\* “I think it’s, I mean, you always feel you have respect for your colleagues but it does, there’s a *greater* depth to it now, and understanding, to certainly what my medical colleagues do, most definitely.” (P1)

\* “I feel like that with some of the panellists as well that have been there, so I developed a more, sort of, intimate awareness and understanding of their worlds than I *ever* had.” (P11)

\* “You appreciate that, when you get to know people and, names, and, you know,

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sit round a table, you can appreciate the pressures that other people are on.” (P6)

**SCRs as thinking/learning/sharing space valued:** 1, 2, 4, 5, 6, 7, 9, 10, 11

\* “I think the fact that it was sharing of experiences and was, was *useful* sharing was the positive side of it.” (P6)

\* “I became a panellist fairly early on, and have attended many since, and definitely see their value.” (P2)

\* “I appreciate the benefits of reflective practice and having that kind of forum [...] that would have been my first experience of it and I found it a positive experience. So ..[inhales] and, again, I probably hadn’t reflected on it until *now*, that that being the kind of starting point for [engaging in and appreciating reflective practice], but it probably was the starting point for it, and it probably has stemmed from, from that.” (P5)

**Shifted perception of value:** 1, 2, 5, 7

\* “I went in with sort of, expectations that we would know it all and we wouldn’t be seeing anything new, I think my perception shifted a lot, as I said, around there, and the value it brings, and the difference it brings, as long as, you know, the facilitators are holding it to be that.” (P1)

\* “The sort of change in my way of thinking occurred earlier, you know, after the, after the first Schwartz Round that I went to [...] I can see that they’re actually really valuable.” [...] After the first sort of, erm session, er, and I went back, er, you know, I was sort of, *I got it* [↑].” (P7)

### Relational Level Subthemes and Examples

**Teaching others/communicating a message:** 3, 6, 9

\* “It was a professional thing. I didn’t do it for my personal benefit. It was to convey .. what it’s like to be someone like me in my kind of workplace.” (P3)

\* “[One] of the points of doing it was to get a bit of a message across and I felt we did. You know, I feel if you are going to do something like this, you’ve got to have a theme or a message or something to it, you know, as well as the sort of, as well as the chance to air some of the difficulties and offer support to people.” (P9)

**Learning from/about others:** 1, 2, 5, 7, 8, 11, 12

\* “I think, you know, you can actually gain quite a lot from just going and listening to what other people have to say.” (P2)

\* “I’d recommend to everybody to go along, especially people in the work that we do with the general public on a day-to-day basis because, you know, you can just learn so much even if you just go initially to observe what’s happening.” (P12)

**Sharing perspectives (cognitive empathy) and strategies:** 2, 4, 5, 6, 10, 12/  
**challenging insular thinking:** 2, 5, 6, 9, 10, 12

\* “I think it just enhances, with other colleagues, of really appreciating the pressures they’re under and why they do what they do, you know when things are, it just enhances that mutual understanding.” (P 11)

\* “[It’s] almost like a bubble, and you just, kind of, are in that service, you’re only kind of orientate in that service and it’s just nice to get a different perspective from, and the challenges in other areas, the positive things in other areas, what might work in something else which could also work in .. a different service.” (P5)

\* “I think that’s very beneficial, any sharing. I think we do get very insular. There, there’s lots of different pressures.” (P6)

\* “[We’ve] all become so... yes, we are all so super-specialized now that it’s um, it is very interesting to hear people, other, other disciplines and other areas and some of the challenges that they are facing, yeah.” (P9)

**Team development:** 4 Quoted in main body of thesis.

**Opening up discussions on difficult/ethically-challenging subjects:** 6, 9, 12

\* “I think for *our* one it elicited quite a lot of questions ’cos of the ethics, the sort of ethics side of, because he was a [...] transplant, the [patient] we talked about, and

whether you should have transplanted [that patient] in the first place type of ..Yeah, but, um, so there were quite a lot of, erm, facets to the story, which I think spurred on some conversation.”

### Organizational level Subthemes and Examples

**Permission, time and, space to stop, think and share – not available elsewhere:** 2, 4, 5, 7, 11

\* “I think that’s, that’s what sort of what comes through for me, that, you know, actually it’s a sort of safe hour, to, er, to, er, just reflect, actually. And it might not even be the subject matter; it’s almost just the process of being given permission to have that hour.” (P7)

\*“It’s the best opportunity for people to stop and go to something that they can just reflect on.” (P4)

\* “I think it’s also interesting for them to see how much the RD&E physical health staff *value* what we deliver [...] ’cos it’s missing that, that, that reflective space, clinical supervision is missing in physical health provision.”

**Cross-service/cross-organizational learning/development:** 3, 5, 6, 7, 8, 10, 12

\*“I think I just had a little glimpse into the complexities in the different organizations, but, but, that will be similar in my organization, so I think I had, as I say, feel more compassion to the pressures managers are under and, er, I have transferred that to my organization from another organization.” (P10)

\*“There was somebody that was working in the department which is for innovative work [...] and somebody came up to us to offer his help [...] We’ve got Ready Steady Go paperwork and it’s all started to be embedded. So, that’s come from it, I suppose, and come after it, so that’s useful, and that feels good that that was the beginning of the journey.”

\*“I think it’s really excellent, erm, er, anything that we can do that strategically and visibly demonstrates mental health and no health without mental health and mental health and physical health working together I think is incredibly important, and, erm, *for example*, the RD&E are just about to do some strategic work about the provision of mental health care within the Trust. [I] was approached to join that working group initially because of my visibility through doing Schwartz.”

