SIMULCOS

Journal Club : The Second Year

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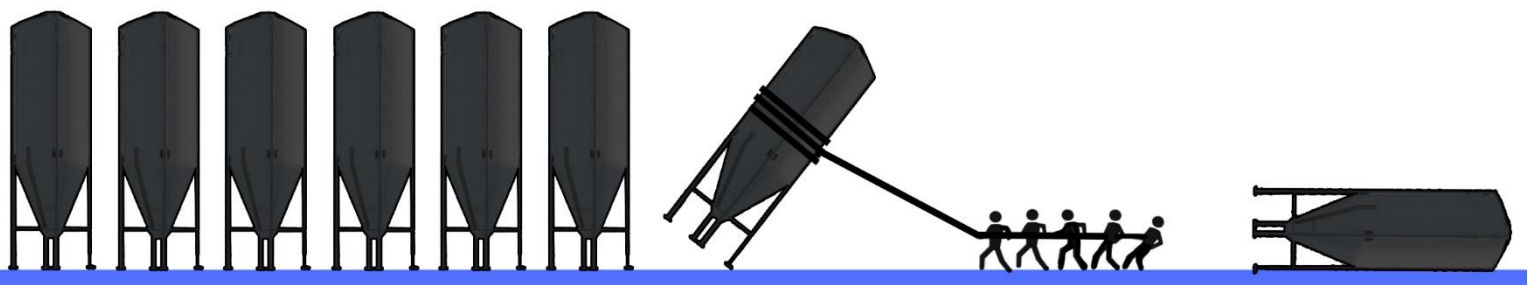

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Introduction

Is there anything more exhilarating than growth? Feeling yourself become someone new as you level up your skills and you can *taste* it! New powers, new places to explore, remembering where you came from and smiling at your old naivety.

That's what it's felt like for me, anyway, these last 2 years of Simulcast Journal Club. When I recorded my first podcast with Vic Brazil, I nervously awaited her to introduce the first paper because in my head I still wasn't sure how you pronounced 'et al'. I was worried it was supposed to be French or something, like you'd pronounce it 'eh Al?'. Turns out it was like Ett. Ett al. Nailed it first take. I'm glad she went first.

Flash forward 24 months and the Simulcast Podcasts have been downloaded over 60,000 times. We've had Sim Royalty engage in the journal club, and we've even been on stage together live journal clubbing in front an audience. It was a little intoxicating, people were so supportive. And I don't stutter in front of Vic now. How things change!

In the following pages you will find 10 summaries of our monthly, open access journal club. We cover some brilliant classics, like Rudolph's 'Safe Container' & Cheng and Eppich's 'PEARLS' paper, but we also look at some fantastic newer topics, like getting into Clinical Debriefing in the Emergency Department, or embracing your inner exhibitionist with 'Intellectual Streaking'.

I hope by reading the case studies, the expert commentaries from geniuses like Chris Nickson & Liz Crowe and by reading the papers themselves, you too will enjoy as exciting a sense of growth and personal fulfilment as I've found in these pages.

Over the last two years I've read at least one paper a month. Not heaps. Just consistently. Achievably. And my world has changed. Not just in how I debrief, not in how I run scenarios, but how I interact with my colleagues, my junior staff and even my friends. Above the table. Leaning in to difficult conversations. Making the Implicit Explicit.

Simulation has changed my life. The community's kindness has helped me irrevocably.
I hope this gives something back.

Enjoy,
Ben Symon

Acknowledgements

Creating the Simulcast Journal Club has been a collaborative venture graced by the generosity of many people. In particular we would like to thank :

- The creators of the AliEM Medic Series for their inspiration and guidance with our online format.
- The network of simulation experts who have provided their expert commentaries and support.
- Our online champions such as Ian Summers, Nemat Alsaba, Susan Eller, Chris Nickson and Eve Purdy for their consistent promotion and interaction.

And most of all, all the simulation educators who have overcome their nerves to post on our blog and contribute to our monthly discussion.

Without any of you there would be no journal club.

About Simulcast Journal Club

The Simulcast Journal Club aims to assist with knowledge translation between coal face educators and academic professionals who are publishing educational research.

CASE STUDY

Every month at simulationpodcast.com we discuss an article with an associated case study to highlight relevant issues. Over the course of the month, bloggers from around the world comment on the article and the case.

PROMOTION

You can follow our twitter announcements on discussions at @symon_ben and @sim_podcast

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EXPERT OPINION

An expert in the field provides their opinion on the issues raised and the article itself.

SUMMARY & PODCAST

At the end of the month, we publish a summary of the article and the discussions in both podcast and written form.

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Journal Club Summary September 2017 "Trouble in Paradise"

The Article :

"It is time to consider cultural differences in debriefing."

Chung HS, Dieckmann P, Issenberg SB.

Simulation in Healthcare , 2013 Jun;8(3):166-70. doi: 10.1097/SIH.0b013e318291d9ef.

Case & Summary Author :

- Dr Ben Symon

Expert Commenter :

- Dr Peter Dieckmann

Editors :

- Dr Victoria Brazil
- Jesse Spurr

First Published : 01/10/17

Simulcast Journal Club is a monthly/ series that aims to encourage simulation educators to explore and learn from publications on Healthcare Simulation Education.

Each month we publish a case and link a paper with associated questions for discussion.

We moderate and summarise the discussion at the end of the month, including exploring the opinions of experts from the field.

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The Case :

It was hot and humid and Dave could tell he was being petulant but the frustration had been building for weeks. A month away from his clinical duties had seemed like a dream come true, but the realities of spending time with the in-laws in South-East Asia had rapidly hit home. It was not bringing out the best in him.

"God I wish your parents would listen to me sometimes. I tell them I'm not hungry, so they order a banquet, and I keep telling them I'm full but they keep pushing food onto my plate! Then they look frustrated when I don't finish the ridiculous amount of food I told them they shouldn't have ordered in the first place! And this was just lunch! They're already planning dinner and that's like… 2 hours away! They're driving me nuts!".

"Gweilos eat to live. Asians live to eat." joked Jess.

Dave fumed. "I get it. I get it. But for 2 weeks I keep saying I don't want any more food and they keep ignoring me! It's like your parents care more about looking generous than actually hearing what I'm saying."

"Aren't you always going on about Frames with your sim stuff?" soothed Jess. "You've got to see it from their perspective.".

"They're pretty old school, and in their culture it's important to be 'hak-hei'. It kind of means that as a guest you're supposed to be polite and decline offers a few times before accepting them. When you keep saying no, they just think you're being hak-hei and load up your plate."

"That's not what frames are about at all." lied Dave crankily.

Frames were only fun when he was the one uncovering them.

Discussion :

As healthcare simulation and debriefing expertise has flourished around the world, it has been acknowledged that a lot of debriefing framework shares a heavily westernised perspective. In Chung et al's article, the authors explore cultural differences in debriefing strategies and discuss traps for new players who are debriefing in a cultural environment different from their own.

What has been your experience with debriefing in different cultures? Is the traditional 'debriefing with good judgment' framework based on a particularly western perspective? If so, how can it be adapted to aid learning objectives in other cultures?

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Journal Club Summary September 2017 "Trouble in Paradise"

Article Summary :

"It is time to consider cultural differences in debriefing" is an article that addresses an important blindspot for many western simulation educators :

We're not the only ones doing it.

Chung et al open the paper by establishing the extensive growth of simulation based education in South East Asia. They then quote a number of articles that highlight the importance of debriefing for learning, strategies for creating psychological safety and the need to communicate in a 'frank, open and honest manner'. But they then acknowledge that all of the papers they quote are from western cultures, and that what works in the West might not generalise to other cultures as easily as might be assumed. In particular, they state that being debriefed "may be more difficult for trainees who come from cultures where the motivation to defer to authority outweighs the choice to disclose views that may seem to contradict those of the instructor."

To highlight cultural differences in communication, the authors utilise the classic case of the Korean Airline disaster featured in Malcolm Gladwell's 'Outliers'[2]. The authors explain that the investigation of the crash found that communication dysfunction between Western traffic controllers and the Korean pilots flying the plane contributed heavily to the crash. In particular, it was noted that the Korean style of 'polite' communication (described as 'mitigated speech') was not assertive and clear enough regarding the plane's plight.

In describing this event, the authors provide a clear example of "East vs West" communication problems, but perhaps more importantly for our learning, they highlight this :

> *"It is important for people with experience of the local culture to develop solutions that will be most effective for that culture."*

In essence, they argue that until you understand someone's frames, you can't help them find a solution. But they to truly understand someone's frame, they argue, one must also understand their culture.

To perhaps highlight the complexity of this issue, they describe further attributes of Korean culture that conflict with Western cultural norms : Its emphasis on memorisation over critical thinking, stronger hierarchical gradients between medical and nursing staff and junior and senior colleagues, and a general fear of 'saying the wrong answer'.

To finish up the article provides a series of questions for future research, such as :

- What motivates Asian students to be active in SBL?
- What are the elements of a *safe learning environment* in different cultures?
- What aspects of culture are 'safety neutral,' and what aspects may actually have effects on patient safety and patient care?

SIMULCAST
Journal Club Summary September 2017 "Trouble in Paradise"

Expert Opinion: **Peter Dieckmann, PhD, Dipl.-Psych**

Peter Dieckmann is senior researcher and faculty developer with the Copenhagen Academy for Medical Education and Simulation (CAMES) of the Capital Region of Denmark. His research focuses on optimizing simulation to create, recognize, and use learning opportunities around patient safety – on the individual and organizational level. Dr Dieckmann is also Associate Editor of the journal *Simulation in Healthcare*.

Peter's response to this month's article:

Thanks, Ben, and all for the invitation to take part in this discussion. Disclosure: I am one of the authors in the study.

Hah – already so much "culture" in this sentence. The disclosure thing…(a more and more sensless ritual). The thank you thing… (a ritual to open conversations).

I think the value of thinking about culture lies in stepping back, looking from a new angle onto our own position, our own standpoint. By comparing, what we take for granted with what the other takes for granted can generate new insights. Question is: do we then also adapt your actions (a question you raise, Ben, in one of your comments: would you do something different?). It requires openness about ones own ways of thinking, feeling (yes, we do have feelings), about our norms, values, and beliefs. It also requires to be able to distinguish understanding from judging – part of what Jessica Mesman from Maastricht calls "passivity competence". Listen, observing, thinking, before responding. Seeing the situation from the standpoint of the others – us much as possible. Some of them, we might simply not be able to reach. It might be too different from my own standpoint to be possible for me to go there. I can think of many people I see daily in the news, whose standpoints are too far for me to reach (and I do not want to reach them – uuuups: Peter distinguish analysis from judgment!). Culture gets engrained – it is not only a way of seeing the world. It is a way of being in the world. Even bodily aspects (think of beauty ideals).

Culture unfolds in so many different context. It is one of those concepts, that seem to be reasonably clear, until you read the first definition. Down it goes, the intuitive understanding. The more your read, the more you think about measurements, the more tricky it gets.

Especially with globalization, the national culture becomes more tricky. I learned that, in running workshops on culture, where we asked people to represent their countrypeople (not -men: I live in Scandinavia, we are far with the gender issues! – Is this along the lines of Australian humor – get my "u"

back it in that word, you damn yankee computer software autocorrection! Or do I get it wrong as principally humor (u!) less German)? Anyway: I asked this nice guy from the UK: Can you role play the stereotypical Brit? He looked at me like: "What? There is not such thing (a person) like this…They / we are from all over the place!" Point taken. So, likely the culture variety within a country is much larger than the variety between countries (imagine a German with humor (u!) – an American, who spells the Fxxx word with all letters – A Dane, who does not drink beer, go on, go on, go on). Departmental culture(s), professional cultures, morning shift cultures, night shift cultures, Christmans (ups – sorry seasonal greetings) shift cultures. Feedback culture…

Might be interesting to explore that one.

Imagine sports teams would have the same feedback cultures as healthcare. Just a moment. Get the picture? Not many goals in sight, my wild guess. That brings me to "assessing" cultures. Well, we do, right? All the time….Those xxx, ts, ts – always like that. They never [clean the table; say good morning] and always…So there is judgment in our cultural understanding and no matter how much we try, it will leak. So, somehow, we will assess cultural norms and will base our actions on this assessment (a good argument for bringing more ethics into simulation and healthcare as such). Question is from which standpoint? If we ask the high-heiriarchy-position people, they might be quite happy. The others might not. The more I think about it, the more I think: the relevant standpoint for the assessment is: is this good for Esther (just learned that from some Swedes: Don't say "good for the patient" but give his patient a name : "Esther". Does make a difference, doesn't it?). …Anyway, for me to find the guidance in how we should balance different cultures, the question of what is good for Esther makes a lot of sense. BUT: The Esthers in different cultures will think differently about what "good" means: absences of disease? Happiness? Go on, go on, go on.

We are currently working with a multicultural team on looking at the hypotheses that we postulated in the paper that is up for discussion. Guess what: we could find empirical differences between cultures with different power distance and the way that debriefers describe their debriefings. The details I do not want to give away here – cross your fingers that the reviewers share your enthusiasm for the topic and accept that there are some methodological challenges. So, there seems to be something there.

In summary – especially in those days of heated debates going on in the UN: there are differences. We kind of begin to get an understanding of them – although that easily goes away as well again. We can then begin to think about what we want to do with the those differences – level them out? Nurture them? Combine them? In some cultures Esther will benefit from advocacies and inquiry that her care givers sit through. In other countries Esther might benefit from another demonstration, of how it should be done right. No words needed. My own standpoint, when running faculty development courses around the world: I have a way that works reasonably well, where I come from. I would like you to take the time to understand it. Then I would like to think with you: how can we adapt this, so that it might fit your context. Or better: I want to help you to develop a way that will work for you. If that way, has a few elements of my way in it. Great. If not, I hopefully have helped you anyway see your way – and even, if you only you found out that my way is not your way.

Peter

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Journal Club Summary September 2017 "Trouble in Paradise"

Summary of this Month's Journal Club Discussion :

Blog Contributors :

- Vic Brazil, Nemat Alsaba, Ben Symon, Mary Fey, Adam Cheng, Ian Summers, Peter Dieckmann, Shaghi Shaghaghi, Ayidah Alqarni, Bishan Rajapakse

Perhaps fitting for a paper that is in many ways a conversation starter, comments this month seemed primarily focused on journal clubbers sharing their own cultural perspectives.

Vic opened the discussion by contrasting Australian humour with American humour, and how the 'teasing' that is used by Australians to signal affection or to soften the blow of a critique is at risk of misinterpretation in other cultural formats. Nemat Alsaba discussed her experiences as a medical trainee as someone with a multifaceted identity : "*born in Saudi Arabia, grew up in America, work in Australia*" and how moving between one culture to another can provide its own challenges in 'relearning the system'. In particular, both her and Shaghi reflect on the importance of hierarchy in some middle eastern cultures, particularly with regard to respecting ones teacher.

Nemat recaps these reflections perfectly with a phrase from her culture :

> *"I am a salve of him who has taught me one single letter."*

Debriefers from a primarily western background, such as Mary Fey, Ian Summers and Adam Cheng, reflected both on their assumptions about communication being challenged by the article. They shared stories of unsuccessful cross cultural debriefs, and shared vulnerability in asking for others to share their stories of 'what could work better'.

Ben acknowledged confusion : how far do we accept cultural norms as they are? How much do we use sim to challenge them?

Overall, it would seem that the article mostly promoted reflection. As Mary Fey stated : *"So, this turns the lens inward – to the debriefer becoming aware of personal biases that can influence us: that quiet learners are "not participating" (or maybe she's a "receiver oriented" communicator)…..that everyone needs to learn to speak up (or perhaps I need to figure out the best communication pathway for learners from cultures who espouse "mitigation talk")."*

A significant frame shift indeed.

Shaghi provided some beautiful examples of turning that lens inward when she shared her experiences as a French Canadian of Middle Eastern Background. *"I had assumed I had more of a "western" upbringing and hadn't given much thought about how my Middle Eastern background could affect my discussions in debriefing. I assumed this until recently when I was told by my simulation mentor… that there was an imbalance in our debriefing the debriefer sessions. Unfortunately, I am more of a taker than a giver. Basically, I didn't have much constructive comments about her debriefing skills. After reading this article, I have been pondering on the reasons why I haven't been able to "give back." Could it just be that her approach is flawless, or maybe I just don't have enough of a critical mind? Or is it that I haven't been aware of the impact of my*

Acknowledgements :

Thank you to Dr Dieckmann for his expert commentary this month.
Thank you to all commenters this month for sharing your thoughts and allowing us to learn from you.
Simulcast would like to thank the creators of the ALiEM MEDiC series for the inspiration for the journal club's blog format and their ongoing support and contributions to the project.

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Journal Club Summary October 2017
"Catherine Winterbottom's 13th Birthday"

Expert Opinion: Ms Karenne Marr

"SPs need to be mindful of the experience of the recipient, to be honest but intuitive"

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Journal Club Summary October 2017 "Catherine Winterbottom's 13th Birthday"

The Article :

"The Association of Standardized Patient Educators (ASPE) Standards of Best Practice (SOBP)."

Lewis, K., Bohnert, C., Gammon, W., Hölzer, H., Lyman, L., Smith, C., Thompson, T., Wallace, A. and Gliva-McConvey, G. (2017). Advances in Simulation, 2(1).

Case & Summary Author :

- Dr Ben Symon

Expert Commenter :

- Karenne Marr

Editors :

- Dr Victoria Brazil
- Jesse Spurr

First Published : 03/11/17

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The Case :

When Cath was 13, she invited 6 of her dearest friends over for a birthday sleepover. Despite spending several hours recording the perfect boy band mixtape and repeatedly mentioning the event in maths class, nobody had RSVP'd. It had turned out that Samantha van den Brink was having a sleepover the same night and that her mother had allowed her to rent 'I Know What You Did Last Summer' on VHS. Her friends had simply prioritised accordingly.
Which was why, years later, the feeling of being somehow uncool was so familiar as Cath sat in the empty conference room and stared morosely at an untouched breakfast buffet. The paediatric special interest group breakfast had been one of things she was most looking forward to this SIM conference, but it looked like she was the only one coming.

