This is the first in a series of interviews with experienced facilitators of the Schwartz Center Rounds. The purpose is to give new facilitators insights and guidance on how to prepare for Rounds and facilitate discussions.

The interviewer is Kathryn Kaplan, PhD, Chief Learning Officer at Maimonides Medical Center in Brooklyn, New York. She facilitates the Rounds with the physician leader, Alan Astrow, MD, Director, Medical Oncology and Hematology. They began the Rounds in January of 2008.

The interview is with Robin Hasenfeld, PhD, psychologist in private practice, and the facilitator for the past eight years for the Rounds at Winchester Hospital in Winchester, Massachusetts.

Interview with Robin Hasenfeld, PhD
Facilitator at Winchester Hospital

K: How do you select cases for the Rounds?
R: I'm an outside facilitator, but I know the small community hospital well. I am familiar with its faces and characters, but not attached to the groups in the hospital. I attend our committee meetings three to four times a year. We plan about three topics at a time and meet from September through June, taking December and the summer off. Our committee generally picks a topic that they think would be of interest to the community, and then we brainstorm about presenters and possible cases. On occasion we work from the case "up" and extract a topic from that—using a recent or past case (when a child dies, for example) and get for presenters the clinicians who were involved. The committee is really good about mixing up the disciplines (e.g., nurses, doctors, patients, homecare, social work, chaplains, etc.). We are finding that at times it is hard to get presenters, due to time, interest, and being a small community hospital, there are only so many people. We are trying to transition to a model where we ask different floors or services in the hospital to develop rounds topics based on what is going on for them.

K: What's your role on the committee?
R: My role on the committee is to flush out the topics and at times to help prepare for topics that I know might be risky for the group, usually because they fear the emotions that may come up. We talked in our committee for about a year before being ready to tackle the case where a teenager died in the ER. I think people needed to be reassured that we could all handle the strong emotions that people had with this situation. In the end, the discussion was very moving and very meaningful for the presenters and the rest of the group.

K: How do you prepare for the Rounds?
R: My approach, as a psychologist, is that I don't prepare by researching and reading. I listen to the discussion when we have the Rounds planning meetings. To prepare the panel I call the speakers by phone. I ask them if they've been to

the Rounds. I then describe the purpose of the Rounds and the format, and I emphasize that these Rounds are non-traditional and not focused on teaching content. I talk a bit about the mission of the Schwartz Center and about Ken Schwartz's story. I usually describe the Rounds as "reflecting rounds"—a place to reflect on what we do as caregivers and how that impacts the relationship with the patient. I tell the panel that we usually have about 60-70 people attend. Then I listen to the presenter talk about the case and ask some questions about it.

I usually ask them to talk about their experience with the particular patient in order to make it more personal. This is when I emphasize that the story of their involvement with the patient is a jumping off point for the discussion, which is really the centerpiece of the Rounds. I also tell them that I will lead the discussion, but that they can feel free to chime in as they please. I try to make them feel as comfortable with the format as possible.

At a recent Rounds, on "medicine and the arts," we had a physician who also is a musician, and a cancer survivor who is a painter. The doc talked about how playing music helped him listen better (how amazing is that!), and the artist spoke about how her art helped her healing. I had asked her to bring some paintings along (which she did). Due to a mix-up of sorts (too complicated to explain), I didn't have a chance to ask the doc to bring in a recording of his music, but I would have if I had had the time. It is always nice to make this real for people.

I also always try to have a few questions in mind for the dreaded silence, but mostly I go with the flow.

K: How do you facilitate the Rounds?
R: In the first year, at every meeting I would tell the group why we are here. I talked for a few minutes about the purpose of the Rounds as a time for reflection; one hour each month where we can sit still and think and talk about how we interact with patients and other staff members, and what impact that has on ourselves as providers and on our patients. I sometimes said that there may be many perspectives on one situation and hopefully, as we talk, we will learn something about how our colleagues experience their work. I also threw out the thought that clinical situations are very complicated and that our discussion will hopefully show how some of these complications play out.

I introduce speakers and the topic, call on people, and ask questions. If the discussion is jumping around, I ask if others want to respond to a particular issue. I try to get the group not just to fire questions at the speakers. I might interrupt, for example, and say, "Before the panel answers, is there anyone else who can answer from the group?" Or I might say, "We've heard from a lot of nurses, would another discipline like to speak?" I try to get different voices and professions to share their different perspectives. I don't want them to just share wisdom but to react to each other. I guess I'm working to decrease the hierarchy in medicine by getting people to talk directly to each other.