**Broader organizational and beyond healthcare conversations:** 1, 2, 6, 10

\* “I was talking to a friend of mine not so long ago whose husband is a policeman, erm, I don’t know exactly what his job is, I think he’s some sort of detective [inhales], he was saying they have, sort of, um, compulsory debriefing sessions and, kind of, compulsory counselling in certain, more difficult areas of the police, and whilst I am not sure that we necessarily need *that*, I think that’s quite good because that’s probably also quite a macho environment, you know. I guess making it compulsory normalizes it, hmm, and I think definitely medicine needs to go .. *some way* to making it okay to, kind of, talk about, erm, how you’re emotionally affected by your work.” (P2)

\* “[He’s] in the police, and he’s very interested, [...] to understand the emotional effects on his officers of serious incidents and things, and they do have some things in the police, but not a huge amount, and he was asking me about Schwartz, and I said, “Well, you know, actually, it probably could work really well.” But then, you know, we’d have this whole thing with copyright and all the rest of it.”

**More holistic thinking – mental health and physical health:** 2, 3, 7, 9, 10, 11, 12

\*“I think it’s really, really important and I think it really helps people to be thinking about whole systems, so, possibly mental health is forgotten, and we all know that without good mental health, you know, it impacts on physical healthcare and vice-versa, you know, part of me thinks that those sorts of things *are* the bridges really to trying to engage with other departments and to share experiences of, you know, perceptions.” (P12)

\* “There’s virtually no area of medicine, really, where there isn’t crossover between the mental health side and physical health and yet we seem to have... in many ways we’ve

sort of geographically separated it by putting them all in separate hospitals or out in the community and then you don't get the cross-working between the staff. So, you know, I think that's one of the strongest aspects of it here." (P9)

Table K3

*Theme: Storytelling, Connection, and Compassion*

### Individual Level Subthemes and Examples

#### **Power and value of space to construct/tell/share story:** 1, 4, 10, 11

\* "It was something that I really enjoyed. I really valued the opportunity. Um, I really enjoyed speaking about my, oh speaking about is not the right word, I really enjoyed sharing my experience." (P4)

\*\*"The actual process, once we got into it, was, was very good, and I thought gosh, that's a really good, um [tuts], use of time, um, of, of sharing some really, really, um, quite... Well, um quite a powerful intervention really." (P12)

\*\*"It was a confirmation of the value of speaking up about your own story, the value of other people listening warmly and connecting with it." (P11)

#### **Feeling listened to, seen, and heard:** 1, 3, 5, 8, 11

\* "So there's something about having undiv-, someone's undivided attention, which is quite rare really, apart from, obviously, in your family or whatever, so to sit there and be listened to, even if it is only five minutes, is a very *powerful* thing to be, to be involved in, to, to, you know, feel that you're having, some sort of, hopefully, good influence, you know, with what you're saying. So, it was a powerful thing, yeah." (P1)

\* "I liked being listened to [laughs]." (P3)

#### **Validation/acceptance:** 2, 3, 5, 11, 12

\*\*"It was probably, erm, more validating, about "Gosh, that was quite a difficult experience but you clearly handled that well and obviously, you know, you've got some good strategies around managing it and continuing to manage it." So, it was generally more validating, I would say." (P12)

\*\*"[You] come out feeling, yeah, validated." (P11)

#### **Catharsis/processing emotion:** 1, 4, 8, 12

\* "I think the presenting bit was quite cathartic [...] I think it was very good to be able to share quite a difficult experience, an ongoing difficult experience with somebody who had been accessing the services." (P12)

\* "Funnily, it's probably been quite cathartic, like a full stop. [...] Yeah, because we'd done a lot of, *reflection* and *thoughts*, and she's been a case we've *discussed* and, you know, we get, we do get other challenging [patients], she is probably *one of the most* challenging, but, erm, er, yeah. So, it does feel like a bit of a full stop in that case now. I, I probably won't keep thinking *back* on her *now*, yeah." (P8)

\*\*"I think just verbalizing those feelings and experiences that I'd had with that particular case, I just felt better inside. Even though I'd been through that consolidation process and reflection work and so on, I think just being able to express that in a safe space, in a context where it was being discussed, was really valuable." (P4)

#### **Self-compassion/self-care/self-forgiveness/:** 2, 3, 10, 11/ **difficulties with this** 2, 3, 6, 7, 8, 12

\*\*"[There's] very much a culture of just, kind of, getting your head down and getting on with it, and not really stepping back and reflecting, not, really, erm, taking time out during those shifts, just, kind of, have a cup of tea, feel like you have to be on the go constantly, but I think being *part* of the Round, and discussing how stressed I felt at various bits of that shift, and other people saying, "Oh yeah, that does sound like it

probably would be really stressful,” kind of, it made me think it was, erm, yeah, important to, er, look after myself a bit more in those situations, I think that’s been a good change for me.”

\*“I just don’t ever get there clinically, it’s middle of the day and, there’s always 18,000 things to do instead and it feels very selfist.” (P6)

\*“It’s very hard to care for yourself, which I think is quite a big thing, isn’t it, you know, in the Rounds, we’re very good at looking after people but not looking after our self.” (P3)

\* “I’m very good at supporting other people, you know, I meet other people and I can be [inaudible] and encouraging, you know, give pointers too, and I’m very good at thrashing myself in a reflective way but I’m not very good at celebrating my good points [laughs].” (P8)

#### **Feeling supported/compassion/empathized with:** 3, 6, 8, 9, 10, 11, 12

\*“I appreciated the sense of empathy that I did get from the audience and the sense of, you know, the sense of people there sort of saying, or sort of thinking, actually you’re doing well in a difficult situation.” (P9)

\* “Just, sort of, again, the occasional nod, or, you know, erm [tutting], er, and people sitting, the closer ones, a bit forward in their seat, definitely empathy towards us.” (P8)

#### **Relational Level Subthemes and Examples**

##### **Sharing Stories/power and value of:** 1, 4, 5, 7, 10, 11, 12/

1, 2, 4, 8, 11

\* “We had one, we had one Schwartz Round, I just can’t remember the topic of it, but it was about spending time with people, and it was around that. I remember after that, that had just been really, really powerful, and working with a couple of patients who were just either really upset, or I just had the feeling that it was really important for their therapy that they had the opportunity to sit and talk with somebody for 10, 20 minutes. So, I think, just, *allowing* the time for that.”