Across the hallway, she could hear laughter coming from the Simulated Patient Breakfast. As she'd wound her way into the conference centre, she'd passed a number of bubbly people heading in. When they'd said they were heading to the 'SP Breakfast' it had taken her a few seconds to register the abbreviation, it wasn't one she used on a day to day basis. Her paediatric SIMs were exclusively mannequin based, and the world of Simulated Patients was mysterious to her. She wasn't quite sure what they'd even have to talk about.

Faced with peer rejection, 13 year old Cath had stayed at home and watched 'Spice World'. But she'd done a lot of growing up since then. As it became clear nobody was coming, Cath took a deep gulp of her champagne, and with a grim look of determination headed across the hall.

It was time she learned about this Simulated Patient thing.

Discussion :

As simulation education has boomed, specialisation in its various subgenres has become viable. In particular, the Standardised Patient community has taken leaps and bounds in becoming it's own community of expertise.

In this month's article, Lewis et al provide the Association of Standardized Patient Educators Standards of Best Practice, but in doing so provide an overview of the principles behind using SPs and the community that has developed around it.

What have you learned from reading this article? How have you found incorporating SPs into your practice? What are the challenges and what can we get better at? Are you an SP? What's your perspective on this release?

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Journal Club Summary October 2017 "Catherine Winterbottom's 13th Birthday"

Article Summary :

Released in open access format, "*The Association of Standardized Patient Educators Standards of Best Practice"* aims to "*provide clear and practical guidelines for educators who work with SPs*". It is a critically important document for simulation educators which can be used as both as set of 'aspirational standards' for those who work with simulated patients but also as an introduction to the field for those who do not. In respect to the pivotal nature of these guidelines, the authors describe it as a *"document that will be "reviewed and modified periodically… as SP methodology grows and adapts to evolving simulation practices.".*

The guidelines were developed through a stepwise process :

- Discussion by a group of North American experts in the field.
- Using a modified Delphi Method to identify domains by consensus.
- Discussion of the draft standards at the ASPE Board of Directors.
- Obtaining opinion from international experts.
- A final separate consensus by a team of reviewers from the ASPE Board of Directors.

They are structured within 5 domains :

- Safe Work Environment
- Case Development
- SP Training
- Program management
- Professional Development

These domains are informed by 5 underlying values :

- Safety – Described by the authors as the 'cornerstone of simulation practice'
- Quality – 'assuring and pursuing continuous improvement'
- Professionalism – 'act in accordance with common ethics, values and standards'
- Accountability – 'a commitment to serving the needs of our stakeholders'
- Collaboration – 'sharing best practices with colleagues on a local and global scale'

The heart of the article is a series of tables outlining a number of principles within each domain. They are extensive and not appropriate to summarise here. At their heart, however, the standards are a call to understand the contributions SPs can make to a simulation curriculum and to highlight their position as educators in their own right rather than actors or props to be added to a scenario for added realism. It's an important reframe, and embarrassing as it may be, it's a bit of a mental leap for some of us. Once that frame shift has been made, however, it becomes inherently logical for us to incorporate Simulated Patient Educators not only into scenarios, but into scenario design, debriefing, and professional development.

SIMULCAST

Journal Club Summary October 2017 "Catherine Winterbottom's 13th Birthday"

Expert Opinion: **Karenne Marr, Simulated Patient**

In the spirit of welcoming Simulated Patients as coteachers, we asked Karenne Marr her thoughts on this month's article. Karenne has been working for 11 years as a Simulated Patient and has been working with the School of Medicine at Bond University since its inception. Her experience includes simulation history taking and physical examination. She has been involved in most areas including Medicine, Physiotherapy, Psychology, Diet and Nutrition and Occupational Therapy.

Karenne's response to this month's article :

Thank you so much for the compliment of asking me to comment on this month's article.
It is however, a huge overstatement to regard me as an expert!
From reading this very comprehensive article I have learnt of the enormous structures in place regarding best practices. It would seem every area of the SP role has been examined and categorised in detail by experts. The body of work is impressive and very well executed.
I will be honest and admit it took me a few read throughs for several points to really resonate, and the stand out things to stick in my brain. I liked the structure of domain and principles, preparation, clear goals, and objectives tailored to the level of learners.

Simulation design that is repeatable. That is something to think about, how to make a scenario not become tired and boring through age and repetition yet still provide the same learning experience. How do we keep it fresh?

Berenson says SPs can provide students with valuable and unique information with their feedback.
LETS TALK ABOUT THAT.
I agree feedback is critical to learning.
I also think this can be an area of intense challenge.
Feedback has the potential to be enormously helpful or intensely harmful.
SPs need to be mindful of the experience of the recipient, to be honest but intuitive. I often struggle with this myself. There are times when I have been happy with what I've said, however many times when I have wished I could retract every word. I never want to cause someone to feel inadequate or dread having to speak with a patient. If the student has not performed as well as they could, I want to leave them a comment that would encourage them to try the scenario again.

I think FEEDBACK is the growth area in SP programs. I would like to think we are united in working towards the evolution of best practices and I do believe whilst providing a safe, realistic educational environment, effective feedback is the big challenge both in teaching it and giving it.

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Journal Club Summary October 2017 "Catherine Winterbottom's 13th Birthday"

Summary of this Month's Journal Club Discussion :

Blog Contributors :

- Sami Rahman, Ben Symon, Karenne Marr, Vic Brazil, Rowan Duys, Jessica Stokes-Parish,
- Debra Nestel, Nemat Alsaba, Shane Pritchard, Carrie Hamilton

It was a fascinating and in depth discussion this month on Journal Club in a conversation with wide breadth and depth as simulation academics, Standardised Patient Educators and clinician educators reflected on their responses to the article and helped each other problem solve SP integration within clinical programs.

There was widespread enthusiasm for the Standards of Best Practice (SOBP) with clinician educators such as Rowan Duys and Ben Symon expressing appreciation for the number of ways the SOBP opened blind spots regarding their practice. Particularly resonant themes for many educators was the article's stance that SPs be actively involved in scenario design, debriefing and ongoing simulation /faculty development. Out of respect for the importance of the standards themselves, some participants voiced concerns regarding how actively the standards would be integrated into community practice, a journey that *Advances in Simulation* has already started by posting both an Editorial and a Podcast regarding the issue.

The contributions that SPs make to simulation practice was admired from a number of bloggers, but perhaps our expert Karenne Marr put it best when she explained :

> *I'm a real human who possibly won't remember what you say, I may not even understand. However I will know and I will always remember how you made me feel.*

Rowan Duys asked for **advice regarding starting an SP program**, and his questions opened the floodgates for a variety of experts to contribute their expertise and ideas regarding 'starting out' with SP integration in a Simulation Curriculum.

Jessica Stokes-Parish provided a number of pieces of advice, including :

1. Assess what you do have (SP numbers, current payment approach, main use for SPs)
2. Establish processes (recruitment, training, supervision, in-role approaches, finances, administration, performance review)
3. Establish levels (what are your SPs doing – are they simply lying there for an exam, or are they providing feedback)
4. Get started, and continually review

Nemat Alsaba offered an important reframe : "The important question when working with SPs is "what are we trying to achieve in that simulation?". She argued that a significant portion of scenarios are best serviced by incorporating an SP and using part task trainers for manual procedures that are involved within the scenario. She also provided a number of pieces of practical advice, including :

1. If finance is an issue to recruit and train SP at the beginning I suggest approaching medical, nursing and paramedics Schools and ask for volunteers. This will be a mutual benefit.
2. Think about sustainability of the program and how you are going to keep your SP interested and committed.
3. When a new SP is joining your program make sure you include them initially as an observer in their first simulation with your program.

Debra Nestel also dropped into the discussion, and highlighted the importance of considering SPs as coteachers :

> *"Although SPs are simulators, they are not objects to be used but functioning as experts and, in my ideal world, offering perspectives as "patients". That is, not offering clinician perspectives…."*

And on a final note, it should be noted that the case of Catherine Winterbottom 'the simulation nerd who had felt deeply lonely in high school', appeared to strongly resonate with a particularly high proportion of simulation educators. May we all rejoice in finding our tribe a little further down the road. Thanks to all contributors this month for a wonderful discussion.

Acknowledgements :

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SIMULCAST

Journal Club Summary November 2017 “Sticks and Stones”

Expert Opinion : Dr Chris Nickson

“Psychological safety is not something you say, it is something that grows from what you do.”

SIMULCAST

Journal Club Summary November 2017 "Sticks and Stones"

The Article :

"Establishing a Safe Container for Learning in Simulation"

Rudolph, J., Raemer, D. and Simon, R. (2014).

Simulation in Healthcare: Journal of the Society for Simulation in Healthcare, 9(6), pp.339-349.

Case & Summary Author :

- Dr Ben Symon

Expert Commenter :

- Dr Chris Nickson

Editors :

- Dr Victoria Brazil
- Jesse Spurr

First Published :

- Dec 7, 2017

Simulcast Journal Club is a monthly/ series heavily inspired by the ALiEM MEdIC Series.

It aims to encourage simulation educators to explore and learn from publications on Healthcare Simulation Education.

Each month we publish a case and link a paper with associated questions for discussion.

We moderate and summarise the discussion at the end of the month, including exploring the opinions of experts from the field.

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The Case :

Joe jumped at the sound of the tree branch crashing and his son's scream, but Nimali had somehow managed to pick him up off the ground before Joe could even assess what was going on. She glared at him with maternal rage. The beer can in his hands wasn't doing great things for his image.

"How's his arm?" he asked meekly.

"Hopefully fine." Nimali said hotly. "No thanks to your parenting. I saw you paying more attention to getting another beer than watching our 6 year old climb a tree, and I'm concerned you don't comprehend he could break his neck up there. Any thoughts on that?"

"Don't A.I. me in front of our kids." he growled. Being married to a Simulation Instructor had been mystifying at first, but 6 years into their marriage he was pretty comfortable with the lingo.

"I just don't understand how little concern you have for his safety!" snapped Nimali.

"I care about him just as much as you do!" he snapped back. "But you think you can protect him from everything! I have a duty to let him learn to take some risks too. Every kid should climb a tree in their childhood. And anyways," he said, "I need him to know I'm not going to be there to catch him every time."

Nimali paused. Her son's tears were drying and she felt her heart rate slow as he quietened down.

"That's true too." She said, "I just think he learns better when he knows we're there for him.".

Joe lifted his son from Nimali's arms and ruffled his hair affectionately. "Then let's all go climb that tree together.". He reached out a conciliatory hand towards his wife and grinned. "Rapid Cycle Deliberate Practice is more effective anyways, right?".

"Oh God." Nimali smiled. "That's the sexiest thing you've ever said to me.".

Discussion :

In our final article for 2017, we look at a pivotal paper in simulation literature and medical education. In 2014, Rudolph et al created the analogy of 'the Safe Container for Learning' and outline strategies to create a safe learning environment for simulation participants.

The principles outlined within the article are critical learning points for all simulation educators and for many of us this has been a transformative article. Three years since publication however, has the simulation community potentially misinterpreted what psychological safety means to these authors? While Nimali's concerns for her son's supervision are valid, is there also truth to Joe's belief in the inherent dignity of risk?

To our journal clubbers, what has this article meant to you? How has it changed your practice? How does your simulation team approach psychological safety? What have been some pitfalls you've identified?

SIMULCAST

Journal Club Summary November 2017 "Sticks and Stones"

Article Summary :

"Establishing a Safe Container for Learning in Simulation" is a paper held dear to the hearts of many medical educators be they simulationists or otherwise. For many it's their first exposure to the concept of "Psychological Safety" in simulation and introduces the metaphor of 'The Safe Container'; described in the article as "*an environment where learners face professionally meaningful challenges and are held to high standards in a way that engages them but does not intimidate or humiliate them*".

Rudolph, Raemer and Simon begin the article by describing a number of threats to learner engagement in simulation, in particular:

1. Poor buy in
2. Frustration with the level of fidelity
3. Professional identity threat through exposure in simulation and debriefing
4. Difficulties discussing suboptimal performance

They then highlight the importance of "*risk taking in the service of learning*", explaining that a willingness to go to the edge of one's social and intellectual comfort zone with a positive attitude is beneficial to learning. They describe features of these traits as "learning oriented behaviours" such as reflectiveness, feedback seeking, speaking up, asking for help, testing hypotheses and reflecting on results.

After establishing these principles, the authors make a crucial point that is often overlooked :

> *"Importantly, psychological safety may not completely mitigate feelings of interpersonal risk. Rather, it tends to create a setting where learners feel safe enough to embrace being uncomfortable."*

The Safe Container, in other words, *is not there to stop us feeling uncomfortable*, it is there to allow our learners to embrace that discomfort in the pursuit of new knowledge.

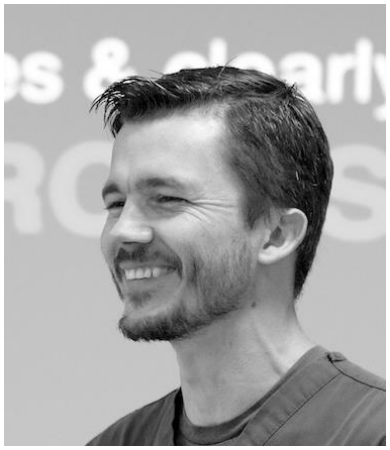
The article takes the stance that the sim prebrief is of critical importance in establishing a safe container. It's described as an opportunity to "*collaborate with learners to set goals and expectations*" that will lead to learning oriented behaviours. Through a literature review, reflecting on the experience of creating the DASH and the authors' "*collective experience in conducting more than 6000 debriefings",* the authors piece together a series of promising practices for presimulation briefing that are noted to be of benefit. Namely :

1. Clarifying objectives, environment, roles, confidentiality and expectations
2. Establishing a fiction contract
3. Attending to logistic details
4. Conveying a commitment to respecting learners and understanding their perspective

The article explores each of these principles in depth, providing examples and advice regarding how to include each principle successfully into your pre-brief.

Appendix 2 of the article is particularly noteworthy for supplying an extensive and detailed appendix providing concrete, practical examples of how to establish an engaging learning environment.

Expert Opinion: Dr Chris Nickson



Chris is an Intensivist and Emergency Physician at the Alfred ICU in Melbourne. He has a passion for helping clinicians learn and for improving the clinical performance of individuals and collectives. After finishing his medical degree at the University of Auckland, he continued post-graduate training in New Zealand as well as Australia's Northern Territory, Perth and Melbourne. He has since completed further training in clinical toxicology, clinical epidemiology and health professional education. He coordinates the Alfred ICU's education and simulation programmes and runs the unit's education website, INTENSIVE. He created the 'Critically Ill Airway' course and teaches on numerous courses around the world. He is one of the founders of the FOAM movement (Free Open-Access Medical education) and is co-creator of Lifeinthefastlane.com, the RAGE podcast and the SMACC conference. His one great achievement is being the father of two amazing children.
On Twitter, he is @precordialthump

I felt a bit "vomity" when I started writing this "expert" response. It might have been the saccharine geek-speak in the dialogue of the trigger scenario… though the helicopter parent analogy was 'sweet as', Ben!… Or, maybe it because this is THE 'Safe Container' article… After all, if you know someone who is serious about simulation-based education, chances are they were taught by one of the Yodas (whoops, authors) of this article… Privileged I am, among them to be. So yes, I now get to play the role of a Sunday Schooler critiquing the Bible's Ten Commandments. I'll apologise in advance to Robert Simon for failing to heed the advice he gave me on my first sim course: "just don't f#@k up!".

Fortunately, unlike me, Ben Symon has written a succinct summary of THE article that really cuts to the chase. His summary of the online journal club interchange is spot on too. Read them. What follows next is my take; you have been forewarned.

OK, we all know that the debrief is where the learning *really* happens (or, at least, where it really takes off). BUT, for the debrief to work – for people to talk openly and honestly about what they did and why, to be challenged and to challenge one another, and then be able reflect on it all – we have to have this magical thing called "psychological safety". It's kind of like a seatbelt you strap on to stop you breaking bones as you carom off everyone else in a demolition derby. Click clack, front and back… Hmm, if only it were that easy.

The focus of THE article is how to construct a prebrief that conjures up this psychological safety magic, how to construct the hallowed Safe Container. I, like you, live by the Rudolph-Raemer-Simon commandments. I do introductions, I demonstrate my belief in 'The Basic Assumption' ("you're all AWESOME!"), I negotiate confidentiality ("what goes on in sim, STAYS in sim…"), I'm explicit about assessment ("this is NOT a test"), and I figuratively sign everyone up to a fiction contract between facilitators and learners ("let's keep it REAL…"), before orienting everyone to the sim environment, the sim process, and finally, the case at hand... Yes, like you, I'm well trained (did I mention I had great teachers?) and I have guzzled down plenty of the 'prebrief' Kool Aid.

Let's face it, there is much that is great about this article. It is written by truly expert experts. I've seen them all in action (mostly Robert and Jenny… I watched Dan Raemer on YouTube once) and I've read many of their works over and over. They've got undeniable Street Cred. Importantly (though I'm not sure I could emulate exactly what they did from the description in the article), they've gone to lengthy lengths to dig up diverse literature from otherwise disconnected fields to build their case… and, oh, how I'd love to have read all of the listed references! Many great ideas come from a confluence of thought from disparate fields of study and the Safe Container is a case in point.