We have, on occasion, had patients come in to speak. I think that it takes a lot of trust for the group to do this, because, as we found out from a few, their experiences with providers are sometimes very lacking--and they say it! Our last "patient presenter" described how she went to another hospital because her treatment at our facility was not caring enough for her. Hence, the trust issue. It takes a mature group to hear uncomplimentary things and still want to ask questions. However, it is really helpful to have patients describe what makes them feel cared for, and what turns them off. In these rounds, we find that providers ask a lot of questions to the "patients", and even though I want to encourage participants to talk to each other, this kind of discussion really nails down "what works" into details and clear descriptions, so I usually let the participants ask away.

In trying to set the tone for the sessions, and in trying to make the mission of the Rounds overt (how to be "present" with people, how to bring compassion into our work-lives for patients and colleagues), I sometimes read a small piece from a newspaper article or something I have recently read. I might get a quote from a magazine article or read a short poem. For our recent Rounds on how to help patients at the end of life (and how to help their families, and even ourselves, to say goodbye), I read a small section of an article from the Boston Globe about a husband's search to help his grieving wife, who had lost both parents in a short time. The message of the article was that sometimes there is not much you can do, except to "be there." We don't always have to do something to show someone that we "get" what they are dealing with. He gives the example of holding his wife's hand and giving her a tissue at a particularly tough moment. Lots of heads were nodding when I read it, and that was before we even started.

I have to say that I am very lucky to be working with a staff that is open to this kind of discussion. We have had staff at all levels talk about personal situations and emotional reactions to patients and colleagues. The committee was careful to select some very good role model presenters for our first few Rounds, and that helped set the tone from very early on.

K: How do you observe what's going on in the moment and assess what it means?
R: I bring paper and jot notes to myself as the Rounds progress. I scan the group and read non-verbal behaviors. Do they seem bored, engaged, or reactive? I assess the group all the time to see what reactions are happening. I just keep staying as fresh and interested as possible.

K: What do you do with difficult moments? For example, what do you do when people go on too long and dominate the conversation?
R: I might interrupt and say, "You have a lot to say, people look like they want to respond. Can you please summarize?" If I set it up ahead of time with the panel, we agree to tease, "Remember our deal?!" Let me clarify--when I talk to people beforehand, sometimes they say something like "I'm worried that I will go on too long." That is when I set up a deal -- something like, 'So I will work with you to help make sure that your comments are detailed enough, but not so long that

people don't have a chance to respond. Is that ok with you?' I've only had to do it a few times. There is one time I should have done it, but didn't, because it was early in my facilitator "career" and I wasn't as confident. It is hard to know when to interrupt and how to do it respectfully. But it is important to keep the conversation going and let other people speak.

K: What do you do if people are coming from an expert, distanced role in their comments?
R: "Tell us your experience. How did you react?" I tend not to use the word "feelings" in our environment. If the person is very intellectual or distanced, I might interrupt them to ask about their experience. There are not rule books on what to do, so I trust myself and what has worked in the past. I might add, "We don't have to be focused on solving problems here. We can take time to pick apart different pieces of this situation in order to help us think about how to handle it better in the future. I want people to talk, reflect, and get how complicated it is to work with people in a compassionate way. It is helpful to have some talk about "how have you handled situations like that?" to get some ideas going about different options, but there are other forums for teaching and working out solutions--committees, CME conferences, etc.

K: What if the person is provocative? We have people who challenge each other or criticize what the panel has done with the case.
R: "Interesting perspective, but how can you disagree with each other and stay open to the other person's point of view? How can you work this out so we don't lose sight of the need to work together for the patient?"

K: We had one person suggest the panel shouldn't feel the way they did.
R: "You are suggesting not having feelings, but that is not possible given the situation. If we think of professional relationships, it does matter how you deal with it. How can we learn from each other about disagreeing without attacking?"

K: And if it escalates?
R: "I want to ask you not to label your colleagues with jargon; let's find a way to humanize this." Or "Wait a second; are you saying if he feels upset, we should ignore his feelings? We want to legitimize human feelings to enlarge our sense of compassion with each other and with patients and their families."