##### **Empathic resonance (emotional empathy)/shared emotion/ Non-verbal feedback):** 1, 2, 3, 5, 7, 8, 9, 11, 12

\* “There’s something really warm and emotional about somebody else *really* taking your story seriously and *visibly* resonating with it. So then that trust that there are other people who will get it, who will get what matters to you and resonate, and then that sort of, resonance is the word, it makes it feel worthwhile[↑] opening up and sharing, you can feel better because of it, you can feel, safer in the world, that there are good people [laughing] in the world, that we are all in it together, all of that, just because a person makes, you know, [...] doesn’t have to be words, you know, they make good, warm, eye contact with you, and you come out feeling, yeah, validated, connected, but stronger as well.” (P11)

\*“[Lots] of the other members of the audience just were very, erm, encouraging[↑], or they nodded alot. There was one in particular, they were definitely doctors, they were near the front, and they were quite, they nodded, I’m nodding my head now while I’m telling you this, they nodded [inhalation], and that made me *feel...* erm, *reassured*, and, erm, you know, a little bit, yeah. Err, and definitely, erm, [tutting] I could definitely tell it was resonating with them.” (P9)

##### **Common ground/shared human experience/less alone:** 1, 2, 3, 4, 5, 6, 7, 8, 12

\*“I think that you, you gain a sense of camaraderie, all being in it together, when you’re listening to other people discuss their responses to things, and identifying with those responses, erm, and I guess, you find it quite, reassuring in a way, that, erm, although maybe it might not be talked about, day to day at work, that other people are, feeling in a similar way, to you, in response to, kind of, clinical situations, and, er, that’s quite reassuring, I think.” (P2)

\*“Some came up afterwards, erm, and said it reminded them of such a thing, and it was nice to think about, you know, that they weren’t actually on their own, and how difficult

it was for us. We'd been honest and, erm, so that made me, sort of, just glad I'd done it really." (P8)

\* "And so, for me, it was positive, erm, to be able to share that and to know that there are other things going on for other people, equally, just as difficult, so you don't feel alone and it's just you or .. what's the word I'm looking for? "Oh, it must be me because I can't handle this very well." [...] I think that's what the Schwartz Rounds can be very powerful about, that actually, you know, you're not alone quite often, there are lots of parallels and similarities with other things going on with people." (P12)

**Compassion/empathy/caring for others:** 1 (+patients), 2 (+patients), 4 (+patients), 5 (+patients), 7, 10 \* "I think I hold it more in mind now. I definitely hold the acts, the small acts of kindness, compassion .. in mind, to really, sort of, practice what I preach. And, I've got a colleague who's disabled and we're very close and, you know, he can't get up to wash his cup and things, so I've gone in today and he works part-time and he's got a mouldy, old coffee cup on his desk so I'll always, when I'm in, wash his cup out if he's not there, and it's just little things like, it's a tiny, little, little thing, but you think, it's just the tiny things that make the difference."

\* "I think that in particular has made me more aware of, just, if there's a procedure or something I have to do, just having, kind of, a nice, little reassuring chat with somebody while I'm doing it, the importance of doing things like that, erm, so I guess, you know, much like, the, kind of, motto of the Schwartz Rounds is compassionate care, I think, erm, just bearing in mind, whilst *you* have a list of jobs to achieve and you might be very busy, erm, and *you* know exactly why you're doing all these things to patients, but actually it's important to also explain it to them really well and make them feel comfortable, and not make them feel like *another* job on your list." (P2)

**Time and space to connect with others:** 2 (patients/colleagues), 4 (patients)

\* "I saw [the resus officer] a couple of days later in the corridor, and, erm, I was definitely in a rush to get somewhere, and she looked like she was too, but, erm, I just felt it was quite important for us to stop and have a little chat *about it* [↑], maybe in a way that I wouldn't have before [...] attending the Schwartz Rounds, just because, so many other [inhales] pressures can stop you from doing things like that." (P2)

**Forgiving/understanding/supporting others/challenges to this:** 1, 2, 4 ((+patients), 6, 7, 10, 11

\* "I suppose it just sort of, you know, serves to remind me that actually, you know, [...] everyone's got their own story, I think, that's what it is. Everyone's got their own story, and you don't know what it is. So why is that person not performing as you would expect them to? Well, erm, you know, it's because you don't understand, er, you know, what's happening for them. [...] I would hope that [empathizing is] something that I'm already quite good at, but it just sort of reminds that actually you're probably not [laughs]." (P7)

\* "think it just enhances, with other colleagues, of really appreciating the pressures they're under and why they do what they do, [...] it just enhances that mutual understanding, I think, I like to think I was quite good at that anyway but maybe I am a bit more forgiving, I'm a bit more encouraging of others." (P11)

**Improved relationships/connections:** 2, 6, 7, 11

\* "It enabled me to have, probably a better relationship with the [...] physician and, erm that's a positive in that I felt a bit more familiar [them] having [taken part in the Schwartz Round] with [them] rather than, um, just sort of in a discharge planning meeting, I think there was a bit more .. of a relationship there from, from doing the process with [them], you know, sort of mutual appreciation type."