Enough of that. I want to go back to what Ben Symon and Mary Fey have each said in their own ways and make something clear: if you think psychological safety is about group hugs, singing Kumbaya, getting your feet massaged, and keeping it all cuddly-feely at all costs; you are wrong, profoundly wrong. Wrong like a Trump presidency. Wrong like Brexit. Wrong like a lot of other really wrong things. The Safe Container is not about creating a comfortable space, it is about making it OK to be uncomfortable. This is important because Ericsson tells us that expertise is forged from repetitive practice at the edge of, or beyond, our comfort zones (Ericsson, 2004). Psychological safety helps convert the Threat of socio-evaluative stress into a Challenge, so that we no longer worry about being embarrassed or having our Identities dismembered, and so that we can do things that help us learn despite the discomfort.

All this has got my 'Amy Edmondson neurons' twitching (her book 'Teaming' is a MUST read) and I find myself asking, "Is this a spanner which I see before me?". You see, in the context of teams, Edmondson has defined psychological safety as "the shared belief that the team is safe for interpersonal risk taking" (Edmondson, 1999). Importantly, she states that this is a tacit belief borne out of a climate of interpersonal trust and mutual respect and that the essence of team psychological safety is *not* altered by making this belief explicit (Edmondson, 1999). So how does saying 'the right stuff' in a prebrief create psychological safety? Well, it doesn't… Psychological safety is not something you say, it is something that grows from what you do. Actions speak much louder than words. Indeed, Jenny Rudolph has said similar things in podcasts on Debrief2Learn and Simulcast. Like me, you may have worked with people that 'talk the talk' but if they don't also 'walk the walk', then trust and respect go up in smoke.

So, in a one-off sim session, your wider reputation as an instructor and how you behave during the prebrief is all you've got to create the Safe Container. If you do sim in the workplace (like Stephanie Barwick and Clare Thomas do), or have repeated interactions with the same group of learners, then things might be different. If you're a day-to-day d!ckhe@d in the workplace, you can't expect to wave the 'Safe Container' wand and turn from toad to prince as you step into the sim room — people will know you for who you really are. Even worse, even if you are an all round 'Good Guy', even the best Safe Container strategy will be devoured if the pervading workplace culture is toxic. This harks back to Peter Drucker's apocryphal saying: "culture eats strategy for breakfast", only so much can be achieved with even the best prebrief strategy if the wider culture is a hungry psychologically unsafe monster. Of course, the pervading culture is even more important if you're are one of those intrepid educators who unleash unannounced 'Guerilla sims' *in situ*… Who dares wins? Not always.

Now, here's a paradox for you to ponder. When I think of the most profound learning experiences in my working life, those that are seared indelibly into my cortex, a collection of colossal cock ups come to mind. These are things I felt really bad about, in some cases things that really threatened my self-identity as a competent doctor. I don't remember there being much 'positive regard' at those times. Yet I think they changed me, forced me to build new mental models, and made me strive to do better. How do experiences like this reconcile with the 'Safe Container'? Or am I just a poster boy for survivor bias spuriously validating a "what does not kill you makes you stronger" mindset?

Also, on re-reading THE article I discovered that the premise, derived from economic theory, that people are 'intendedly rational' was something that bugged me. This is because people like Daniel Kahneman and Dan Ariely argue that much of our behaviour is actually "irrational", and driven by a bundle of heuristics and cognitive biases of which we may not be aware (Ariely, 2009; Kahneman, 2012). These are typically adaptive in the right circumstance, but can be maladpative in others. This makes me wonder… Are we really privy to the mental processes that direct our behaviour? How much of what we hear in a psychologically safe debrief actually involves involuntary post-hoc rationalizations rather than insights into what was really happening in someone's mind at the time?

Another question for you, how important is the fiction contract? It centers on a belief that participants will learn more the greater their immersion in the unfolding simulation. Is this really true? Perhaps not, so long as the learning experience is 'authentic' (i.e. can be translated into the real world). For instance, low physical fidelity simulators can

teach uroscopic procedures effectively (Matsumoto, 2002) and in some circumstances observers of simulations can learn as much as participants (Stegman et al, 2012). What do you make of this?

Finally, as believers we are left with another confronting question, how do we really know if the Safe Container works? Does the Safe Container lead to better patient care or better patient outcomes, or even improve participant behaviour and performance in the real world? If the studies that answer these questions with definitive proof exist, I'm abashedly ignorant.

Having said all this, despite the caveats, I can't see myself wavering from the script anytime soon. This is an outrageously important article and a valuable guide to anyone who steps foot into the sim arena. The Safe Container rules, OK?

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SIMULCAST
Journal Club Summary November 2017 "Sticks and Stones"

Summary of this Month's Journal Club Discussion :

Blog Contributors :

- Melanie Rule, Ben Symon, Derek Louey, Steph Barwick, Clare Thomas, Rowan Duys, Cathy Grossman, Marrice King
- Mary Fey, Jane Stanford, Jenny Rudolph, Nemat Alsaba, 'NoSafeSpace', Ben Lawton

The discussion this month was extensive and wide ranging, but interestingly very little was said about the paper itself. Primarily discussants attempted to problem solve challenges in establishing psychological safety, including :

- It is difficult to establish a pre-brief at an In Situ Simulation within a clinical environment
- A psychologically safe simulation does not need to be free of stress
- Creating a safe container takes nuance and experience, and we will sometimes fail

It is difficult to establish a pre-brief at an In Situ Simulation within a clinical environment

Journal clubbers appeared in firm agreement that pre-briefing is an important component of establishing psychological safety, however given the sometimes sudden nature of In Situ Sims, a number of responders including Steph Barwick and Clare Thomas had developed interesting work arounds. Steph noted that putting the prebrief after the sim but before the debrief still appeared effective at moving her learners towards a growth minded approach, while Clare Thomas mentioned she will often call staff who will be attending an In Situ Sim prior to the day, to allow her to prepare them for it in advance. Nemat Alsaba mentioned she will sometimes send an email. These work arounds highlight an interesting point, that establishing psychological safety doesn't always have to occur at the same time as the sim.

A psychologically safe simulation does not need to be free of stress

As alluded to in the case study, experiential learning cannot happen without risk, but there was a broader spectrum of opinion regarding what psychological safety means. A number of journal clubbers described memories of high social anxiety in simulation, while others described feeling "highly scrutinised".

Derek Louey argued that "*psychological safety, if defined as the ability to speak and act without fear of negative consequence self-image, status, or career; is somewhat a fiction*", although this was countered by Mary Fey when she argued that "*simulation is just the place to allow learners to perform under duress for the purpose of developing strategies to succeed in difficult situations. A safe environment is one in which the learners trust that the facilitator is not out to get them, and has their best interests at heart. In the context of this type of trusting teacher-learner relationship, they are willing and able to tolerate stress and discomfort in the service of learning.*".

When Jane Stanford asked the team to describe their 'sweet spot' of psych safety is, Ben Symon and Jenny Rudolph discussed it as being a point where learners "can engage in "reflective" versus "deflective" routines", avoiding praise as a defensive mechanism and instead focusing on "*getting better at getting better*".

Creating a safe container takes nuance and experience, and we will sometimes fail

Different educators in the journal club appeared to have different approaches to psych safety. Mel Rule described taking a longitudinal approach by starting out gentle, making sure she maintains a consistent manner in her clinical and educational roles with her learners, and gradually with time establishing a 'circle of security' from which the team can begin to challenge itself. Ben Lawton echoed that these principles appear similar to learning principles in toddlers in developmental paediatrics. Derek Louey voiced difficulties regarding our interpretation of others stress levels, expressing concern regarding how to balance the benefits of activating our learners with pushing them beyond a break point we may not recognise. Jane Stanford suggested "*developing the broader culture of safety with words, actions, behaviours, authenticity*", but also asked "*is it enough to trust in the principle of respecting the learner?".* Rowan Duys described the benefits of long term relationships in 'hacking' psych safety to allow a pre-established peer group to take risks together more easily. Marrice described the negative impact on learning poor psych safety can cause : "The times I did not have psychological safety, and was ridiculed and made fun of for my choices; I did not hear the what I could do better the next time, just that I was so stupid.", but also highlighted that "The times I had psychological safety, I still left mentally smacking myself for making such a stupid mistake. That mental smacking I gave myself worked though because faced with that situation again I did not make that same wrong choice. I had the other better choices explored to choose from.".

Acknowledgements :

Thank you to Dr Chris Nickson for his expert commentary this month.
Thank you to all commenters this month for sharing your thoughts and allowing us to learn from you.
Simulcast would like to thank the creators of the ALiEM MEDiC series for the inspiration for the journal club's blog format and their ongoing support and contributions to the project.

References :

1. Rudolph, J., Raemer, D. and Simon, R. (2014). Establishing a Safe Container for Learning in Simulation. *Simulation in Healthcare: Journal of the Society for Simulation in Healthcare*, 9(6), pp.339-349.
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SIMULCAST

Journal Club Summary February 2018 : "Sound and Fury"

Expert Opinion : Dr Vicki LeBlanc

"This is just the starting point…
now it's time for the hard work"

SIMULCAST

Journal Club Summary February 2018 "Sound and Fury"

The Article :

"The Human Factor : Optimising Trauma Team Performance in Dynamic Clinical Environments "

Hicks, C. and Petrosoniak, A.

Emergency Medicine Clinics of North America, 36(1), pp.1-17

Case & Summary Author :

- Dr Ben Symon

Expert Commenter :

- Dr Vicki LeBlanc

Editors :

- Dr Victoria Brazil
- Jesse Spurr

First Published :

Simulcast Journal Club is a monthly/ series that aims to encourage simulation educators to explore and learn from publications on Healthcare Simulation Education.

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The Case :

For a brief moment in the chaos, time had seemed to pause. The cacophony in the resus room was rising but through it all the quiet wail of the infant's parents was cutting through it all as if their grief was physically squeezing Cath's heart.

She felt the vivid tremor of her hands.

In that instant it was as if she could physically see the emotions in the room, manifesting like coloured balls of light that bounced and echoed around the bedside.

She saw her Fellow Nitin knock away the cannula tray and reach for the Intraosseous, the stress glowing a vivid red from within his chest.

She saw Harriett the social worker kneeling by the parents' chair, shielding the team from some of the thick, black grief that poured out through their tears.

Brad and his team from ICU had walked in and gravitated straight to the ventilator. He was a wonderful man but she could feel his frustration with the team brewing. She had been friends with him long enough to know he was about to snap, and the fact she was disappointing an old colleague filled her with a yellow flush of shame.

As her panic began to overwhelm, the nursing team leader moved into Cath's field of vision. She spoke just loud enough to be heard.

"You've got this. We're here for you.".

Cath closed her eyes and slowed her breathing.

It was time to take back control.

Discussion :

Destined to become a classic paper we are pleased to feature Hicks & Petrosoniak's newly released from *Emergency Medicine Clinics of North America*. While not specifically focused on simulation, *'The Human Factor'* takes knowledge formed and refined within the simulation room and translates it back into clinical practice.

As Simulation Educators many of us have been conduits for bringing the gospel of CRM into the healthcare workplace and as such this paper provides an important deep dive into current thinking on human behaviour and training strategies to improve our performance in a crisis.

We look forward to hearing your thoughts on this paper, and in particular:

1. What strategies from this paper might help Cath's team regain control of a chaotic situation?
2. How might this paper effect your educational practice and debriefing strategies in CRM?
3. Will it affect your clinical practice as well?

SIMULCAST

Journal Club Summary February 2018 "Sound and Fury"

Article Summary :

For many years Simulation Educators have embraced the gospel of Crisis Resource Management, preaching to our staff about the importance of these principles and emphasising their importance in clinical practice. For some of us however, the conversation has started to feel a little shallow. To truly master 'teaming' in resuscitative environments requires a deeper dive into understanding human emotion and our physiological responses to stress, and repeatedly naming CRM principles in our debriefs does not necessarily translate into better teamwork in our resuscitation rooms.

Acknowledging that problem in their introduction, Chris Hicks and Andrew Petrosoniak's landmark paper 'The Human Factor' is a rich and deep paper, filled with specific and detailed strategies to improve teamwork that have been refined from both extensive history in the emergency setting, but also from reflections within the field of simulation.

"Resilience is built, not born".

Hicks and Petrosoniak structure their paper around 4 different levels within resus teams, which the name 'Self', 'Team', 'Environment' and 'System'.

In order to optimise the Self, the authors describe the difference between a 'challenge' and 'threat' response and advocate a number of specific strategies to maintain sufficient 'mental posture' to maintain flexibility and resilience in a crisis setting. The strategies include :

- Controlled breathing techniques
- Self talk, Cue Talk and Cognitive Reframing
- Mental rehearsal
- Stress inoculation
- Overtraining

With respect to optimising Team behaviours, the authors advocate for a number of communication specific strategies including :

- Avoid mitigating language
- Defining a resuscitation lexicon
- Practicing closed-loop communication
- Using graded assertiveness
- Setting common expectations via prebriefing and share mental models
- Modifying team structures to adapt to patient's dynamic needs

When optimising the Resuscitation environment itself, attention should be paid to :

- Iterative departmental design focused on identifying latent safety threats
- Optimising physical proximity of critical equipment and removal of extraneous items
- Utilising a 'Logistics and Safety Officer' to optimise team function during resuscitation

With regard to optimising 'System' in itself, the authors recommend :

- Judicious use of checklists and handover protocols
- Use of clinical pathways for complex events
- In Sit Simulation and Debriefing

Rather than simply naming these concepts, each strategy advised is explained in significant, specific detail.

Expert Opinion: Dr Vicki LeBlanc, PhD

Vicki LeBlanc, PhD, is Chair and Professor of the Department of Innovation in Medical Education at the University of Ottawa, and Director of the University of Ottawa Skills and Simulation Centre. Dr LeBlanc earned her PhD in experimental psychology from McMaster University in 2001.

Dr LeBlanc has over 15 years of experience leading research into a) optimizing the use of simulation in health professions education and b) the effects of emotions and stress on the performance of health professionals and front line workers. She has authored over 100 peer-reviewed publications, and regularly presents her work nationally and internationally. She also has a number of national and international leadership roles, including serving as an Associate Editor of the journal Advances in Health Sciences Education, as well as working with the Royal College of Physicians and Surgeons of Canada to advance simulation-based education.

Thank you for the opportunity to comment on the paper "The Human Factor" by my colleagues Chris Hicks and Andrew Petrosoniak. As a disclosure, Chris and I go back ten+ years. I was a young professor, trying to convince the field that we needed to go beyond skills and knowledge, in order to recognize that the emotional state of team members had a critical impact on clinical performance. Chris was a senior EM resident enrolled in a MEd program who crossed my path because he shared the same perspective. Back then, this idea was a tough sell – the prevailing thought was that you either "have what it takes" or not. The focus was on ensuring that we gave our trainees the knowledge and skills required. The rest was up to them to figure out. Chris and I (and subsequently Andrew) felt quite strongly that the field of medical education needed to be pushed beyond this mindset. We, along with other like-minded research teams[1], set about doing this with research, evidence, and advocacy.

Ten years later, how things have changed! We have open conversations about errors being part and parcel of patient care; we increasingly recognize the importance of context and environment; and the integral role of stress and other emotions on performance is widely accepted. In "The Human Factor", Chris and Andrew share their vast experience – both from the clinical and research perspective - with aspects that can influence care at the level of the 'Self', 'Team', 'Environment' and 'System'. This paper is the result of years of hard work and hard thinking by two thoughtful and passionate educators.

I'm thrilled that we're now having these conversations, and Chris and Andrew's paper provides good details of proven approaches. However, this is just the starting point…now it's time for the hard work. It's one thing to talk about these elements and to provide examples of how they can work. But, like any other skills or system change, improvements will require significant training, commitment to change, and multi-faceted approaches. My hope for the field is that we commit to the hard work to truly bring change, and to study it as we go along (to ensure that we better understand this complex interplay of factors). For example, at the individual level, superficial attempts at emotional regulation (e.g. lunch & learn lectures, reminders "in-passing") will not help. While talking and writing about it is useful for increasing awareness, this will not be sufficient to provide learners with the skills to appropriately recognize and regulate their emotions. It's important to keep in mind that our approaches to stressful situations represent hardened tendencies developed over a lifetime. So, when we're trying to teach them new ways to approach stress, whether it's tactical breathing or reframing, we're asking our learners to unlearn strategies they've developed over a

lifetime and to learn a new one…and we often think/hope we can do this in just a few hours. Myself included! Chris, Andrew and I have recently found that even a half-day session, with practice and feedback, is not quite enough to overcome residents' initial approaches to potentially stressful situations. As a result, we're now looking at more longitudinal approaches borrowed from behaviour modification fields. Implementing this will require quite a bit of faith on the part of our learners and program directors who are trusting us with quite a bit of their (and the program's) time. The reward? We'll (hopefully) build the resilience that Chris and Andrew call for.

This example, although relating to the targeted level of stress management, can also speak to the other levels described by Chris and Andrew. At the "team" level, changes in communication approaches, terminology and assertiveness won't happen after an hour or two of training. The training is merely the starting point, where skills and tactics are introduced. Just as with any skill (e.g. learning to surf), mastery requires hours of practice, with and without feedback. At the "environment" and "system" level, true changes require institutional commitment and integration. A nice example of this can be found in Posner et al's paper[2] looking at in-situ simulation for the identification of latent safety threats – and the strengths and advantages of different approaches.

In closing, I want to commend Chris and Andrew for the broad perspective taken in their paper. While many of us likely work at one of the levels, due to limited resources or the need to dig deep into an approach, it's essential for us to collectively stick our heads up from the rabbit hole. Changes and interventions at any given level are going to interact with factors at other levels – positively or negatively. Navigating this interconnectivity will be essential to building individual and system level resilience to crisis situations.