K: Do you think it's a good idea to have a few "plants" in the audience that would prepare ahead of time where we want the discussion to go and to raise questions or share experiences at tense moments?
R: You would have to see if that would interrupt the natural flow of the group. Instead, I might make sure that in your introductory remarks, you say that people have different points of view. The purpose of the Rounds is to listen to different perspectives and not demean them. We are learning here what to do as a team to treat the patient. Make the theme of respect overt.

I would also add that some of the beauty of the Rounds is that we never know where they are going to go. I think that people get the gist of that over time. I am less concerned about getting certain points across in terms of content, because we usually circle around the same issues time and again---
'How do we improve our ability to listen to patients? What do we do that gets in the way?" If you have things in mind that you would like the group to consider, those might be formed into questions that you might ask the group in a quieter moment, or when you think it is time to switch the perspective. So, you might not need "plants." Give yourself permission to ask or point out something you think is important. At the same time, sometimes, in my experience, these things flop. So, you also have to give yourself permission to have a question go nowhere. It is ok, the group will go to where it needs to go, and you have many, many other opportunities to create the culture you want.

K: Tell me about the role of the facilitator in summarizing at the end. What do you tend to do?
R: First I might review the content points, e.g. "We've had a discussion today about 'when doctors disagree, do sparks have to fly?' We've heard how hard it is to disagree because of egos, or because we're friends and don't want to hurt each other." Then I might challenge the group, e.g., "We get used to our point of view, to be decisive is part of our training. What we find out in this discussion is that to be open also shows respect. We give richer care to the patient when we speak honestly and respectfully as well as take better care of ourselves and our colleagues."

I often make a few comments about content kinds of things, I sometimes add "process" comments (e.g., the tone of the group, or about interchanges between certain people), and I try to remember to ask "What have you thought about today that you might take into your work/personal life?" Unfortunately, sometimes I forget this one. I heard it from another facilitator and really liked the feel of the question. It encourages people to keep reflecting.

K: Let me ask you the question I would have asked if we talked prior to our last Rounds, When Doctors Disagree: Do Sparks Have to Fly? What questions might you have prepared for "the dreaded silence?"
R: "Has anyone been a patient when doctors disagree?" I don't make it complicated. For instance, we had a case about helping patients die. The chaplain had a model she had used a lot and taught in the hospital about how to help people say goodbye. I was concerned that this might turn into a forum to teach the model, so I had a few questions up my sleeve, such as, "What's it like to say good-bye to a loved one? Where do families get stuck? How does the team say good-bye to a patient who dies? Does anyone have any personal experiences they are willing to share?"

K: So you are really saying the role of the facilitator is to help shape the culture through the themes we emphasize in each discussion.
R: Basically, I see the role of the facilitator as underlining certain things. The

more we use the participant's words, the more we emphasize certain concepts. By repeating and reinforcing certain ideas, we can create the culture of curiosity and respect, even if there is disagreement. In fact, the disagreement often reminds people that depending on where you come from, your perspective on a situation can be very different from someone else's.....and, perspective is not right or wrong. We can also be explicit about the mission, by stating the values of cooperation, tolerance for complication and emotion in our work lives, and compassion.

Yes, and know it’s normal to be nervous. Calm yourself down by remembering you are facilitating the Rounds for a reason. You’re a person who gets the concepts. Show the group how complicated things are. How we make decisions about what to do is not easy. We sometimes need to slow things down to really learn from the process. As facilitator, you can have an impact on the group dynamics from the introduction, being mindful how you respond and move the discussion forward, and how you summarize. Sally Mack, the facilitator at Massachusetts General Hospital, shared with me early on that her underlying message is that you’re not in this by yourself. That’s her key point and she repeats it at the end of every Rounds. My key point is reflection and talking to each other. Your key point at Maimonides may be about respect.

K: This conversation has been so inspiring, I would like to interview more experienced facilitators to help new facilitators develop. I want to find out their strategies and how they use themselves in the service of the group.
R: That’s a great idea. First, I would think facilitators need to learn the mechanics by talking to each other. Next, I think they need to get reassurance that they are finding their own rhythm and that they each bring something unique to their Rounds over time. Finally, facilitators get to the point they trust they can handle whatever comes along.

K: Thank you. Being specific has enlarged my sense of how to facilitate. It’s a process and role that I hope continues to grow in me with confidence while staying curious.
R: My pleasure. I didn’t realize how much I would get out of reflecting on facilitating and how I’ve developed over the years.