**Camaraderie:** 2, 11

\* "I quite enjoy, one of the things I love most about it is the real sense of partnership with other professions, my, you know, friendship with [colleague], who I didn't know at all before, [they've] now become a family friend [...] I feel like that with some of the



panellists as well that have been there, so I developed a more, sort of, intimate awareness and understanding of their worlds than I ever had.”

#### **Common social identity; no “us/them”:** 1, 5, 6

\* “Even just working together is positive, because it’s not us and them anymore, it’s a shared sort of [...] shared challenges. You know, and you appreciate that, when you get to know people and, names, and, you know, sit round a table, you can appreciate the pressures that other people are on.” (P6)

#### **Organizational level Subthemes and Examples**

##### **Power of stories to transform 11/ Levelling hierarchy: “Just people”:** 1, 5

\* “[It] didn’t really feel in that kind of forum that there was necessarily a hierarchy; it was just people in a room. [...] It’s, it wasn’t like, I don’t know, 7, 8, 7, 6. It was just, they’re just people in a room that you’re talking to and then you’re listening to them and again they’ve all got their similar experiences, so it dissipates, like, a bit.” (P5)

##### **Compassionate, caring culture vs. target-driven, business culture (theory vs. practice):** 1, 2, 3, 4, 7

\* “There’s pressure to, complete therapy in a certain number of weeks. The kind of complexity our clients come with, can’t be done. We’re doing these questionnaires at the end of therapy at the moment, and one of the main themes of the questionnaires is, “It’s *great*, we want more.” [Laughs] if you’ve had the kind of trauma our clients have had, I wouldn’t be able to exist, couldn’t make it out the door. [...] to just get a relationship with them and communicate with them, takes about six months to a year [laughs] just to get to that level, let alone doing the deep psychological work. Er, so there is a lot of pressure, and then that comes down to resources.”

##### **Disconnect frontline staff/management - “us”/“them”** 1, 3, 4

“Mainly, I think they’re thinking about how to save money. It’s all about *SMART* thinking, and .. *LEAN* work, and [...] hotdesking, doing all the things we can to, er, save money. I’m not that aware of, sort of, compassionate thinking ..which is odd for a mental health trust [laughs] there are targets that come from outside our Trusts, they have to meet [...] those are *important*, but they can feel like a bit of a stick..and there’s not much of a carrot. ”

##### **Systemic/ sociopolitical pressures/resource constraints affecting connection/empathy/compassion:** 1, 3, 4, 6, 10, 11, 12

\* “You know, it’s hard, it’s hard to care for each other, when we’ve got all the pressures, you know, coming at us. Erm, er, you know, as it has, it is in anywhere in the health and social care sector, you know, the pressures are just relentless, um, and there aren’t enough hours in the day, and there aren’t enough people on the ground.” (P7)

\* “Just being with the person. I think, though, that’s going to be a real challenge in the coming health environment, that I can see, sort of, coming. Especially in an acute hospital, with pressures for discharging people, and wanting people out as soon as they’re medically fit. So, I think if the new chief executive, whoever that might be, came onto the ward and saw me having a sit and a chat with a patient for half an hour about whatever, I think they’d probably flip their lid, if I wasn’t working on getting them better, or whatever.”

##### **Lack of patient voices/stories:** 4, 10

\* “I just wonder, what would the value be in having patient Schwartz Rounds. Would there, I don’t know if you can do it mixed, I don’t know if that would then make it not a very safe space for professionals to be truly honest and open. But there was interest there.” (P4)

##### **Organizational responsibility to care for staff:** 1, 3, 7

\* “[They] need to invest psychologically in staff because, work is very psychologically

demanding, funnily enough, and if they don't want staff to burn out, they've got to look after them." (P3)