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2. Posner GD, Clark ML, Grant VJ. Simulation in the clinical setting: towards a standard lexicon. Advances in Simulation. 2017 Dec;2(1):15.

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Journal Club Summary February 2018 "Sound and Fury"

Summary of this Month's Journal Club Discussion :

Blog Contributors :

- Suneth Jayasakera, Ben Symon, Vic Brazil, Sarah Janssens, Derek Louey, Nemat Alsaba
- Lauren Kennedy, Bishan Rajapaske, Paul Elliott, Sophie Brock

The response to the paper from bloggers this month was universally positive with only mild critique of the paper itself. Interestingly different journal clubbers found different parts of the article resonated more strongly with themselves than others. Overall, common themes identified were :

- The paper is quite detailed and requires reflection and rereading for maximal impact.
- The principles described in the paper are quite universal and relevant to teams outside a trauma setting.
- The paper reframes a number of philosophical pre-conceptions about resus teams

The paper is quite detailed and requires reflection and rereading for maximal impact.

The paper was described by various bloggers as 'meaty', 'information dense', and full of 'so much gold'. Many of us mentioned needing to read it and come back to again in order to absorb more specific details and tips. While this could in many ways be considered a strength of the article, Vic Brazil questioned whether in fact the paper could have been 'published as a 3 part series'.

The principles in the paper are relevant to teams outside of a trauma setting.

Multiple responders noted that the themes and structure of the case were relevant to those of us outside major trauma setting. Sarah Janssens, an obstetrician, for example, discussed how the concept of a Logistics and Safety Officer or event manager resonated with some behaviours that midwives she works with already implicitly do.

Ben Symon expressed concern that having the paper labelled as 'trauma' focused undersells the paper to other subspecialties, although Lauren Kennedy felt that surgical teams appear *'much better at publishing (trauma) team training initiatives and programs.. than ED or ICU'.*

The paper reframes a number of philosophical pre-conceptions about resus teams.

A number of journal clubbers identified aspects of their resuscitation teaching that were challenged by the paper. Derek Louey discussed his thoughts on the importance of Followership, Bishan Rajapakse found the breakdown of 'Threat Response' vs 'Challenge Response' particularly useful, while Paul Elliott shared a rich analogy regarding how a previous colleague taught about the importance of shared mental models and 'thinking out loud'.

Acknowledgements :

Thank you to Dr Vicki LeBlanc for her expert commentary this month.
Thank you to all commenters this month for sharing your thoughts and allowing us to learn from you.
Simulcast would like to thank the creators of the ALiEM MEDiC series for the inspiration for the journal club's blog format and their ongoing support and contributions to the project.

References :

1. Hicks, C. and Petrosoniak, A. (2018). The Human Factor. *Emergency Medicine Clinics of North America*, 36(1), pp.1-17.

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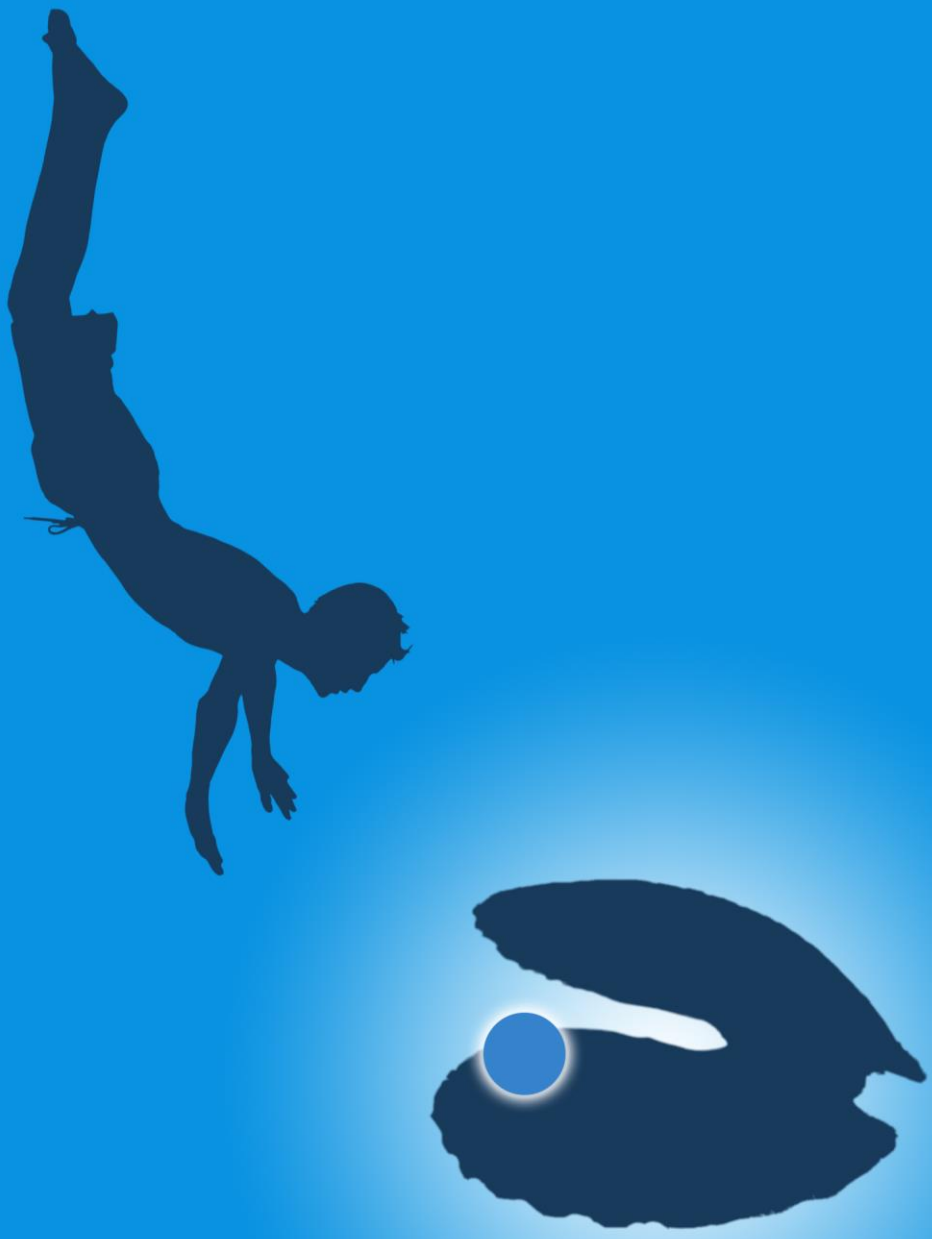
Journal Club Summary March 2018 : "PEARLS before Snythe"



Expert Opinions :

Dr Komal Bajaj

Dr Michael Meguerdichian

"There is so much beautiful music that is yet to be made"

SIMULCAST

Journal Club Summary March 2018 "PEARLS before Snythe"

The Article :

"Promoting Excellence and Reflective Learning in Simulation (PEARLS)"

Eppich, W and Cheng, A.

Emergency Medicine Clinics of North America, 36(1), pp.1-17

Case & Summary Author :

- Dr Ben Symon

Expert Commenter :

- Dr Komal Bajaj
- Dr Michael Meguerdichian

Editors :

- Dr Victoria Brazil
- Jesse Spurr

First Published : 06/04/2018

Simulcast Journal Club is a monthly/ series that aims to encourage simulation educators to explore and learn from publications on Healthcare Simulation Education.

Each month we publish a case and link a paper with associated questions for discussion.

We moderate and summarise the discussion at the end of the month, including exploring the opinions of experts from the field.

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The Case :

It had been easier, Brad thought, when Dr Snythe had been focused on destroying his simulation program. But with the publication of Brad's improved CPR stats post implementation of the PICU Simulation Program, he'd been both confused and delighted to find the rival intensivist suddenly supportive of his work. There had been, however, an unexpected catch.

Snythe was suddenly excited about the educational benefits of simulation. And he wanted *in*.

While Brad had tried to maintain the fundamental premise as Snythe tried to negotiate both learning to debrief and learning to use his frontal lobe, he was ashamed to admit that his archenemy's combination of enthusiasm mixed with concrete thinking was making him frustrated, and in some ways, downright snarky.

"You're getting there, Snythe." He said after their latest debrief. "But remember your debriefing molecule. I felt like today you lacked a decent 3 phase structure, and it lead to a very instructor centred debrief. It came across as a bit all over the place." He paused and muttered under his breath. "Kind of like your resuscitations.".

"I heard that!" snapped Snythe, "And I wasn't going for your traditional model. I've been reading a lot about PEARLS and I wanted to give it a try today. I assume you haven't seen it but they've just released a debriefing tool.".

He pulled out his tablet and showed Brad a crisp, blue and white cognitive aid. "Gotta get with the times, old friend." He grinned. "Wouldn't want to come across as outdated and irrelevant.". He paused and grinned wickedly. "Again."

Brad scowled. The truth was he'd heard a lot about PEARLS in conversations with sim educators, but he'd never really 'got it'. Sounded like he'd better jump on the bandwagon though. It had been a while since he'd felt motivated to read much sim literature, but nothing got his inner bookworm going like a good case of career rivalry.

It was time to time to head to debrief2learn. For knowledge…. and more importantly, for revenge.

Discussion :

In 2015 Eppich and Cheng released a new structure for debriefing that is practical, pragmatic and more flexible than some more traditional approaches. Over the next few years they have released a number of papers to assist in translating their original landmark paper.

For our journal club discussants this month, what has PEARLS meant for you?
How have you found using the new debriefing tool? Or if you haven't used it, check it out and let us know what you think? The team behind it are keen for your input!

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Journal Club Summary March 2018 "PEARLS before Snythe"

Article Summary :

The PEARLS paper is an essential foundational paper for simulation educators and is frequently noted by new clinical educators as an extremely useful paper to use when first learning how to structure a debrief.

While many of us may have been taught a traditional 3 phase model in our early simulation training, the PEARLS paper acknowledges that there are times where the structure of a debrief will need to be altered depending on a number of factors such as the time available, learner insightfulness, technical vs human factors content.

The authors state they have four aims for the paper :

(1) "Provide a rationale for scripted debriefing;
(2) Discuss a rationale for a blended approach to debriefing based on challenges to be addressed and debriefing method;
(3) Present a PEARLS debriefing framework and guidance for its application;
(4) Offer early experiences of implementing the framework in simulation educator courses"

To provide **a rationale for scripted debriefing** the authors quote a number of articles that justify the stance that the use of scripts can improve learner's knowledge acquisition.

They then move on to discussing **a rationale for taking a blended approach**, and succinctly break down the three major debriefing variants used in clinical practice :

(1) Learner self assessment (aka 'The Plus/Delta')
(2) Focused Facilitation (often through the use of Advocacy and Inquiry to guide a deeper understanding)
(3) Focused Teaching (to correct critical errors for which it would be unsafe to ignore, in a time efficient manner)

While taking the stance that all debriefs should be *"active, collaborative, and self-directed and learner-centered"*, they discuss some of the benefits of each technique in turn.

They then present the **PEARLS Debriefing Framework**, a tool which breaks down a debrief into 4 key phases : Reactions, Description, Analysis and Summary. The bulk of variability or technique blending involves the Analysis phase, whereby the authors argue one may need to switch between Learner Self Assessment, Focused Facilitation and Focused Teaching.

After providing a number of details tables and charts that provide more in depth information about varying educational strategies, the authors conclude the article by acknowledging the tension between providing a structured script for debriefing and potentially coming across as so rigid that the tool appears prescriptive. While emphasising their intent to provide some structure to debriefers, they also argue that :

> *We agree that educators should avoid formulaic speech and tokenisms as well as linguistic rituals by being curious and authentic; Educators need to find and speak with **their** voice*

Importantly, in 2017 the authors released the PEARLS Debriefing Tool, a cognitive aid for debriefers to use. It is open access and available at https://debrief2learn.org/pearls-debriefing-tool/ .

It has been formally published at : Bajaj K, Meguerdichian M, Thoma B, Huang S, Eppich W, Cheng A. The PEARLS Healthcare Debriefing Tool. Acad Med. 2017. [Post Author Corrections].

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Journal Club Summary March 2018 "PEARLS before Snythe"

Expert Opinions : Komal Bajaj (MD, MS-HPEd) & Michael Meguerdichian (MD, MHPED)

Komal Bajaj, MD, MS-HPEd is Clinical Co-Director of The Simulation Center in New York. She is a Reproductive Geneticist and an Associate Professor at Albert Einstein College of Medicine. Komal's research interests include in-situ programs, healthcare quality metrics, the use of clinical checklists, and challenging conversations. Komal attended Northwestern University's Feinberg School of Medicine and completed her OB-GYN residency training at Northwestern University, followed by a fellowship in Medical Genetics at Albert Einstein College of Medicine. Komal received her Master's in Health Professional Education from the Massachusetts General Hospital Institute for Health Professions. She is a board-certified OB-GYN and board-certified clinical geneticist.

Michael Meguerdichian is the Clinical Co-Director of the H+H:Simulation Center and Medical Director at The Harlem Hospital Simulation Center.. Michael is also an Emergency Medicine physician working at NYC Health + Hospitals Harlem. He started working at The Simulation Center in 2011 and in 2016, he received a Master's in Health Professional Education. With the team, he has helped develop many of the curricula at the H+H: Simulation Center. Leading the fellowship, Dr. Meguerdichian is working towards molding medical education innovators to face the challenges of healthcare today. His research interests include studying the limitations of working memory, degradation of knowledge and skills as well as the benefits of deliberate practice

"At its finest, a debriefing after a simulated or clinical event can be a wonderful symphony of reflection, moving participants (and usually facilitators!) towards improved practice. We treasure such beautiful music, because we've both had moments where our facilitation results in a kazoo solo rather than a Schubert classic. As was pointed out in the discussion by Jesse and others, the cognitive load of facilitating a debriefing can be quite high. Novice debriefers are managing the load of *learning* debriefing while dealing with the load required to *execute* one. We find as more seasoned debriefers, that the stressors of debriefing in the clinical environment or managing expert learners may make a debriefing particularly challenging.

We developed the PEARLS Healthcare Debriefing Tool to lessen the load of debriefing while making the innovative debriefing approach developed by Walter and Adam more accessible. The PEARLS debriefing model integrates three common educational strategies to provide flexibility to the debriefer when addressing varied context and performance domains. Drawing on contemporary design principles, we built a cognitive aid that could be available on smartphone, highlight its flexible structure, and serve as a "cognitive scaffold" (thanks Warwick!) when needed.

Multiple respondents acknowledge the adaptations experienced debriefers make to the PEARLS approach. Vic so generously shared some of her expert adaptations in one of her posts. We make these adjustments depending on the participant mix and what sort of debriefing music we might be arranging that day. The front of the PEARLS Healthcare Debriefing Tool addresses each debriefing phase, identifying associated objectives, task(s), and providing sample phrases and questions. A facilitator may need to utilize prompts from one or more columns (or none!) during a particular phase depending upon his/her debriefing expertise and the context of the debriefing.

As Ann mentions, we hope to encourage a broader application of debriefing, whether it is conversations in clinical teaching, faculty development, as well as outside of healthcare. Kudos Nick for exploring its use with your police collaborators. We've had some fascinating debriefings using the PEARLS approach with colleagues in applied analytics, banking, and junior high students! We acknowledge the wonderful scores that have already been composed and look forward to continued innovation. Undoubtedly, there is so much beautiful music that is yet to be made!"

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Journal Club Summary March 2018 "PEARLS before Snythe"

Summary of this Month's Journal Club Discussion :

Blog Contributors :

- Warwick Isaacson, Ben Symon, Ben Lawton, Melissa Morris, Nick Harvey Smith, Demian Szyld, Vic Brazil
- Jesse Spurr, Chris Speirs, Walter Eppich, Matt Nettle, Adam Cheng, Christina Choung, Ann Mullen

In some ways, "Everybody Loves PEARLS" could effectively summarise this month's journal club discussion. Critique was minor and specific and praise was everywhere! We were particularly touched to have the authors drop by and comment as well!

Overall themes from the discussion could be :

- It is very useful for new debriefers, but has hidden depths for advanced practitioners as well.
- PEARLS provides an elegant debriefing structure while avoiding constrictive prescription.
- There remains room for future innovation.

PEARLS is useful for new debriefers, but has hidden depths for advance practitioners as well :

Warwick Isaacson opened the discussion by reflecting on his journey in a new educational role. He discussed the early brain strain of structuring a debrief that can seem effortless in the hands of an expert and how useful the tool has been to provide a 'cognitive scaffold' for his early ventures into the learning conversation. Similarly Melissa Morris discussed how useful she finds it in "*quickly imparting some type of standard for facilitation*". Matt Nettle stated the benefits of the paper eloquently with his statement that

> *"the PEARLS paper really provided me with a solid foundation for what sometimes is a sea of varied debrief processes and educational theory, all of which can sometimes swirl in the moments of cognitive load while facilitating feedback"*

PEARLS provides an elegant debriefing structure while avoiding constrictive prescription :

Ben Lawton provided his thoughts about the tension between experts and novices and that the "*best guidelines act as scaffolding rather than a cage*". He acknowledged that like much of debriefing literature it relies heavily on expert opinion rather than hard evidence, but praised the paper for its flexible thinking.

Demian Szyld also praised the article extensively, but acknowledged concerns regarding the 'Plus/Delta' model and potential traps when a learner has poor insight into their own errors.

There remains room for future innovation :

Matt Nettle described PEARLS as "*version 2.0 for models of feedback*", and a number of responses involved people sharing either how they have built upon the foundations of PEARLS, or how PEARLS could be adapted to unexpected situations. Vic Brazil shared some specific adaptations and variations within the PEARLs format that she has found useful, while Nick Harvey Smith, Jesse Spurr and Ann Mullen described using PEARLS in alternative formats, such as in debriefing with the police force and in critical event debriefings.

