Debriefing Styles

We are aware that some techniques instructors use are not always focussed on the needs of the learners. Below are some points for reflection.

When you've led a debrief have you ever:

- Felt insincere when you said something to try to make a candidate feel better?
- Said "that was excellent" when it really wasn't?
- Let major problems go without comment because the candidate didn't recognise there was a problem?
- Found yourself doing all the talking in the debrief?
- Asked questions that left candidates puzzled about what you were trying to get at?
- Felt judgmental or patronising?

With the increased focus on learning from reflection after simulation there is recognition that the "how do you feel, what went well, what could you improve on" formula has significant limitations*.

Instructors have often tried to remain relentlessly nice and **non-judgmental.** Unfortunately, this doesn't necessarily help learning. Learners want perceptive feedback; however, the non-judgmental instructor can avoid giving direct feedback by trying to lead the learner to find the answer. The learner is left struggling to guess what the instructor thinks but won't say. As a result, the opportunity for learners to gain from an instructor's valuable insight and expertise is often lost.

It also becomes difficult to maintain the pretence of being non-judgmental as the instructor's judgments leak. For example, an open question about use of a defibrillator in a scenario could be posed, apparently non-judgmentally, as "I wonder whether you thought the way you used the defibrillator was a problem?" The learner then has to guess what it was about the defibrillator that the instructor thought was a problem – the rhythm, the timing, the dose, safety, resumption of compressions. Why not get on with it and just say what could be improved? The following technique can help.

Debriefing with good judgment, aims to explore the reasons for actions through discussion. It begins with you (the person leading the debrief) having respect for the learner and a genuine curiosity about the learner's actions. Then there are three elements to the technique – reactions, understanding and summary.

In the reactions phase, learners will share with you what they initial thought. It can start with a simple question like "how did that go?" Let them talk. They may identify things that you were not aware of, or want to deal with particular issues that you did not think were important. This will help set the direction for the next phase.

At this stage the instructor should acknowledge the learner's thoughts, but not agree or dismiss them. If learners are upset an instructor can normalise the perspective, such as by saying "this happens nearly all the time in this scenario", or "we all make mistakes this is a great opportunity to learn".

The understanding phase can be started in three simple sentences.

"I saw …… "
"I am concerned/impressed because ….." (the advocacy)
"I wonder how you see it?" or "what was going through your mind at the time?" or "what do you think?" (the inquiry)

For example, following an illness scenario of an infant with croup in APLS

"I noticed you continued to try to get IV access, while the child was getting more distressed and the saturations were dropping. I am concerned that a child in that condition may have gone on to have a respiratory arrest."

Then declare your thoughts about what you want to explore:

"what was going through your mind at the time" or
"I'd like us to talk about alternative ways to manage that situation"

These alternatives can direct the discussion in a number of ways, for example considering different approaches to the problems of obtaining rapid vascular access in a distressed child or management of airway and breathing.
By using the conversational technique of advocacy and inquiry you be open and honest about your concerns while placing the focus of the conversation on your advocacy for the patient. This technique also addresses the learner's concerns and make it socially acceptable to acknowledge and discuss errors.

To encourage discussion there needs to be less rigidity about whether positive or negative points are raised and who speaks when. The instructor is more a facilitator **- talking less, open to allowing the learners determine the direction of the learning and identifying what is right for them.**

There may be some specific clinical or behavioural teaching points to make.
The specific points from the scenario could then lead to a discussion of implementation to clinical practice.

The summary encapsulates the take-away messages about what worked well and what to improve for next time. As a follow on from the situation above…

"we've learnt some techniques of how to support a child with airway problems, while minimising their distress to prevent further obstruction."

This style of debriefing takes time to learn. If you're interested in debriefing there are a few references below, including the new version of the ALSG Instructors Guide. Demonstration of a learning conversation is on the apls.org.au website, under Instructor Development.

Key points
Maintain your respect for the candidates and curiosity about what they are doing
Identify the gaps between actual and ideal performance
Listen to what the candidate thinks is important
Be transparent about your thoughts

Give specific feedback about what happened and why you think it is important. Explore why decisions were made. Discuss and teach.
Give a balanced summary with take-home messages

(modified from article in 2010 APLS newsletter_? Author, edited Ben Symons & Jane Stanford)

Further reading & other resources:

Bullock I, Davis M, Lockey A, Mackway-Jones K. - **Pocket Guide to Teaching for Clinical Instructors 3rd edition**. BMJ Books
Rudolph J, Simon R, Dufresne R, Raemer D. **There's no such thing as 'non-judgmental debriefing: A theory and method for debriefing with good judgment"** Simulation in Healthcare 1, 49-55; 2006

Sargeant J, Lockyer J, Mann K, Holmboe E, Silver I, Armson H, et al. **Facilitated Reflective Performance Feedback: Developing an Evidence- and Theory-Based Model That Builds Relationship, Explores Reactions and Content, and Coaches for Performance Change (R2C2).** Academic medicine : journal of the Association of American Medical Colleges. 2015;90(12):1698-706.

Cheng A, Hunt EA, Donoghue A, Nelson-McMillan K, Nishisaki A, Leflore J, et al. **Examining pediatric resuscitation education using simulation and scripted debriefing: a multicenter randomized trial**. JAMA pediatrics. 2013;167(6):528-36.

Eppich WJ, Hunt EA, Duval-Arnould JM, Siddall VJ, Cheng A. **Structuring feedback and debriefing to achieve mastery learning goals.** Academic medicine : journal of the Association of American Medical Colleges. 2015;90(11):1501-8.

APLS Instructor Ben Symons hosts a journal club blog for simulation enthusiasts via
http://simulationpodcast.com
April 2017 discussion centred around Rudolph et al. **There's no such thing as 'non-judgmental debriefing: A theory and method for debriefing with good judgment"** article

http://simulationpodcast.com/2017/04/02/simulcast-journal-club-april-2017-hello-old-friend/
This site will also give you access to podcasts that include discussions with Jenny Rudolph, Adam Cheng & Walter Eppich.

Note:
*Whilst the **feedback sandwich** was used for short/specific feedback
'Tell them what went well
Tell them what they could improve
Re-iterate what they did well, ending on a positive note'
With this model - often the instructor does all the talking and may miss the opportunity for dialogue. Learners familiar with the technique often ignore the initial positive statement, waiting for the inevitable negative comment.

Another structure '**reflective critique'** or **plus Delta** model asks the candidates: "what did you do well, what would you change & what would you do next time". This form of focussed debriefing has been advocated for use with 'rapid cycle deliberate practice' skills teaching - where the aim is for candidates to practice the skill again directly after the feedback has been given. Two points of caution when using this model are:

1. Directing the candidate to 'talk about what went well' may miss the opportunity to learn what the candidate thinks about their own performance (& so limits your opportunity to adjust your feedback to address their concerns)
2. The subsequent questions may come across as having a hidden agenda – where the instructor is wanting the candidate to 'self-identify' what they need to change or do differently next time.