**Appendix L: Models of SCRs in Adaptive and Less Adaptive Contexts**

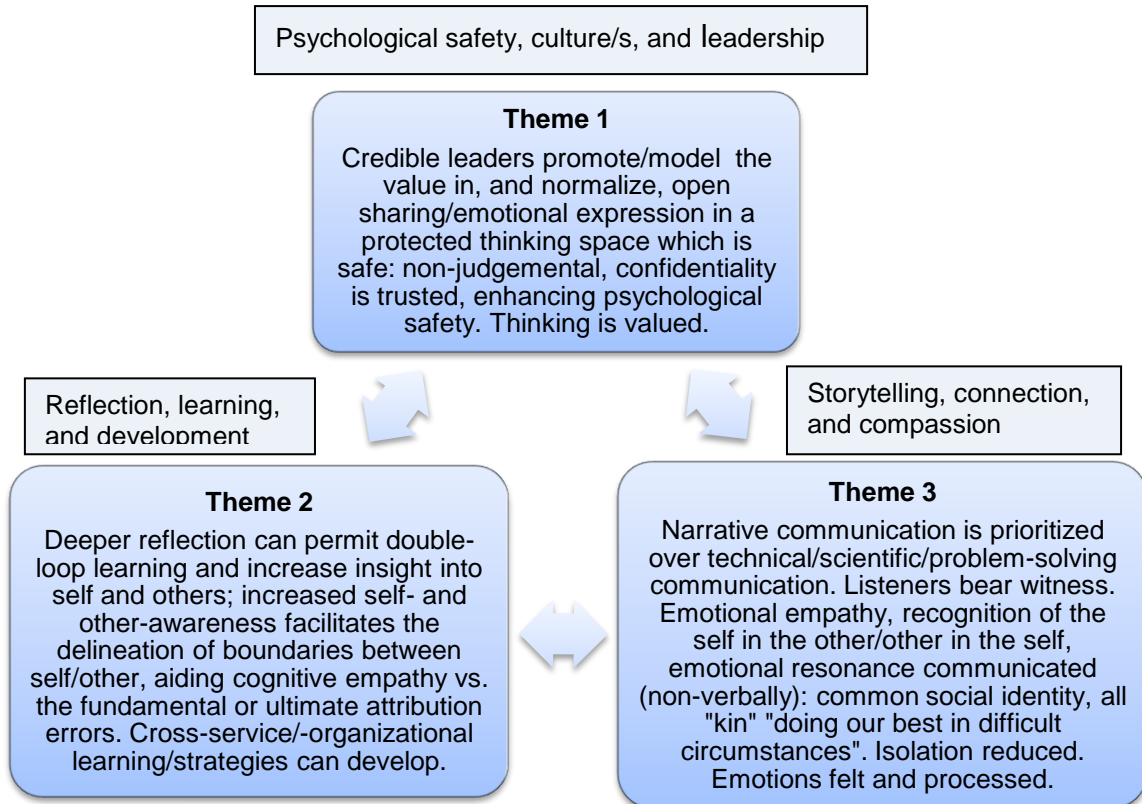


Figure L1. Model of SCRs functioning in adaptive context.

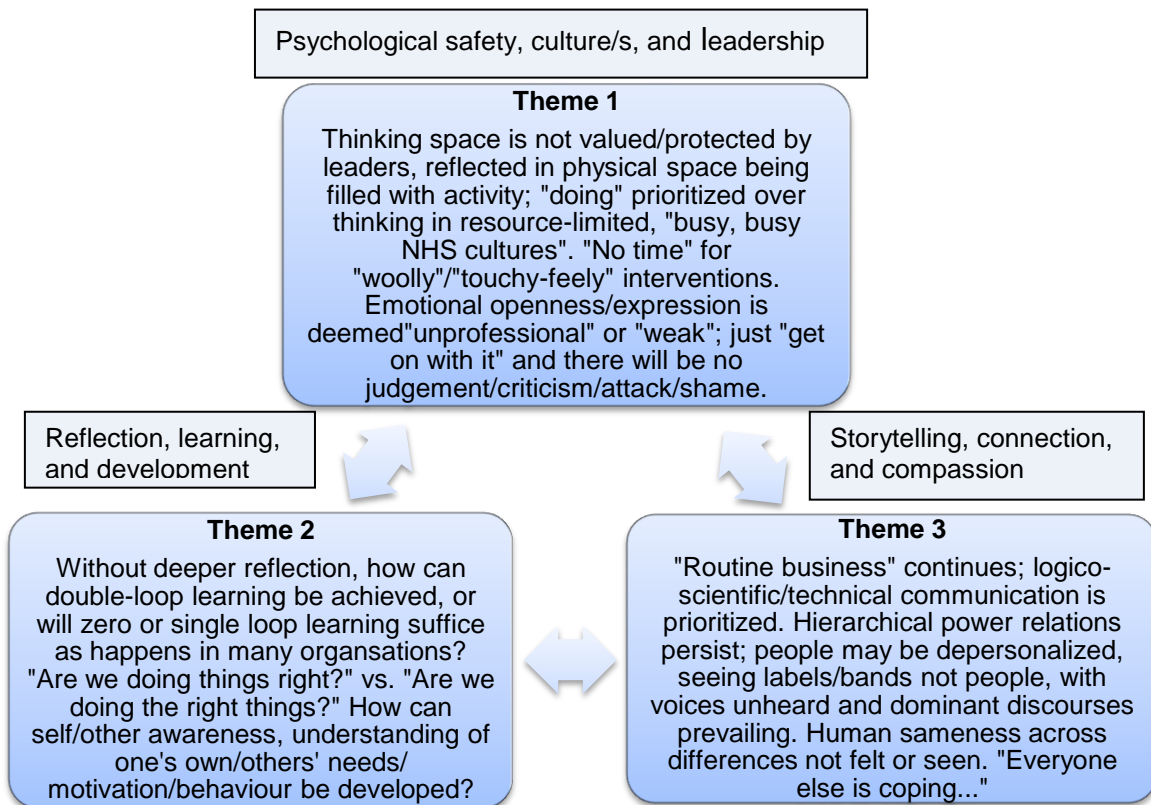


Figure L2. Model of SCRs not functioning ( in a less adaptive context).



**Appendix M: Table of Enablers and Barriers to Accessing RD&E-DPT****Schwartz Center Rounds**

<b>Enablers</b>	<b>Theme</b>	<b>Barriers</b>
<p>Consultants in both Trusts described as aware of SCRs, e.g., through discussions at meetings; perception of high RD&amp;E consultant-other staff ratio. Some participants described promoting SCRs to colleagues, e.g., placing SCRs posters from email updates in ward areas. One participant described informing new starters of SCRs at RD&amp;E induction events.</p>	<p>Awareness/knowledge of SCRs</p>	<p>Panellists perceived many staff in both Trusts as unaware of SCRs. Awareness did not necessarily indicate knowledge of what SCRs were/whom for/their purpose. Not all staff (e.g., non-clinical/support workers) access Intranet where SCRs advertised. Not all previous panellists receiving SCRs updates/aware SCRs still running, including someone in a senior position (in DPT). Panellists had not all discussed SCR experiences with colleagues.</p>
<p>Two participants described it being easier to “present” to “strangers”, i.e., staff from a different organization/seniority level unknown. One participant indicated reflection easier with external facilitators.</p>	<p>Audience members (familiar/unfamiliar) and SCRs size</p>	<p>One participant described awareness of people’s positions/seniority as anxiety-provoking. Another described not being able to engage in more meaningful sharing in a formal location with so many people. Others said SCRs size could inhibit people from speaking up/sharing.</p>
<p>Six participants discussed the importance of leadership/management/executive-level support, whether in terms of senior staff modelling participation and attributing value SCRs/giving psychological and/or actual permission to attend; one senior leader described the importance of being granted “permission to have that hour” as a safe</p>	<p>Cultural differences/staff mentality and leadership/management/ Executives support/position</p>	<p>Seven participants discussed barriers in four areas: *(Sub-)cultures within healthcare and their concomitant norms/values precluding participation, e.g., “macho”/medical cultures viewing emotional expression/discussion as weak/unprofessional/not valuable/unhelpful; * Perception of SCRs as “routine business”/not offering anything</p>