Acknowledgements :

Thank you to Dr Komal Bajaj and Dr Michael Meguerdichian for their expert commentary this month.
Thank you to all commenters this month for sharing your thoughts and allowing us to learn from you.
Simulcast would like to thank the creators of the ALiEM MEDiC series for the inspiration for the journal club's blog format and their ongoing support and contributions to the project.

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1. Eppich, W. and Cheng, A. (2015). Promoting Excellence and Reflective Learning in Simulation (PEARLS). *Simulation in Healthcare: The Journal of the Society for Simulation in Healthcare*, 10(2), pp.106-115.
2. Bajaj K, Meguerdichian M, Thoma B, Huang S, Eppich W, Cheng A. The PEARLS Healthcare Debriefing Tool. Acad Med. 2017. [Post Author Corrections].

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Journal Club Summary April 2018 : "Unconditional Love"

Expert Opinion:

Dr Sarah Janssens

"We need to continue to love our simulation and look for the warts!"

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Journal Club Summary April 2018 "Unconditional Love"

The Article :

"Evaluation of learning from Practical Obstetric Multi-Professional Training and its impact on patient outcomes in Australia using Kirkpatrick's framework: a mixed methods study"

Kumar A, Sturrock S, Wallace EM, et al (2018)
BMJ Open 2018;8:e017451. doi:10.1136/bmjopen-2017-017451

Case & Summary Author :

- Dr Ben Symon

Expert Commenter :

- Dr Sarah Janssens

Editors :

- Dr Victoria Brazil
- Jesse Spurr

First Published :

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The Case :

Nimali looked wearily at the end of financial year forms that had piled up on her desk. Trawling through the accounting reports her stomach sank as she noticed how close to the bottom line their centre was treading. They were keeping their heads above water and the CEO of the hospital was a fan of simulation, but still… they were an expensive unit and some of the medical wards had been complaining of cut backs.

She turned to Nitin who was quietly typing on the other side of the office. "Do you ever worry all this isn't worth it?", she asked.

Nitin paused for a moment and smiled. "I haven't been here as long as you of course, but even I can see the difference in culture that your facility has brought to the hospital. People communicate better. The departments interact more warmly. It's a hospital people can be proud of. Don't doubt yourself Nimali."

Nimali was touched, but she was rarely one to avoid reflection.

"But is that us?" she asked, "Or are we just riding on the coat-tails of other cultural changes? Have we really made a difference to patient outcomes? It's so damn hard to prove with research, this weirdly nebulous stuff! We argue that simulation changes so many things, but we have so little evidence to prove it. I don't know. Sometimes I worry we're deluding ourselves.".

Nitin looked at her with a compassionate grin. "How does one so talented have so much self doubt? You make a difference my friend. Don't worry. One day you'll prove it.".

His words were genuine, too. Having learned so much from her on his fellowship, Nitin was convinced Nimali could do anything. Then again, he thought quietly, he was biased. The truth was he'd been in love with her from the first time he'd heard her talk about psychological safety.

Discussion :

Simulation Educators often have a dual burden to both educate and promote their service as a powerful way to improve patient safety, but we have often struggled to prove it works. Have we in some ways developed an unconditional love for the medium without evidence of actual patient impact? In this month's paper, we hope to learn from Kumar et al's approach, where they used a mixed methods study to assess whether a simulation program made an actual measurable impact on patient outcomes.

SIMULCAST
Journal Club Summary April 2018 "Unconditional Love"

Article Summary :

It's often hard to prove what we do makes a difference, and in many ways finding hard proof that simulation education changes patient outcomes is the Great White Whale of simulation education research.

In this open access paper from Kumar et al, the authors attempt to catch that whale by using a mixed methods analysis to evaluate whether the implementation of an internationally recognised Obstetric Simulation Program is associated with an improvement in patient care for 3 suburban Victorian hospitals. By combining a quantitative, number crunching approach with a more complex qualitative analysis, the authors are able to explore the 'hard data' of patient outcomes *and* the thematic educational outcomes of the program.

As such this two prong approach involves :

1) Exploring pre-existing data for emergencies involving eclampsia, shoulder dystocia, neonatal resuscitation and PPH from 2 years before and after the implementation of the PROMPT program. Data explored included things like cord lactate, volume of blood loss, neonatal injuries and use of certain interventions.
2) Analysing data from pre and post course questionnaires (involving Likert scales and free text responses) to explore any changes in staff attitudes and to explore any particular trends in thematic analysis.

In the end, the paper was able to show mostly statistically insignificant trends towards better patient outcomes for a lot of specific complications (less fractures, better APGAR scores, less brachial plexus injuries) with occasionally statistically significant change (such as an increase in patients with large volume PPH going to OT post delivery, and increased use of Bakri balloons). The thematic analysis of learner feedback revealed a lot of themes regarding reflection on Crisis Resource Management in particular.

In the end, the hospitals involved have formalised the PROMPT program into their training programs with mandatory biannual attendance for birth suite staff, so it appears to have generated strong buy in within the organisation of these hospitals.

As for those of us in simulation education there's some promising hints in this paper of hard evidence of our endeavours, but at the moment (for this paper at least) we appear to still be Captain Ahab, continuing to search the sea for evidence of the whale we prize so dear.

SIMULCOS

Journal Club Summary April 2018 "Unconditional Love"

Expert Opinion: Dr Sarah Janssens, Obstetrician and Gynaecologist

Dr Sarah Janssens studied medicine at the University of Queensland and began working at Mater after completing specialty training in 2012. Since then she has developed her skills as a simulation educator through courses including NHET-sim and the Center for Medical Simulation's Simulation as a Teaching Tool and Advanced Debriefing courses.

Sarah has developed and delivered a variety of interdisciplinary immersive obstetric simulation activities.

Sarah also has a keen interest in using simulations to teach procedural and surgical skills. Her achievements in this area so far include: Implementing a laparoscopic simulation training curriculum for gynaecology trainees, Introducing a transvaginal USS simulation training curriculum, creating the NOVICE course (O&G Pre-Vocational Interactive Clinical Education) to teach junior doctors basic obstetrics and gynaecology skills.

Qualifications: Bachelor of Medicine/Bachelor of Surgery, Fellow of the Royal Australian and New Zealand College of Obstetrics and Gynaecologists.

Thanks Ben for the opportunity to comment on this paper. It will be hard to out-do your clinical vignette, and the comments of your new and veteran contributors! I love the way you have used Nitin and Nimali to bring into sharp focus our tendency to be so in love with simulation that we don't see the warts. We need to continue to love our simulation and look for the warts – not so we can abandon our love, but apply liberal amounts of imiquimod – a painful procedure (or so I hear….)

The PROMPT program (www.promptmaternity.org) is an unconditionally loved program. It is a multiprofessional simulation program developed in the UK and adopted by RANZCOG. We love it because in the UK it led to considerable improvements in clinical outcomes, including serious neonatal morbidity such as HIE and brachial plexus injury.[1] The work of the PROMPT group has been at the forefront of demonstrating T3 outcomes for SBE in obstetrics, making the argument for implementing sim in my hospital an easy one to win.

The ability to scale up and replicate the impact in other settings is a challenge for any program. PROMPT has taken on this challenge, going on to adapt and implement PROMPT globally with some regions publishing the related clinical improvements.[2 3] Following implementation of PROMPT in Victorian hospitals, reported clinical improvements were marginal, however only 50% of clinicians received training, limiting the potential impact of the program. Given this, I was very pleased to see this paper, which evaluated the effects of the PROMPT program in a smaller cohort of three Melbourne hospitals.

Kumar et al set themselves the admirably ambitious target of evaluating the PROMPT program over four of Kirkpatrick's levels of training effectiveness, using some variations proposed by Barr et al. Utilising routinely collected data and a mixed methods approach they report on participant reactions (Level 1), participants change in knowledge (Level 2b), organisational change (Level 4a) and clinical outcomes (Level 4b).

For me the highlight of the paper was the rigorous qualitative analysis of the free text "take home" learnings which provided a really deep dive into what the participants are getting out of the program. (I always wonder if those comments go into a drawer somewhere until they are shredded – in this case, no!) Reassuringly for the PROMPT faculty, the themes uncovered align well with many of the principles taught in the program. Perhaps I'm being a bit picky here, but I do feel the claim of knowledge acquisition from self reported comments was a bit over – reaching and like Luke Summers agree that it may have been better reported as a change in attitudes rather than acquisition of knowledge.

The way that the authors describe using Lewin's unfreezing model of change to embed the program in the hospital culture also deserves to be highlighted. Thanks to Vic Brazil for pointing us in the direction of different evaluation models for educational programs (AMEE guide 67: "Educational programs are fundamentally about change"). Too

often we implement a program with little thought to change management principles, and thus can put the adoption and sustainability of the program at risk, no matter how good it is. Additionally, at the 4a level, I feel the paper would have benefited from the inclusion of organisational changes occurring as a result of the program beyond the program becoming mandatory (eg environmental changes/documentation upgrades).

Regarding the clinical outcomes many of the discussants lamented the difficulty of finding meaningful improvements. There was much discussion on the forum about reasons why this is and Suneth gives a wonderful description of the potential intangible benefits of such a program. His other argument aligns with my own (self-serving) one: given the high quality of maternity care in Australia, so much of what we do is now tinkering at the edges- adverse events so rare, that it is becoming increasingly difficult to demonstrate improvements. Despite this, the program did manage to demonstrate a trend towards a reduction in complications from shoulder dystocia (an outcome not reported in the VicPROMPT study) which is worthy of ongoing monitoring as the program continues. The finding of poorer documentation post PROMPT is interesting (wart alert!) and should feedback into a review of the program. I also do wonder if increasing use of the Bakri balloon in PPH may reflect increasing practitioner familiarity with a product introduced in 2011 rather than the program itself.

The paper itself suffers somewhat by attempting to condense this vast evaluation into one manuscript and the reader may be left a little confused at times as the paper progresses with little contextualisation for each of the levels assessed. Having said that, the authors have achieved something we should be striving to do more routinely, that is, evaluating a program through multiple lenses, using the data we routinely collect as part of program evaluation and clinical data systems.

To wrap up, this paper and subsequent discussion has highlighted for me:

- Program evaluation is not simple one size fits all
- There is value assessing a program from multiple perspectives and considering a broad range of both qualitative and quantitative outcome measures
- Don't expect overwhelming improvements in patient outcomes (but I'm going to keep looking when I can)
- We need to think about "intangible" benefits and how they might be captured (ideas???)
- We should consider behavioural change theory in program implementation

Thanks again to the Simulcast team for such a great journal club.

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2. Weiner C, Samuelson L, Collins L, et al. 61: 5-year experience with PROMP (PRactical Obstetric Multidisciplinary Training) reveals sustained and progressive improvements in obstetric outcomes at a US hospital, 2014:S40-S40.

SIMULCAST
Journal Club Summary April 2018 "Unconditional Love"

Summary of this Month's Journal Club Discussion :

Blog Contributors :

- Luke Summers, Ben Symon, Bec Szabo, Derek Louey, Vic Brazil, Ben Lawton, Suneth Jayasekara

There was quite a breadth of opinion this month with a variety of perspectives, although the meta-conversation on some levels appeared to be focused on justifying why this paper couldn't find the positive results we would hope for as a group of simulation educators.

Justifying the outcome of the paper

There were a number of acknowledgements as to why the paper had been unsuccessful in providing hard data that an educational intervention can improve clinical outcomes. Luke Summers noted that *"high risk low frequency events… by definition would require massive studies to be able to identify any significant objective improvements",* whereas Suneth Jayasekara went further, stating that *"I think this study was set out to be a negative study right from the get go. Monash is in all likelihood a mature obstetric centre with highly trained and experienced obstetricians and midwives. To significantly improve the performance of these practitioners in the outcomes they looked at by a 1/2 day course would be very unrealistic."*

Derek Louey argued that "*The problem is it is difficult to prove that any educational activity improves hard clinical outcomes because of multiple confounders that influence clinical performance.*".

Vic Brazil on the other hand challenged the underlying premise of the article, arguing that *"The flaw of choosing 'format driven' education, on the basis of a binary 'it works (or not)' world view. My qualitative research friends would say we need to explore what works, for whom, when, and under what circumstances. Educational interventions are rarely 'cookie cutter' and have different impacts in different hands. My thought is that these judgments are what makes a great sim educator."*

Admiration for the methods used

Multiple comments were made regarding the quality of the study and its choice of methods. Ben Lawton noted that obstetric complications in general appear ripe for this kind of study :

"*PROMPT is an inherently attractive course to try and measure the level 4 outcomes for as the patient population it is training people to look after are fairly homogenous (generally healthy women of childbearing age) for whom the vast majority of complications experienced come from a fairly small list and all have an outcome (a baby) who is assessed with a widely accepted and validated outcome measure (an Apgar score) regardless of whether there is a study going on.".*

There was appreciation for the paper's use of Kirkpatrick's Framework, (Reaction, Learning, Behaviour, Outcome) , although as Vic noted *"Kirkpatrick's isn't the only model. Thinks like 'logic models' and other approaches may be better for complex interventions. I am no expert on this but i know where to look…….* https://www.ncbi.nlm.nih.gov/pubmed/22515309*"*

Hope for the future

Suneth Jayasekara argued that while there were only positive trends shown by this particular study, the educational benefits of such interventions may be more successful in less tertiary centres where the levels of experience are not as concentrated. Ben Lawton on the other hand, argued that other PROMPT studies *"have shown improvements in Apgars in big population cohorts after the introduction of PROMPT, which still has the weakness of proving association but not causation. Though this has been demonstrated after the introduction of PROMPT in a few different countries. This might be a bit of a stretch but I can't help feeling that taken together these trials behave like a clumsy step-wedge study and might be as good evidence as we are going to get for a while that this type of training is effective."*

Acknowledgements :

Thank you to Dr Janssens for her expert commentary this month.
Thank you to all commenters this month for sharing your thoughts and allowing us to learn from you.
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References :

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SIMULCAST

Journal Club Summary June 2018 : "First Aid"

Expert Opinion: Liz Crowe

"The greatest risk to patient safety is a failure to learn from incidents and events"

SIMULCAST

Journal Club Summary June 2018 "First Aid"

The Article :

"Charge nurse facilitated clinical debriefing in the emergency department."

Rose, S. & Cheng, A. (2018).
CJEM, 1-5. doi:10.1017/cem.2018.369.

Case & Summary Author :

- Dr Ben Symon

Expert Commenter :

- Liz Crowe

Editors :

- Dr Victoria Brazil
- Jesse Spurr

First Published :

Simulcast Journal Club is a monthly/ series that aims to encourage simulation educators to explore and learn from publications on Healthcare Simulation Education.

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We moderate and summarise the discussion at the end of the month, including exploring the opinions of experts from the field.

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The Case :

"I was wondering if you could arrange a debrief for the team, Cath?" said Christine quietly. "I know it was a week ago, but I'm getting a lot of questions from my staff about the outcome for the patient and the choices we made on the day."

Cath swivelled her chair towards the window and frowned.

"I agree it'd be a good idea, and I've been wanting to get some critical event debriefs happening for months, but we don't have anyone trained in that area! I can debrief a simulation pretty well, but there's some evidence that doing this badly could worsen PTSD symptoms! And the times I've tried to get one going, people are off shift or unable to come in and anyway it's frankly uncomfortable debriefing an event that I was in charge for. I think we need to wait until we've got some trained professionals to do this sort of thing. I'm sorry Christine.".

Christine eyes flared with frustration. "I don't think you quite understand. I'm having trouble staffing Resus! A few nurses have asked to just do short stay only for a while, Andrew's called in sick twice this week, and that's not like him, and there are also some systems issues that came up with that trauma that frankly we need to acknowledge and fix before the next serious paediatric trauma comes in.".

"I agree that physicians shouldn't always be in charge of debriefing." She continued. "But you guys are the only ones who get leave and enough pay to cover an expensive debriefing course. Surely there has to be another way we can do this?".

Discussion :

Clinical educators are increasingly being asked to participate or contribute to the development of critical event debriefings in the hospital environment, but numerous barriers can get in the way. In this month's article from Stuart Rose & Adam Cheng, we examine a system implemented in 3 hospitals in Calgary, Canada that utilised Charge nurses to facilitate over 200 critical event debriefs in their emergency departments.

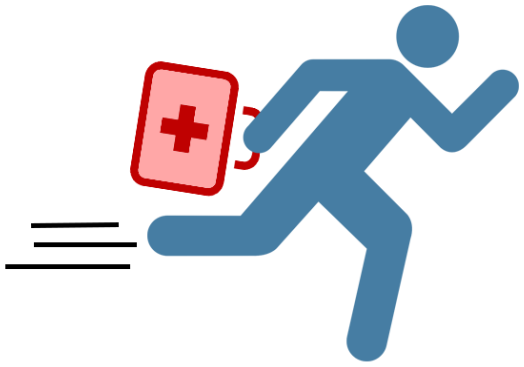
For the journal clubbers this month, what did you think of the article? Have you been asked to get involved in critical event debriefing? What have been the barriers for you? Does this article point you towards another potential solution?

SIMULCOS

Journal Club Summary June 2018 "First Aid"

Article Summary :

After a Resus, physicians and ED nurses are often immediately pulled away to see other patients, making debriefs rare.



But Charge Nurses don't tend to have a single patient load, are situationally aware, experienced and team minded...

So they can also make great debriefers!

So in 3 Hospitals in Calgary, *Rose & Cheng* created a new, tightly scripted model for ER debriefing that involves immediate, on site debriefing by ED charge nurses.
It is triggered by either CPR, Intubation, Level 1 Trauma or staff request and is called the **INFO** model.

INFO model =
Immediate,
Not for Assessment,
Fast, **F**acilitated, **F**eedback
Opportunity to ask questions.