Enablers	Theme	Barriers
<p>space to stop and think. Executive-level champions to promote and support SCRs.</p> <p>One participant described senior staff, “more comfortable in their skin”, with more developed professional identities, would be “more comfortable to go out on a limb for things they want to do than more junior staff.”</p>		<p>qualitatively different from reflective practice/supervision in mental health;</p> <ul style="list-style-type: none"> <li>* Viewing participation as “selfist”/difficult to prioritize something “life-enhancing”/positive when competing work demands;</li> <li>* Experiencing/perceiving managers/leaders/chief executive as unsupportive.</li> </ul>
<p>Eight participants discussed facilitators’ contribution to their feeling supported/encouraged/validated/appropriately prepared for/debriefed following SCR panellist experience. Debriefing had not always been carried out- considered important in processing panellists’ experiences.</p> <p>Two participants discussed how discussion or their own sharing could have been enriched if facilitators had “supportively [probed]” or facilitated more direct conversational/thematic linking between themselves and attendees.</p>	<p>Facilitation and safety</p>	<p>Five participants discussed difficulties as follows:</p> <ul style="list-style-type: none"> <li>*Telephone vs. face-to-face preparation. Facilitators unable to be present for preparation impacted on their experience/sense of validation;</li> <li>* Not feeling safe in terms of guidance/expectations of panellists’ role (possibly linked to participant’s seniority) being clearly explained;</li> <li>*Introductions at SCRs using medical titles after being told to use first names/level the hierarchy;</li> <li>* Feeling boundaries/confidentiality of SCR space not clearly set, inciting anxiety about what might be taken beyond that context.</li> </ul> <p>Regarding SCRs at a different organization, one participant expressed how people felt unsafe due to one facilitator being in a senior management position/with multiple roles; attendees/panellists feeling they could not trust confidentiality would be</p>

Enablers	Theme	Barriers
<p>One participant explained that although she had felt obliged to present (with reservations) as she did not wish to decline the offer from a senior colleague she respected, the experience turned out to be immensely positive and transformed her view of SCRs. Another participant described feeling “pleased” to be asked.</p>	<p>Feeling obligated</p>	<p>upheld.</p> <p>Five participants discussed feeling obliged or the obligation prospective panellists might feel when when facilitators “twist[ed] their arms” to present. One participant emphasized the importance of people being given opt-out, especially if a topic was pertinent/“raw” for them.</p>
<p>Three participants reflected medical consultants/senior staff more able to attend SCRs than others due to their autonomy in managing their time (connected to their social location/hierarchical power).</p> <p>One participant suggested flexibility in timing and duration of SCRs would facilitate participation of nurses, e.g., 30-minute SCR matching lunch break, or later SCRs following an early shift (15.45-16.45).</p> <p>One facilitator described how without the “obligation of being part of the organization” of SCRs, it might be hard to value them and “an easy thing to drop off [the] agenda” given their “busy working life”.</p>	<p>Seniority level/job demands/job cover/timing</p>	<p>Nine participants discussed how work pressures precluded SCRs attendance even for interested parties wishing to attend. Two managers described how, although they encouraged and tried to facilitate staff attendance, a lack of cover and shift patterns meant staff could not necessarily be released even though they felt they would benefit.</p> <p>One participant used the metaphor of an iceberg, describing SCRs as only reaching the “tip”, and “cutting off a whole pool of people” who were in lower positions in the hierarchy and/or non-clinical staff who needed to undergo “rigmarole” to gain permission to participate.</p>
<p>One participant reflected how it was “easier for RD&amp;E” staff to attend SCRs given their location. One DPT employee</p>	<p>Logistics</p>	<p>As well as timing, five participants discussed logistical issues, e.g., parking difficulties/geographical</p>

Enablers	Theme	Barriers
observed DPT employees based at Wonford House, the same Exeter site as the RD&E, did not appear to be attending.		distance to Exeter from diffuse work bases hindering DPT staff from attending SCRs. Similar issues were cited in terms of arranging group-level SCRs preparation.
Three participants discussed the lecture theatre as enabling: “containing environment”/facilitating eye contact with attendees/contributing to “normalizing”/assimilating SCRs in a location associated with educational/scientific events.	Lecture theatre/ location set-up	Five participants reflected on difficulties with the location whether due to formality of lecture theatre-difficulty feeling relaxed - feeling highly exposed/on a stage/having “others looking down” on them. Two participants said they would prefer to be in a circle or have others sitting at the same level.
All four SG participants reflected on the positive gains SCRs organizational involvement had brought them including camaraderie/new friendships/one participant described it as a “salve”.	Steering Group (SG)	Three participants who were also SG members reflected on the burden of resources or “additional stress” involved with SCRS, whether engaging in SCRs as a “voluntary activity” in their own time or with it taking time from other professional demands which could trigger angry responses from colleagues. One participant described how it had been said DPT was not receiving “value for money”/ return on investment like the RD&E.
Three participants described how they/others would try to attend SCRs when the topic was particularly relevant to them, “especially if it resonates”.	Topic of SCRs/ perceived relevance	Three participants discussed the topic and/or relevance of SCRs; two described topics as often “hard-hitting”/ “traumatic”/ “extreme”, and the need for this to be balanced. One stated she did not discuss her SCR presentation with colleagues as she did not think it would hold relevance for them. Another described feedback from a colleague who felt an SCR had not been “clearly

<b>Enablers</b>	<b>Theme</b>	<b>Barriers</b>
		advertised” and they had “wasted an hour of clinical time”.

### **Appendix N: Notes on Transcription**

↑	Indicates a rise in intonation
<i>Italics</i>	Indicates emphasis in speech
..	Brief pause
...	Long pause
[..]	Ellipsis of speech

Punctuation follows the manner of speech of individual participants.

### **Appendix O: Dissemination statement**

Further to the embargo period, the final thesis will be available via the Online Research Exeter database and may reach academics, clinicians, patients, the public, and any interested parties.

In June 2017, the research findings will be presented to an academic and clinical audience for peer review, as part of the Doctorate in Clinical Psychology at the University of Exeter.

The findings will also be orally presented to the RD&E-DPT Steering Group.

The results will be disseminated to participants, the RD&E-DPT Steering Group, and the RD&E and DPT R&D Departments, who will also be informed of the completion of the study.

The target journal for dissemination of the study's findings is the *Journal of Health Services Research & Policy* which fosters a multidisciplinary approach in investigating current issues affecting healthcare research and policy.

**Appendix P: *Journal of Health Services Research and Policy* Instructions  
for Authors**

<https://us.sagepub.com/en-us/nam/journal/journal-health-services-research-policy#MANUSCRIPTSTYLE>

*The Journal of Health Services Research and Policy (JHSRP)* publishes scientific research on health services from a wide variety of disciplines and rigorous health care policy analysis. The Journal also engages in, and responds to, current scientific, methodological and policy debates in health care. The Journal aims both to reflect current concerns and to contribute to setting the agenda.

**1. Draft papers and abstracts**

Only manuscripts submitted online in accordance with the guidelines below will be considered for publication. The editorial office will not provide individual advice or feedback on draft papers or abstracts before submission.

Please submit your paper through our journal website (<http://mc.manuscriptcentral.com/jhsrp>) to ensure rapid consideration - we operate a fast response system whereby the editors decide within 3-4 weeks whether to send the paper for peer review, or reject at the first stage because of lack of suitability. Note that papers which do not adhere to word and reference limits and are not in the correct format are likely to be rejected outright.

As we are a multidisciplinary journal, and there are 3 main criteria we look out for:

- the importance and originality of the research/policy question;
- the extent to which the implications of the findings for policy or practice have been drawn out and have been justified;
- and the degree to which the paper would be understood by an international audience which is not necessarily familiar with the health system in question - the paper needs to avoid being parochial and focus on the underlying issue of international interest.

**2. Peer review policy**

All papers submitted for publication undergo peer review.

All Original Research, Essays and Review articles are initially reviewed by one or both Editors who select two appropriate reviewers unless the manuscript is of poor quality, outside the scope of the *Journal*, or not considered sufficiently original or important given the space constraints of a quarterly journal, in which case it is rejected without peer review. Generally, we choose one reviewer who can comment primarily on the methodological aspects of the paper and one who can primarily assess its policy relevance and implications. We invite authors to suggest two reviewers, one of whom we may use. Most of our reviewers are based in Europe, North America or Australia/New Zealand and are suggested to us by members of the Advisory Board and other established researchers in the field.

For ethical reasons, attempts are made to mask reviewers to the identity of the authors by excluding the names and affiliations of authors and acknowledgements from the



manuscript. Our aim is to make initial decisions on manuscripts within 12 weeks of receiving them.

The contents of the manuscript should be treated as confidential and should not be discussed with anyone else without prior permission from the editors. Reviewers are asked to comment on the following issues:

1. Importance of the research/policy question
2. Originality of the research/policy question
3. Strengths and weaknesses either of the study design, data collection and data analysis (for research papers) or the policy analysis/commentary (for policy papers)
4. The writing, organization and presentation of the data in the paper
5. The extent to which the implications of the findings have been drawn out and have been justified
6. The degree to which the paper would be understood by an international audience which is not necessarily familiar with the health system in question (not applicable for systematic reviews)

Reviewers are not asked explicitly to give their opinion as to whether or not the paper should be published.

The Editors aim to decide on each paper within 4-6 weeks of receipt of the second review. Three decisions are available: accept; resubmit; and reject. Authors are sent the editorial decision together with copies of the two reviewers' comments (anonymised). The Editors usually send individualised feedback letters to authors, if the authors are being invited to resubmit the paper. Reviewers are sent the other reviewer's anonymised comments for information.

#### *Covering letter*

The covering letter is important. To help the Editors in their preliminary evaluation, please indicate why you think the paper suitable for publication.

#### [Back to top](#)

### **3. Article types**

**Please note that all word counts include the abstract, main text and references.  
Please do not exceed the word limit.**

#### *Quantitative empirical research*

Papers could be up to 3000 words *inclusive* of abstract, main text, and up to 30 references, plus up to six figures, and/or tables and boxes

#### *Qualitative and mixed methods*

Papers can be up to 5000 words *inclusive* of abstract, main text and up to 30 references, plus up to two figures, and/or tables and boxes

#### *Essays (i.e. commentaries and theoretical pieces)*

Essays can be up to 4000 words *inclusive* of abstract, main text and up to 30 references

*Systematic reviews*

Reviews can be up to 5000 words *inclusive* of abstract, main text and up to and 50 references

*Editorials*

These should be 800-1200 words including up to 12 references

*Perspective articles*

These require an unstructured abstract and can be up to 2000 words including up to 30 references. Please consult [section 8.8](#) for more details.

*Worth a Second Look articles*

Articles can be up to 1500 words including up to 12 references. Please consult [section 8.6](#) for more details.