Rollout included a 4 hour train the trainer for nurse educators and local champions, and then a 2 hour program to teach the scripts and principles to Charge Nurses.

They have now completed :

254 debriefs
involving
1300 staff

Could the INFO model help your department implement debriefing?

SIMULCAST
Journal Club Summary June 2018 "First Aid"

Expert Opinion: Ms Liz Crowe

Liz Crowe is an Advanced Clinician Social Worker who has worked extensively for 20 years with individuals, families and children impacted by grief, loss, trauma, crisis and bereavement. She has worked in Brisbane's major children's hospitals in intensive care, emergency departments, cancer wards and all areas associated with children's health. In her current job in a children's intensive care unit, she is exposed daily to death, violence, trauma and illness and is now recognised as one of the most experienced counsellors in this field in Australia.

Liz is currently a PhD Candidate with the School of Medicine, The University of Queensland. The focus of her research is *Staff Wellbeing in the Paediatric Intensive Care Unit*. She regularly speaks on the national and international circuit regarding : *Loss and Grief, Staff Wellbeing, Difficult Conversations, Talking to Children about Loss and Grief, Working with Schools in crisis, Mental Health at Work, Resilience for children and adults, Self Care, Gender Relationships, Parenting, New Mothers and Sexuality, Adjustment to Parenthood.*
You can follow her on Twitter @LizCrowe2 .
You can listen to Liz's podcast on clinical debriefing here at St Emlyn's blog.

"There is a legal and moral responsibility to protect staff from workplace distress, trauma and its consequences. Regardless of where individuals currently work in healthcare there should be an expectation to do what is reasonably practical to eliminate or minimise risk to worker health and safety. Organisations that have awareness that employees may be exposed to distressing events need to have a consistent and effective management strategy for those who may be exposed (Greenberg, 2001). Yet the reality in most health institutions is vastly different. Staff involved in any type of critical incident have a 'hunger' for something to occur either formally or informally as means to learn, grow professionally and at times more importantly validate their own feelings and emotions. Debriefing is an efficient and cheap resource that is offered in the absence of anything else. Debriefing is frequently perceived as a 'safe' option despite no standardisation in the literature, no strong evidence for outcomes, that facilitators rarely have any formal training and no appropriate tool for evaluation as to its perceived risks and benefits.

Staff who work within the healthcare environment are routinely exposed to potentially stressful and significant events due to the very nature of their work (Huff,2006). Stress and poor health amongst health care staff is a contributing factor to organisational inefficiency, high staff turnover, decreased quality and quantity of care, increased costs of health care and poorer rates of job satisfaction (AbuAlRub, 2004). Sadly, for most hospitals a systematic response to staff wellbeing, particularly in relation to a critical event, is dependent on the good will of senior staff. Across the globe it is led by either medical and nursing staff or in some institutions by staff with a psychological background such as social workers, psychologists or those with mental health training. Most staff who provide debriefing are operating outside their role descriptions and without any formal agreement from health leadership. Typically, these clinicians will have been directly involved in the critical event themselves. This has both benefits and risks. Every day events that create distress are often internalised by staff with unknown consequences and outcomes. Occupations such as the Police, paramedics, fire services and the armed forces that have similar exposure to trauma, death and the impact of illness and violence have established infrastructure, resources and policies for response with counselling, debriefing, psycho-education and peer support structures.

Another major challenge for the establishment and understanding of the impact and effectiveness of debriefing is that there are numerous processes conducted in the health setting that use the term 'debriefing' though what this constitutes varies enormously. There are 'hot', 'cold', 'operational', 'emotional', 'defusing', 'distress', 'clinical', 'formal' and 'simulation' debriefings. There is no global consensus for what 'debriefing' means.

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Journal Club Summary June 2018 "First Aid"

With the release of the Cochrane Review in 2002 (Rose et al) debriefing of any nature was deemed to be at best benign and at worst dangerous. Health professionals were told to cease all debriefing with no other mechanism or intervention suggested as an alternative. It is important to note that the Cochrane Review was evaluating single session interventions for a very different population than health professionals. The cohorts who were involved in compulsory debriefings included MVA victims, relatives of seriously injured individuals 12 hours post the injury, women who experienced miscarriage, acute burns victims who were still undergoing active treatment and women who had just given birth. Only one study included second responders. Out of the 11 studies the outcomes of debriefing were that 3 groups improved, 2 groups were psychologically worse and in 6 groups there was no significant difference. From this small sample size of varied populations debriefing has been labelled 'dangerous'.

Rose and Cheng have done a wonderful job in their paper '**Charge Nurse Facilitated Clinical Debriefing in the Emergency Department'** of describing and discussing their current model of providing 'hot' or immediate debriefing following critical events which they have called INFO (*immediate*, *not* for personal assessment, *fast* facilitated feedback and *opportunity* to ask questions). Development of a 'feasible and sustainable' debriefing structure in an emergency department is a solid foundation to further research and understanding of impact as well as sending an important message to staff that their skills and contributions are valued. The use of an ED charge nurse who is present at resuscitations, though not directly involved, has benefits in that the person will be known to the team and so hopefully is respected and accepted. Previous research has demonstrated that the majority of occupations want to be debriefed by someone who has credibility and intimate knowledge of the work, rather than an external facilitator.

The INFO tool is clear and the use of a 'script' keeps the facilitator on task allowing the process to be conducted and completed in the 10-15 minutes allocated timeframe following an event, recognizing that staff are required to return to clinical duties or proceed to a change of shift. Creating a "Teach the Teacher" model ensures there is a pool of trained facilitators and that the model should not be depleted over time due to staff attrition. Objectives for the INFO debriefings are centered around improved communication, education and an efficient way to provide feedback about concerns within the system which are reportedly met and implemented quickly. The article reports on practice and cultural outcomes as a result the introduction of INFO. This model is clearly able to be replicated in other health settings which is always important in published papers. One of the limitations of the study would be the subjective reporting of benefits without any real evaluation and no benchmarking on, before and after implementation. It is also unclear whether the quality and outcomes of debriefings have varied since the facilitation role was transferred from physician led to nursing led.

One of the greatest challenges in advancing the use of debriefing is how to provide evidence in relation to outcomes. Evaluating the effectiveness of a debriefing process is complicated. How do you evaluate individual outcomes in a group intervention when those individuals will have started with a variety of psychological baselines, will engage in various self-help or self-destruction activities post the event and will also be exposed to personal and professional traumas and rewards during the evaluation period? A post-traumatic stress disorder (PTSD) measurement tool is frequently cited as the gold standard. Yet PTSD can not be diagnosed until 4-6 weeks after the traumatic event and debriefing of any description would typically occur before these this. Measurement of PTSD following a critical event may also not be the most appropriate benchmark, impact on sleep, use of substances, irritability, impact on concentration and anxiety may be more significant and tangible? Another major barrier for evaluation is the ethics of the use of randomized control trials following a critical incident allowing some staff to be supported and others to fend for themselves. Tuckey and Scott (2014) did conduct a randomized control study with emergency service personnel using four measurements- , namely, post-traumatic stress, psychological distress, quality of life and alcohol use. They found that those who engaged in debriefing used significantly less alcohol and reported greater post intervention quality of life. As is reported in other studies they did not find any effects on post-traumatic stress or psychological distress – this may be because the measurement tool is wrong rather than debriefing has no value.

However, how to successfully evaluate and provide any supporting scientific basis for debriefing remains confusing with subjective reporting common. Therefore, the lack of evaluation of this article should not be seen as a flaw.

There are several points worthy of reflection in relation to the article and model. Firstly, I would like further information on who is included and excluded from the debriefing experience? Is it only staff who were directly involved in the event itself? Are administration and staff support personnel such as wards people included? In our hospital there are strict criteria for who can and cannot attend debriefs. Debriefing is only offered to clinical staff who were directly involved in the event. Support staff and line managers are not allowed to attend as it changes the focus and level of safety disclosure. Should support staff require any type of support this is done outside the clinical debriefing format with a more emotional focus.

The article implies that the INFO process is a forum for feedback and discussion rather than what is traditionally known and understood as debriefing. The term 'feedback' is used several times in the tool. There appears to be no articulated space for anything more than individual reporting which the authors may argue is the defined purpose of a debrief immediately post a critical event? The exclusion of any emotional content or space for distress is also interesting. Humans are emotional beings by nature. Personal observation of over 15 years of facilitating debriefs immediately post an event or in the subsequent weeks that follow is that it is the emotions attached to the event or the operational conduct that is causing distress or disturbance to work and to neglect these components in the debrief heightens distress.

The INFO model presents as having a strong system response for feedback and without any emotional inclusion I am curious as to how psychological safety is established so that staff can talk about any concerns around team dynamics, communication or leadership within the event? While open to debate on the issue of note taking and scribing during a debrief, it is not something that is supported by literature or experience. Debriefing is not the place to evaluate staff performance or conduct investigations. Anything that is written down during a debrief can later be used in a processes or health investigation and should be thought through very carefully. It also gives an impression of performance review. If there is something concerning that has arisen from the debriefing it can be consented amongst the group verbally to report back to management without note taking ever occurring.

The other area of interest to me with the INFO model is it only appears to follow a resuscitation. Emergency Departments and hospitals are dynamic environments with unpredictable events. Is the INFO model ever used to debrief events following episodes of violence or aggressive behaviour, unexpected death, confronting cases or moral distress?

With no evidence I can only report that the best debriefings I have been involved with achieve a combination of objectives. Debriefs similar to the INFO process occurring immediately after an event bring the team together to pause and hold them in a space to reflect and learn on what has just occurred, assess any risk and decide whether or not they may need to gather again in the future. A more in-depth and delayed debriefing should only occur if staff who were involved in the incident believe it is required and would be useful to them on any level. The purpose of a more detailed debrief 5-7 days post the event (this is optimal timing so that people are less heightened and have more objectivity) is again multifactorial. Personally, we start with a full history and understanding of the event which is important given that not all staff ever really have all the details. To explore what happened during the event, perspectives on leadership (not judgement), what was happening with communication, what occurred operationally, what were the learnings? Then to reflect on how people have felt subsequently about the event. Interestingly often when the history and operational functioning of the event have been unpacked many staff, particularly junior staff will state their distress had been around concerns they failed to act quickly enough or be a functioning contributor to the event and now with all the details this distress is eliminated. We then talk at length about what is a 'normal' emotional response to a critical event and provide discussion of a psychoeducational nature. Staff benefit from awareness of the symptoms of acute distress in the days following an event and an understanding that the majority of first line

responders endure the temporary state of acute stress disorder and return to normal function with minimal disruption (Aucott & Soni, 2015). Staff are empowered to recognize emotional responses that could be described as 'coping' and does not require pathologizing or intervention. We also always use two facilitators for the delayed debrief. Debriefing in the immediate post event space is common in our organization. A more formal delayed debriefing is only instigated at the request of staff recognizing there is an under-estimation of resilience in the health workforce.

The greatest risk to patient safety is a failure to learn from incidents and events, medically and psychosocially. Following a critical incident or resuscitation staff want to want to engage in debriefing (Berg, 2014). The commencement of any formalized system to provide debriefing is a strong foundation to understand further the needs of staff with regard to education, development of skill levels, post traumatic growth, increased psycho-educational needs and the addressing of emotional needs. The INFO model of debriefing is a solid starting ground that is able to be replicated and developed further by other health environments.

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SIMULCAST
Journal Club Summary June 2018 "First Aid"

Summary of this Month's Journal Club Discussion :

Blog Contributors :

- Farrukh Jafri, Ben Symon, Stuart Rose, Susan Eller, Ian Summers, Derek Louey, Lucinda Mithen
- Sarah Janssens, Laura Rock, Suzanne Nelson, 'Leo'.

This month's article caused some enjoyable controversy and disagreement, with 3 strong themes being :

- Admiration for the simplicity of the INFO tool and its local success
- Desire for more detail within the article itself
- Disagreement regarding whether to separate technical debriefs from emotional debriefs.

Admiration for the simplicity of the INFO tool and its local success :
The discussion began with Farrukh, Ben and Stuart sharing reflections about event debriefing within their local services. Farrukh expressed admiration for the simplicity of the INFO approach and its use of Charge Nurses to enable consistent debriefing standards.

> *"The shifts are always so busy and I often feel overloaded, so it often now does not dawn on me to debrief. This is the complaint I get also from other staff members who have not debriefed, it's just too busy. This is why I really like the idea of a designated member to debrief, a charge nurse sounds perfect." – Farrukh Jafri*

Desire for more detail within the article itself :
Seemingly in response to appreciation for what the paper had to say, multiple bloggers asked for more detail from the article itself. Sarah Janssens, Susan Eller and Derek Louey all expressed a desire for more information, with Derek expressing concern regarding the editorial nature of the paper.

Disagreement regarding whether to separate technical debriefs from emotional debriefs :
Much of the meat of the discussion came from debate about whether psychological 'first aid' should be included in post event debriefings. By the end of the month, there appeared to be two main camps : Those who felt emotion could not be separated from cognition, and thus needed to be acknowledged; and those who voiced concerns regarding the potential psychological damage of addressing emotionally distressed staff without expert training within that field.

Stuart (the author), Farrukh and Derek each expressed the dangers of turning a post event debrief into a counselling session. Derek highlighted a Cochrane review that cautioned debriefing may be associated with higher PTSD scores, while Stuart argued that debriefing emotional issues takes time, and as such should be done at a later stage when it can be facilitated more thoroughly. He also noted engaging in too many emotional issues in a 'hot debrief' could lead to the lengthiness of the process becoming a barrier to debriefing at all.

Others in the discussion such as Lucinda Mithen, Suzanne Nelson and others felt more strongly that emotional defusing was an important part of a post event debrief. Ian Summers argued :

> *"I have found in clinical debriefing (and sim) debriefing that a failure to hear and acknowledge the inherent emotion or sadness of an event to be a barrier to some of the people there." – Ian Summers*

Laura Rock contributed the final comment of the month, arguing :

> *I do think we should seek two goals for managing intense emotion: 1) diminish intensity of emotion by naming and validating it to allow for effective cognitive processing and 2) explore the emotion to better understand what's behind it. Emotions are a window into what really matters to people and if we take emotions at face value we risk losing a better understanding of ourselves and others. – Laura Rock*

Acknowledgements :

Thank you to Liz Crowe for her expert commentary this month.
Thank you to all commenters this month for sharing your thoughts and allowing us to learn from you.
Simulcast would like to thank the creators of the ALiEM MEDiC series for the inspiration for the journal club's blog format and their ongoing support and contributions to the project.

References and Further Reading :

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Journal Club Summary July 2018 "Relationship Strain"

Expert Opinion : Stephanie Barwick

"The 'elephant in the room' can derail a debriefing because the elephant draws its power from the fact that it lurks in the shadows and loses its power as soon as the light is turned on"

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Journal Club Summary July 2018 "Relationship Strain"

The Article :

"Difficult Debriefing Situations : A toolbox for simulation educators"

V. J. Grant, T. Robinson, H. Catena, W. Eppich & A. Cheng (2018)

Medical Teacher, DOI: 10.1080/0142159X.2018.1468558

Case & Summary Author :

- Dr Ben Symon

Expert Commenter :

- Steph Barwick

Editors :

- Dr Victoria Brazil
- Jesse Spurr

First Published : 01/08/18

Simulcast Journal Club is a monthly/ series that aims to encourage simulation educators to explore and learn from publications on Healthcare Simulation Education.

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The Case :

It was a conversation that Nimali had been avoiding but coming home to a filthy kitchen and a frying pan full of cold, day old rice had pushed her conflict avoidance tendencies out the window. She strode resentfully down the hall to find Joe and her son cuddled up on the couch. Her husband cheerfully raised his glass in a casual welcoming gesture and turned back to his phone.

"I'd like to talk about what's going on in the kitchen." She said icily. "Is an ounce of cleaning too much to ask when you've had the whole day off with the kids?"

"Not now mate." sighed Joe. "I'm tuckered out. This one had me up since 4am." He patted their son as he lay half asleep in his lap.

"I think that's a bit dismissive." countered Nimali. "We've had this fight a number of times and it's a real trigger for me. The dynamic seems to be that I ask you to step up and then nothing has changed. I'm working full time again now, I need you to pull your weight!".

"It's not my fault I got retrenched, Nimali." Joe scowled. "And it's not lazy of me to leave some housework till after he gets to bed.".

Nimali sighed and sat down next to him on the couch. She reached over and took the wine glass from his hands. "I get it, hun. I do. I know it's been hard finding new work, especially when you loved that team so much. And I'm sure it's not uncommon for men to struggle with their identity a bit after losing work. But I've taken on more hours to support this family. If we're really honest you're being a great Dad but I'm still doing most of the housework on weekends, and when you don't follow through, it makes me feel like you don't respect how hard I'm working to keep us afloat."

Joe didn't answer at first, but Nimali let the silence hang. Calmly, without any anger, she held his gaze.

A few more seconds passed, and then he leaned impulsively forwards in the couch and kissed her on the cheek. "I hear you." He said. "And I'm glad that we could have a discussion without any damn debriefing techniques for once.".

Nimali smiled.

Discussion :

In the case study today, Nimali faced a reluctant, dismissive encounter at home. While she and many of us may feel we have mastered the basics of debriefing, most of us could name similar times in our lives when a conversation was uncomfortable or difficult. In this open access paper by Grant et al, the authors provide us with a list of common debriefing conundrums while simultaneously providing useful verbal and non verbal techniques to approach them.

For our bloggers this month, what did you think of the paper? Do you think it will help your practice? Are there any challenges you experience commonly?

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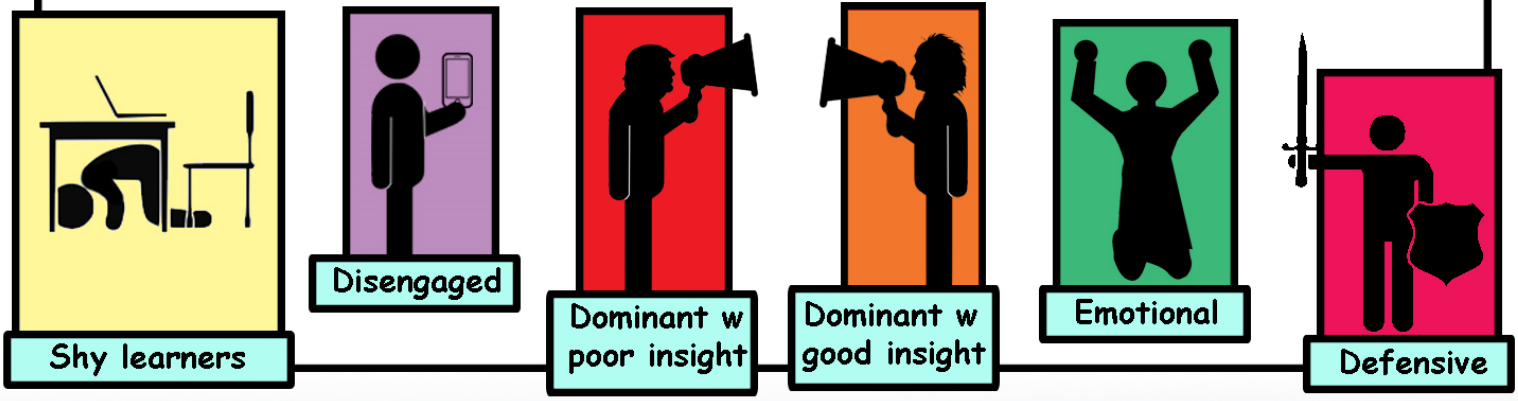
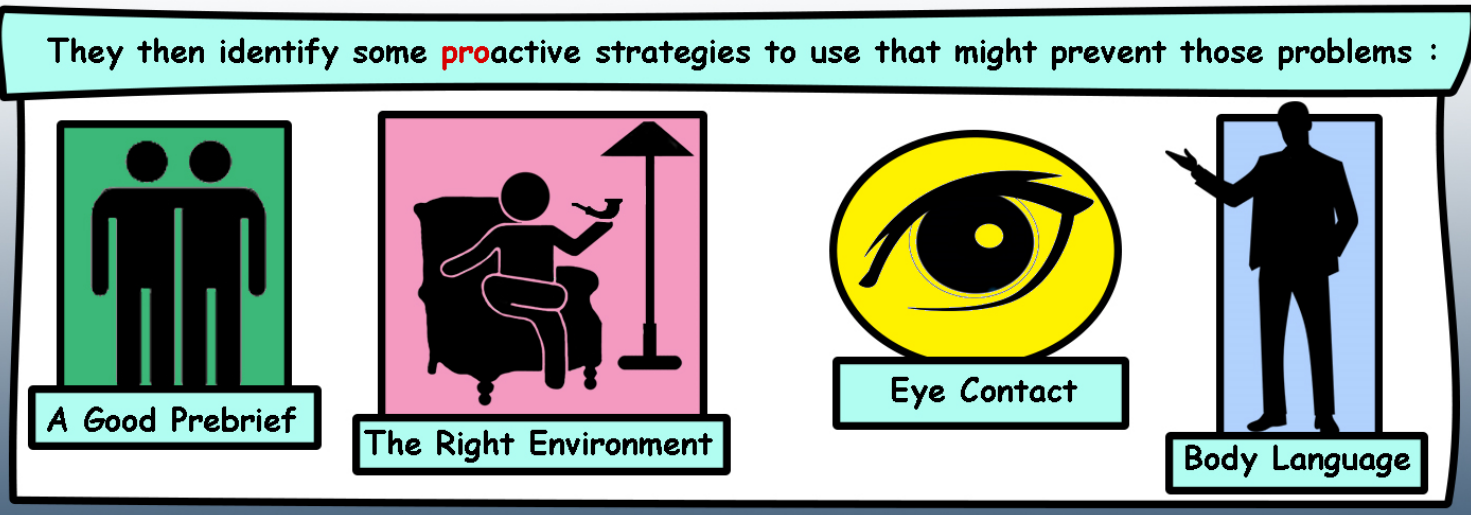
Journal Club Infographic July 2018 : Difficult debriefing situations: A toolbox for simulation educators

V. J. Grant, T. Robinson, H. Catena, W. Eppich & A. Cheng (2018), , Medical Teacher, DOI: 10.1080/0142159X.2018.1468558

Firstly, Grant et al identify 6 common types of challenging debriefing situations :



They then identify some proactive strategies to use that might prevent those problems :



And then move on to some reactive strategies :

Some useful tools for your debriefing utility belt!

Infographic by @symon_ben

Expert Opinion: Ms Stephanie Barwick

Steph is both a Registered Nurse and Registered Midwife and is the acting Director of Simulation at Mater education in Brisbane. She has a combined passion for critical care nursing and simulation-based education and has successfully implemented a sustainable organisational wide in-situ simulation program at the Mater. Since returning from her simulation fellowship at the Centre for medical simulation in Boston, she has been leading the educational development of the Speaking With Good Judgement Program.

Steph is undertaking research looking at methods to better implement in-situ simulation and its impacts upon the healthcare consumer who may be exposed to this type of training.

I remember after a particularly difficult debriefing I had, I did what every reputable educator would do and googled 'difficult debriefings' in the hope that I would find some debriefing self-help magic. I was disappointed, like the authors of this paper mention, I couldn't find anything specific to help in my time of need. I was ready to return the 'debriefing license' that CMS had handed me a year earlier but was lucky enough to have a fabulous team around me and together we discussed strategies for the future. A few of those strategies are discussed in this paper which shares with the reader contributing factors to difficult debriefing as well as proactive and reactive strategies that can be implemented into practice.

As educators we know that for successful learning to occur the debrief needs to be conducted in a way that facilitates discussion and reflection, and the difficult debrief can threaten this experience for both the learner and the debriefer. This paper shares insights, experiences and strategies from well-known experts with many years of experience in the field. I really love that papers like this are published as it demonstrates how valuable our experiences are and how helpful they can be when shared with the simulation community.

The types of difficult debriefing situations discussed in the paper give a clear picture of what to be aware of before and during debriefings. A difficult debrief may also be pre-empted by the presence of these types of behaviours in the prebrief or during the simulation. I quite liked the way the contributing factors were categorised into learner-specific and situation-specific factors. I would love a third category, debriefer-specific factors, with further discussion about how what the debriefer brings to the table can contribute to difficult debriefings. Interestingly, I found myself reflecting on some of the learner-specific factors and thinking that sometimes I have demonstrated these behaviours as the debriefer as well. I have at times found myself internally defensive when learners push back on a case I have developed, through experience I have learnt to self-regulate in the moment, but I wasn't always like that and would find myself responding with defensiveness in the debrief. Sometimes debriefings become difficult because of the feelings we have had or the debriefing moves we have chosen.

As we don't always have complete control over how our learners experience the simulation or debriefing or what they bring with them, the 'toolbox' of solutions presented in this paper gives us a number of useful strategies in preparation for and management of difficult debriefings and is my favourite part of the paper. A lack of debriefing training amongst those who conduct debriefings is common; Fey and Jenkins (2015) demonstrated this in a study looking at debriefing practices of prelicensure nursing programs in the United States. They found that only 47.5% of educators conducting debriefings had received debriefing training, and so I think papers like this one are extremely important (Fey & Jenkins, 2015).

It was really useful to separate the strategies into proactive strategies and reactive strategies and want to highlight what Mary said about the importance of the proactive strategies. If you get this right, you are less likely to need the reactive ones. Proactive strategies like the prebriefing and creating psychological safety can negate the need for the reactive strategies. Congruence between how the debriefer conducts themselves day to day and in the debriefing is essential. I believe this is the same for using body language as a proactive strategy in debriefing. If you aren't open and inviting with people outside of the debriefing, learners may perceive an action opposite to this as inauthentic and

not engage openly and honestly. Like Mary and Susan mentioned in the comments, I would have also liked to see some narrative around rapport building between debriefer and learner as a proactive strategy. I would also suggest that a well-designed and pre-tested scenario is also a proactive strategy that can help mitigate the risk of being at the helm of a difficult debriefing.

Considering the debriefing environment as a proactive strategy is a great inclusion. Many of the debriefings I have conducted have been after an in-situ simulation and so the debriefings occur in the clinical environment. This adds to the challenge of ensuring an environment where learners feel comfortable and safe enough to engage in a debriefing. The regular work activity continuing on the other side of the door can be distracting for the learners which can impact their engagement and contribution to the conversation. Being transparent about this is important, I will often say, "I recognise that there is a busy clinical environment outside and so I ask if we can put that to the side for the next 15 minutes while we spend some time reflecting on the experience we've just had". I find this gives learners permission to focus in that moment on the conversation we are all engaging in.

In the reactive strategies, like Eve and Rebecca, I particularly appreciated the specific communication tools for difficult debriefings and the sample wording provided. Figure 1 will definitely be something I will be referring back to and sharing with fellow debriefers. Of the reactive strategies described in this paper, I'd like to touch on 2 that really resonated with me; Naming the dynamic and Learner follow-up. Like Mary and Farrukh mentioned, when challenging situations come up in a debrief we have the dilemma, do we avoid, or do we lean in – the best option is to lean in and name the dynamic. The 'elephant in the room' can derail a debriefing because the elephant draws its power from the fact that it hides in the shadows and loses its power when the light is turned on (Zerubavel, 2006). Name it to Tame it is my mantra when faced with this situation. Drawn from psychology, this mantra, links to the concept of affect labelling whereby an emotional state that is experienced can be disrupted by the simple act of labelling the emotion (Lieberman et al 2007). In other words, naming a negative emotion or dynamic has the power to tame it.

I have followed up with learners many times after a difficult debrief so was extremely happy to see this included in the paper as a one of the reactive strategies. This kind of follow up acknowledges that learners may need time and space to process information and emotions, as mentioned in the comments from Vince. I have also checked in with learners' post debrief if I am worried about how their emotional state was during and after the debrief as I feel a duty of care as the debriefer to ensure my learners are not damaged by the experience. Every time I have checked in with a learner it has been a really positive experience.

My final thought would be that debriefing is a two-way conversation, so I would suggest there are some proactive and reactive strategies that could also rest with the learners. Some responsibility to an effective debrief, lies with how well the learners are engaging, reflecting and receiving feedback. I think this means training our learners in how to reflect and receive feedback well. Stone and Heen (2014) state that receiving feedback well means 'managing your emotional triggers so that you can take in what the other person is telling you, being open to seeing yourself in new ways'. This is a skill that takes practice but could be a proactive strategy, as a learner, that could help reduce the occurrence of the 'difficult debrief'. The Role of receiving feedback is a topic one of my colleagues, Melanie Barlow, is studying PhD and a focus of education in our unit at the moment.

Overall, I found this paper very helpful and really believe it will be one of the 'go-to' papers for both novice and experienced debriefers. It will certainly be one I share with colleagues and refer back to regularly.

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- Zerubavel, E., & ProQuest. (2006). *The elephant in the room : Silence and denial in everyday life*. Oxford: Oxford University Press

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Journal Club Summary July 2018 "Relationship Strain"

Summary of this Month's Journal Club Discussion :

Blog Contributors :

- Mary Fey, Eve Purdy, Ben Symon, Farrukh, Jafri, Susan Eller, Rebecca Smith, Vic Brazil, Vince Grant

The responses to this month's article were markedly positive. It was with some relief however, given the paper's pedigree, that the group felt comfortable providing some small critiques as well.

The theme of the responses overall, could be condensed into :

- Appreciative thirst for more depth or inclusion of other strategies
- A sense that the paper gives permission to the debriefer to engage in difficult conversations.

Bloggers shared common experiences in difficult debriefs and appreciation for the specific strategies outlined in the paper. Mary Fey started the conversation :

> *What the Grant et al paper provides are practical strategies for "leaning in"; helpful to novice and experienced debriefers. The phenotypes they describe are all situations we've dealt with: disengagement, domination by one who has poor insight, domination by an expert, defensiveness, etc. I find the most helpful section of the paper to be the "toolbox", in which the authors describe both proactive and reactive strategies. It's been my experience that, with difficult debriefing situations, an ounce of prevention is worth a pound of cure. As my prebriefings have gotten better over the years, my debriefing difficulties have decreased proportionately. – Mary Fey*

Eve Purdy offered some critique regarding the cognitive strain of Figure 2, which was echoed by multiple responders who argued it was complex to the point of being difficult to use. Vic Brazil discussed how useful it would be to view some multimedia that actively demonstrates the use of the techniques outlined in the article.

Other bloggers shared their appreciation of various techniques either mentioned or not discussed within the paper. In particular the use of Rapport in and out of the sim lab, the use of the environment to establish safety, and engaging in post debrief follow up with learners.

Many responders reported that the paper encouraged them to address the elephant in the room. By providing concrete strategies for doing so, it's possible the paper has made what seems previously an insurmountable challenge to now be of an achievable difficulty. Rebecca Smith stated :

> *Tackling 'the elephant in the room' is daunting when you are a beginner and it's often tempting to avoid uncomfortable conversations for fear of eliciting a strong emotional response or causing harm to your learners. I'll still be taking my co-facilitator with me but I'm looking forward to trying some of these strategies and pushing myself as a debriefer. – Rebecca Smith*

Ben Symon and Susan Eller raised the importance of considering how the debriefer contributes to unexpected challenges as well, with Susan pointing out that one critical strategy she uses is 'listening' :

> *I found that one of the things I needed to do in pre-brief to avoid challenging debriefing sessions was to listen to participants concerns or experiences with simulation. To be mindful, but not focused, on their experiences or triggers regarding simulation. – Susan Eller*

Acknowledgements :

Thank you to Steph Barwick for her expert commentary this month.
Thank you to all commenters this month for sharing your thoughts and allowing us to learn from you.
Simulcast would like to thank the creators of the ALiEM MEDiC series for the inspiration for the journal club's blog format and their ongoing support and contributions to the project.

References and Further Reading :

1. V. J. Grant, T. Robinson, H. Catena, W. Eppich & A. Cheng (2018): Difficult debriefing situations: A toolbox for simulation educators, Medical Teacher, DOI: 10.1080/0142159X.2018.1468558
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Journal Club Summary August 2018 : "A Vulnerable Moment"

Expert Opinion: Ms Jane Stanford

"Revealing is part of creating an honest and shared learning environment"

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Journal Club Summary August 2018 "A Vulnerable Moment"

The Article :

"Intellectual streaking: The value of teachers exposing minds (and hearts)"

Bearman, M. and Molloy, E. (2017).
Medical Teacher, 39(12), pp.1284-1285.

Case & Summary Author :

- Dr Ben Symon

Expert Commenter :

- Ms Jane Stanford

Editors :

- Dr Victoria Brazil
- Jesse Spurr

First Published :

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The Case :

It had been 2 years since the simulation centre had opened and the champagne from the evening's celebration was flowing freely. Nitin sat on the couch sleepily, one arm around a Sim Man in a party hat and the other holding his glass. Across the way was Nimali, ever the educator, exploring with her fellow staff members the things they'd all learned together over the last 24 months. He could only hear the occasional murmur over the sounds of John Legend playing through the speakers, but the words "Name the dynamic" filtered through with clarity.

"Name the dynamic." he smiled wistfully at Sim Man. "That's not always easy to do, is it?". Sim Man, for his part, made no comment. Minutes later, Nimali walked up with a smile and jumped down on the couch between them.

"And what have you learned this year?" she asked Nitin warmly.

He gazed at her for a moment, and paused. "Emotion before cognition, I guess?" he stuttered. He stared hesitantly at her expression, it seemed framed with curiosity, compassion, and perhaps…. Just maybe, a hint of understanding? He took a breath.

"I've learned that you care about people, Nimali. This stuff isn't just words to you, you actually want people to thrive. I've learned that you show your vulnerabilities to help learners with their own…"

He cautiously edged his hand closer to hers.

"In this last year…. I've learned that I love you. I've loved you from the moment you explained to me the basic assumption and I realised you genuinely hold it for every person you meet." His speech quickened, gaining confidence and honesty.

"I don't know how you do that, how you can be such an expert yet so generous with your spirit. I struggle with that sometimes, I judge people privately a lot… but you…. I've never heard you say an unfair thing about anyone."

Gently, cautiously, scanning her face for any hint of repulsion or interest, he placed his hand on hers. "You're my safe container, Nimali Jones. I couldn't love you more if I".

But his words were cut short as Nimali leaned forward and kissed him on the lips.

Discussion :

In this month's case study, Nitin allows himself a moment of emotional vulnerability in order to get close to someone he cares about, but in doing so he also takes a risk. In Margaret Bearman and Elizabeth Molloy's 2017 article in *Medical Teacher*, they explore the benefits of 'Intellectual Streaking' whereby a facilitator is open and honest about their own knowledge deficits. As with Nitin's romantic overture, it is a move that has potentially significant benefits to rapport building, but done poorly may also have some unexpected drawbacks.

So in this very special second anniversary of our online journal club, what do you think of Intellectual Streaking? Is it a sophisticated move that rapidly creates rapport, or can it shatter the respect your learners have for you?

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Journal Club Summary August 2018 "Intellectual streaking: The value of teachers exposing minds (and hearts)"

Bearman, M. and Molloy, E. (2017). Medical Teacher, 39(12), pp.1284-1285.