*8.7 Climate Change and Health Services articles*

These contributions can be original research articles, reviews, essays or editorials. Please consult [section 8.7](#) for more details.

## **5. How to submit your manuscript**

Before submitting your manuscript, please ensure you carefully read and adhere to all the guidelines and instructions to authors provided below. Manuscripts not conforming to these guidelines may be returned.

Only manuscripts submitted via the online manuscript submission and peer review site, which can be found at <http://mc.manuscriptcentral.com/jhsrp> will be considered for publication.

All submissions must be in English. Text should be double-spaced with a minimum of 3cm margins. Text should be standard 10 or 12 point.

To allow for blinded peer review, details of authorship (for each author: one qualification, job title, appointment at the time of the research, current address and email address) and acknowledgements must not be included in the main manuscript, but must be supplied separately.

When submitting a manuscript, the title page, main text, tables or boxes, figures and acknowledgements must be saved and uploaded as separate files:

- Title page file – Manuscript title, Author(s)' name; author's position, department, institution and country; Name, email, telephone and fax of corresponding author
- Main text file – Manuscript title, Abstract, Main Text and References (minus author details, acknowledgements and any running heads of author names, to allow blinded review)
- Keywords (approximately 3 keywords)
- Tables [or Boxes] – separate file(s)
- Figures – separate file(s)
- Appendix – separate file(s)
- Acknowledgements – separate file
- Supplementary file – supplementary material can be added.

## 9.2 Journal Style

### *Title page*

The first page should contain the full title of the manuscript, 3 keywords, the author(s) name(s) and affiliation(s), and the name, postal and email addresses of the author for correspondence, as well as a full list of declarations.

The title should be concise and informative, accurately indicating the content of the article.

### *Abstract*

Original research and Review articles should include a structured abstract (objectives, methods, results, conclusions). Essays and Perspectives should include an unstructured abstract.

### *Tables and Boxes*

Tables and Boxes should be outwith the text. Tables must be prepared using the Table feature of the word processor. Tables should not duplicate information given in the text, should be numbered in the order in which they are mentioned in the text, and should be given a brief title.

### *Figures*

Figures should be outwith the text. All figures should be numbered in the order in which they are mentioned in the text. All figures must be accompanied by a figure legend. If figures are supplied in separate files, the figure legends must all be listed at the end of the main text file.

Line drawings should be produced electronically and clearly labelled using a sans serif font such as Arial. Graphs may be supplied as Excel spreadsheets (one per sheet). Other line drawings should be supplied in a suitable vector graphic file format (e.g. .eps)

All photographic images should be submitted in camera-ready form (i.e. with all extraneous areas removed), and where necessary, magnification should be shown using a scale marker. Photographic images must be supplied at high resolution, preferably 600 dpi. Images supplied at less than 300 dpi are unsuitable for print and will delay publication. The preferred file format is .tif.

### *Abbreviations*

Symbols and abbreviations should be those currently in use. Authors should not create new abbreviations and acronyms. The RSM's book Units, Symbols and Abbreviations provides lists of approved abbreviations.

### *Units*

All measurements should be expressed in SI units.

### *Statistics*

If preparing statistical data for publication, please read the statistical guidelines (section 8.8).

## 9.3 Reference Style

Only essential references should be included. Authors are responsible for verifying them against the original source material. SAGE uses the Vancouver referencing system

([http://www.uk.sagepub.com/repository/binaries/pdf/SAGE\\_Vancouver\\_reference\\_style.pdf](http://www.uk.sagepub.com/repository/binaries/pdf/SAGE_Vancouver_reference_style.pdf)): references should be identified in the text by superscript Arabic numerals after any punctuation, and numbered and listed at the end of the paper in the order in which they are first cited in the text. Automatic numbering should be avoided. References should include the names and initials of up to three authors. If there are more than three authors, only the first three should be named, followed by et al. Publications for which no author is apparent may be attributed to the organization from which they originate. Simply omit the name of the author for anonymous journal articles – avoid using 'Anonymous'. Punctuation in references should be kept to a minimum, as shown in the following examples:

1. Handy CB. *Understanding organizations*. 3rd edn. London: Penguin, 1985
2. Hart E. Ghost in the machine. *Health Serv J* 1991;**101**:20–1

## **9.4 Manuscript Preparation**

The text should be double-spaced throughout and with a minimum of 3cm for left and right hand margins and 5cm at head and foot. Text should be standard 10 or 12 point.

### ***9.4.1 Your Title, Keywords and Abstracts: Helping readers find your article online***

The title, keywords and abstract are key to ensuring readers find your article online through online search engines such as Google. Please refer to the information and guidance on how best to title your article, write your abstract and select your keywords by visiting SAGE's Journal Author Gateway Guidelines on [How to Help Readers Find Your Article Online](#).

### ***9.4.2 Corresponding Author Contact details***

Provide full contact details for the corresponding author including email, mailing address and telephone numbers. Academic affiliations are required for all co-authors. These details should be presented separately to the main text of the article to facilitate anonymous peer review.

### ***9.4.3 Guidelines for submitting artwork, figures and other graphics***

For guidance on the preparation of illustrations, pictures and graphs in electronic format, please visit SAGE's [Manuscript Submission Guidelines](#).

Figures supplied in colour will appear in colour online regardless of whether or not these illustrations are reproduced in colour in the printed version. For specifically requested colour reproduction in print, you will receive information regarding the costs from SAGE after receipt of your accepted article.

### ***9.4.4 Guidelines for submitting supplemental files***

This journal is able to host approved supplemental materials online, alongside the full-text of articles. Supplemental files will be subjected to peer-review alongside the article. For more information please refer to SAGE's [Guidelines for Authors on Supplemental Files](#).