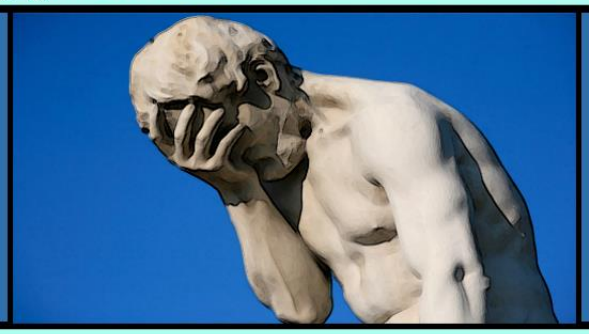
Bearman and Molloy argue that educators often strive to portray an unrealistic image of intellectual perfection.

With extensive prep, we cover our knowledge gaps...

All the while insisting to our learners it's OK to expose their flaws!

Expressing surprise when they remain guarded.

The authors argue some 'intellectual streaking' to expose a teacher's "uncertainties, internal dilemmas, emotions, thought processes, or failures can be illuminating and valuable for learners and teachers alike", and enhance learner engagement.



Although going overboard has risks...

Infographic by @symon_ben , utilising CC0 pics from pixabay.com

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Journal Club Summary August 2018 "A Vulnerable Moment"

Expert Opinion: Ms Jane Stanford, APLS Educator

Jane works in the role as Educator for Advanced Paediatric Life Support (Australia). In this position, Jane sees herself as a trainer - supporting high level athletes (passionate clinicians) playing a team sport (educating their peers) where the goal is not related to scores but personal satisfaction in teaching and learning. Over the past 6 years, she has seen different styles that support peer learning with groups that vary in terms of levels of experience and disciplines. As a trainer, much of the work is done behind the scenes and/or in watching the effects of behaviour. This helps Jane identify a range of options for others to draw on. As part of a Masters of Evaluation, Jane has led a research project that examined the validity of using a written test (the Script Concordance Test) for measuring clinical reasoning for APLS. This study was done as an extension of studies in Adult Education, where the complexity of isolating the effective elements of supporting change for motivated professional learners is an ongoing challenge. Outside of this, Jane loves being on the receiving end of others' creativity, especially if it has a random element!

This article appealed to me for several reasons; credible authors, article published in a respected educational peer-review journal, mischievous title and then a succinct outline of a behaviour - "revealing dilemmas", thought processes or failures for demonstration of resilience and "reflection in action".

Another title could have been "teaching with emotional intelligence", acknowledging that the processes of learning and application of knowledge in the context of uncertainty require more than a cognitive process (1)

An article by credible authors in an established health education journal provided external recognition (underpinned by theory and data) for the consequence of sharing vulnerability.

The title and succinctness of the article provided factors that I believed would increase the chances of the article being read and generating reflection and discussion. This was specifically for a cohort of clinicians who are volunteer teachers – interested and passionate but realistically not eager to decipher too much educational jargon. I had seen many of this cohort demonstrate a 'nimble' and wise use of personal reflection. The 'revealing' accompanied genuine anticipation of learners' potential challenges with either the learning experience (safe enough to feel uncomfortable) or enacting what would be cognitively OK to do, but practically difficulty.

The main reason though was because I hoped the article would assist in creating safety for the facilitators! As Ian Summers mentioned, imposter syndrome carries its own burden; internal 'chatter' is a distraction and can prevent those facilitating from being in the moment, listening and responding to the learners.

French philosopher Jean-Paul Sartre describes the internal tension of maintaining credibility in this way:

> *Merit has to be sought, just like truth; it is discovered with difficulty; one must deserve it. Once acquired, it is perpetually in question: a false step, an error, and it flies away. Without respite, from the beginning of our lives to the end, we are responsible for what merit we enjoy. (2 p. 19)*

The response to imposter syndrome can vary and depends on the health of one's ego. I was interested to read an interpretation of Simone de Beauvoir's (1940s existentialist philosopher and fellow student of Sartre) response to imposter syndrome as an early female philosopher. *"My curiosity was greater than my pride; I preferred learning to showing off."*[i] I wonder if this reflects how the frame of 'genuine curiosity for learning' enables the balance of what and how much is revealed and keeps the focus on a common goal…….enabling the situational awareness that 'keeps you fitter than security'.

In my support role, I have noted the response to facilitators revealing their inner discomfort/fear when performing lifesaving procedures, physical response/momentary paralysis when hearing the code for a child arrest, admitting that clinically *they* have lost situational awareness and/or expressing the discomfort of receiving honest feedback.

Like several of this month's contributors, I also have witnessed how the revealing gave permission for others to do so and it opened up the discussion to practical strategies for managing the fears, the physical shaking, the 'empty mind'. It created authenticity for being open to supporting team members, empathic listening and deeper self-reflection. The revealing was part of authenticity in putting knowledge or change into practice or creating an honest and shared learning environment.

However, clinicians who are unconsciously competent at supporting others' learning don't appear to be able to easily 'hear' positive feedback (3)

I have been promoting the article as a way of *supporting facilitators* who I regarded as authentic, credible and caring teachers! This was because it articulates the behaviours I've seen, (as Jenny Rudolph's analogy conveys) 'holding' learners in the intellectual and emotional environment that enables growth and change.

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Journal Club Summary August 2018 "A Vulnerable Moment"

Summary of this Month's Journal Club Discussion :

Blog Contributors :

- Shannon McNamara, Ben Symon, Melanie Barlow, Glenn Posner, Janine Kane, Sarah Janssens
- Susan Eller, Ian Summers, Victoria Brazil, Eve Purdy, Jenny Rudolph

This month's discussion was a lively interaction regarding the benefits of Intellectual Streaking. While there was widespread agreement that Intellectual Streaking was appreciated and of benefit to learners, this was followed by some unpacking of the specifics of 'when is it useful' and 'how much should we show'?

Overall themes included :

- Intellectual Streaking is regarded as a useful teaching tool
- Intellectual Streaking is of most benefit when used specifically to empower or educate learners
- Not everyone felt 'Streaking' is the right term

Intellectual Streaking is a useful teaching tool

Shannon McNamara, Mel Barlow and Janine Kane started the discussion by validating both the importance of the article and educator vulnerability. While acknowledging the importance of '*the yin of vulnerability and the yang of maintaining learner's confidence'*, there was strong support for the technique as a strategy to humanise educators and learners alike. As Janine states, *"Sharing our own vulnerabilities with our students and peers leads to a more open and honest experience for everyone".*

Glenn Posner postulated that while the term is fun, the technique is really just a variation of the debriefing technique of normalisation. Intellectual Streaking, he argues, is an extension of "*the facilitator not only telling participants "this happens to learners all the time" but specifically, "this has happened to me"'.*

Intellectual Streaking is of most benefit when used specifically to empower or educate learners

After asking the group where the line between 'appropriate' and 'too much' vulnerability sat, we began to tease out some interesting specifics. Ben argued that "*demonstrating personal vulnerability and intellectual streaking is of most benefit when it is shared in the interests of the learners, rather than shared because it's of interest to the educator.".* Streaking is not always done to benefit the learners, sometimes it can be to maintain dominance, to avoid criticism or to maintain focus on the educator.

Jenny Rudolph extended her safe container for learning analogy to explore fallibility. *"Imagine that learning is relational and dependent on "being held", not just a cold intellectual activity. Vulnerability and fallibility by teacher/educator/instructor needs to be a "dose" that does not threaten the perceived integrity of the holding environment. So I've noticed that when I admit I've made a mistake with a lightness or humor but clearly "keep my balance", learners seem to respond very well. I believe it would be a different story if I appeared to be ashamed or deeply discombobulated myself because then that threatens the holding environment that I am creating.".*

So what's the right balance? As Ian Summers put it :

> *Use sparingly. Like all good (intellectual) strips: leave a little to the imagination, choreograph for effect and light carefully. And be fitter than security*

Not everyone felt 'Streaking' is the right term

Vic Brazil, Eve Purdy and Shannon McNamara all voiced concern that streaking is in some ways the wrong term. While appreciating that the innate humour of the discussion would aid translation of the concept, Vic argued that *"I think streaking is perhaps a poor analogy, as i'm not sure most of the naked folks running across the cricket field are exposing vulnerability… they are mostly showing off, drawing attention and causing trouble.".*Eve Purdy doubled down on this by providing us with a fascinating history of *actual streaking* and its use as a tool of dominance and attention seeking. She closed the discussion beautifully with the following caution :

> *"If stories and anecdotes don't bring us closer to learners or learners closer to each other, rather they act to re-territorialize something we feel we are losing then we just aren't doing it right."*

Acknowledgements :

Thank you to Jane Stanford for her expert commentary this month.
Thank you to all commenters this month for sharing your thoughts and allowing us to learn from you.
Simulcast would like to thank the creators of the ALiEM MEDiC series for the inspiration for the journal club's blog format and their ongoing support and contributions to the project.

References :

1. Bearman, M. and Molloy, E. (2017). Intellectual streaking: The value of teachers exposing minds (and hearts). *Medical Teacher*, 39(12), pp.1284-1285.

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Journal Club Summary September 2018 : "Explicit Thoughts"

Expert Opinion: Dr Gabriel Reedy

"Complex and difficult situations like simulation debriefing, and indeed like patient care, benefit tremendously from an open and explicit approach to communicating"

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Journal Club Summary September 2018 "Explicit Thoughts"

The Open Access Article :

"Co-Debriefing for Simulation Based Education"

Cheng, A., Palaganas, J., Eppich, W., Rudolph, J., Robinson, T. and Grant, V. (2015)
Simulation in Healthcare: The Journal of the Society for Simulation in Healthcare, 10(2), pp.69-75.

Case & Summary Author :

- Dr Ben Symon

Expert Commenter :

- Dr Gabe Reedy

Editors :

- Dr Victoria Brazil
- Jesse Spurr

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The Case :

Nimali had sat herself opposite Catherine in the debrief circle, ostensibly to maintain good eye contact with the whole group but secretly she was quite relieved that Catherine was lead debriefer. Deciding how to tell her husband that she'd kissed a co-worker and then… 'debriefed with very bad judgment' was weighing on her mind much more than the current group's middling performance in a withdrawal of care scenario.

Catherine looked over and raised a mischievous eyebrow, Nimali gave an amiable eye roll in return. Telling Joe would be hard, but he'd have to have known it'd been coming for a while. At the same time her and Nitin hadn't defined their relationship either. Nitin was in full puppy dog mode which was gratifying after being married for so long, but sometimes it seemed like he was more in love with an idealised version of her as an educator than her actual self. At the moment it seemed they'd decided to leave the implicit confusion about their explicit behaviours unacknowledged. She suspected Nitin was scared behind his relentless smiles.

She glanced up at Catherine and sighed, Catherine gave her a knowing grin. Thank goodness for trusted friends who could read each other like a book. She just could not care less about this debrief right now and Catherine knew it. She took a sip on her coffee mug and started to think back guiltily to the night of the work party. It had been such a passionate kiss, and Nitin had looked surprisingly good with his shirt off.

"Nimali!" said Catherine, "You look like you've got some strong thoughts about Henrietta's question?"

Nimali choked on her coffee. So much for reading each other like a book.

Discussion :

Co-debriefing can be challenging for a lot of reasons, and in this paper by Cheng et al, the authors outline a number of potential approaches regarding how to debrief more effectively with a colleague. Behind that though, is also the theme of 'above the table of negotiation', the idea that we can debate the flow of the debrief with our colleagues in front of our learners without significant detriment.

For our journal club bloggers this month, what challenges do you experience debriefing? How have you overcome them? Does this paper help?

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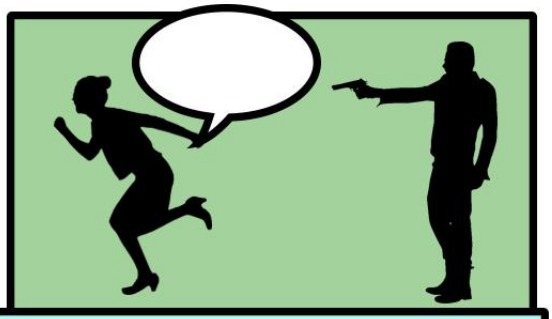
Journal Club Infographic September 2018 "Co-debriefing for Simulation-based Education"

Cheng, A., Palaganas, J., Eppich, W., Rudolph, J., Robinson, T. and Grant, V. (2015).
Simulation in Healthcare: The Journal of the Society for Simulation in Healthcare, 10(2), pp.69-75.

Cheng et al identify a number of reasons that codebriefing doesn't always go perfectly :

Mismatched Agendas

Not using expertise optimally



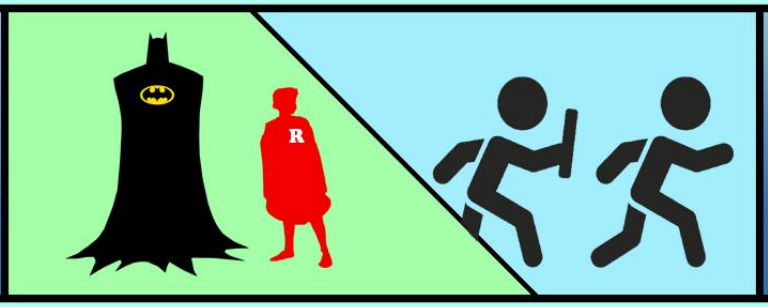
Conversational hijacking

Open disagreement between debriefers

Debriefers talking to a single professional group

A Debriefer Dominating the Coversation

They outline 2 strategies for co-debriefing :



1. Follow the leader : Lead Debriefer & Wingman
2. Divide & Conquer : Each debriefer leads certain topics.

Pre-established agreement on LO's and assigning roles can prevent confusion.

They also describe 'above the table' negotiation, essentially encouraging debriefers to feel free to communicate transparently with their co-debriefer in front of their learners. Useful in debriefing, and in life!

Infographic by @symon_ben , utilising CC0 pics from pixabay.com

Expert Opinion: Dr Gabriel Reedy (@gabereedy)

Dr Gabriel Reedy is a Reader in Clinical Education at King's College London, where he is programme director for the Masters in Clinical Education and senior faculty in the Simulation and Interactive Learning (SaIL) Centre of Guy's and St. Thomas' NHS Foundation Trust in Central London. He is a Chartered Psychologist and Associate Fellow of the British Psychological Society, as well as a Fellow and Chair of the Education Committee of the Academy of Medical Educators. He is a member of the Research Committee of the Society for Simulation in Healthcare. His research focuses on how interprofessional clinical teams work—and learn—to safely and effectively care for patients.

Most of my colleagues at the start of their debriefing careers imagine that co-debriefing is so much easier than solo debriefing. Like Nimali, they imagine that the support a co-debriefer provides can take the pressure off: they're not solely responsible for creating and maintaining a safe and beneficial learning environment in the debrief.

The truth, of course, is much more complex. And that truth is made clear to them when they have one of the experiences that colleagues talked about in the comments thread: when they misread a non-verbal cue; when their co-debriefer starts to dominate the discussion with their passion for the topic or with greater subject matter expertise; when the two of them start going different directions with their questions and learners get confused and disorientated; or when they or their co-debriefer feel "missed" by each other and leave the debriefing feeling as if they missed out on the opportunity to connect emotionally and intellectually.

Conversely, I have both seen and participated in many co-debriefings where I feel like my own experience and learning—and participants' experience and learning—was immeasurably richer for having been co-debriefed. It's this positive potential of co-debriefing that calls us to consciously and thoughtfully consider how to continue to refine the practice. It's in that spirit that I've used this article as the basis for faculty development in debriefing on a few occasions. I think it's very helpful in that regard.

I think Table 1 is helpful not as an exhaustive list of things that can go wrong in co-debriefing, but only an indicative one – and that its value is in reminding us of breadth of ways in which problems can arise. Like we saw in the comments section, it also encourages people to share their own experiences of troublesome co-debriefing moments. Of course, drawing on our own experiences can make for some powerful and meaningful learning! I also remind people in our faculty development sessions that sharing and listing these moments primarily gives us something to work with, and to develop strategies that keep our co-debriefing positive and beneficial for each other and our learners.

In my simulation centre, we train debriefers to work together with a structured pattern slightly different to the ones outlined in the article. In the modified three-phase debriefing model we use in the centre (Jaye et al., 2014), co-debriefers each take the lead for a different phase, while remaining actively engaged and ready to contribute in other phases should the need arise. This helps limit the potential for confusion, and lets each debriefer feel confident about when and how their expertise can contribute. In our approach, one debriefer opens with the descriptive phase, first by recounting the scenario then by delving into depth on questions about the technical or clinical aspects that the scenario evokes. They then hand it over to their co-debriefer, who takes the lead on the analysis and application phases. We also find that this can help to pre-empt the potential issue of clinical and technical issues (and those who might have quite a lot of clinical subject matter expertise) dominating the debriefing, at the expense of the deeper emotional and human factors issues that we aim to talk about in the analysis phase.

In my own experience, I cannot highlight enough the importance of co-debriefers coming together in advance to confer, discuss, strategise, and agree on their approach and a plan. Even when I'm debriefing with colleagues whom I know well and have worked with extensively, it's when we skip this step that things can go wrong. To this end, the checklists in Table 2 are extraordinarily helpful in guiding that conversation. I also feel strongly about the importance of coming together to debrief after the event, and I push myself to be honest and critically reflective about my own performance. I also strive to remain curious about the experience and perceptions of my co-debriefer around the interaction and the environment we created. In guiding these conversations, I find tools like the DASH (Brett-Fleegler et al., 2012) and OSAD (Arora et al., 2012) to be particularly helpful and developmental. The strategies listed in Table 2 for debriefing each other after the event are equally helpful.

Of the many suggestions for successful co-debriefing discussed in the article, however, I think the one that is the most valuable for me is what the authors refer to as "open negotiation." In my centre, we sometimes use the phrase "over the table" to talk about this process, situating it against the "under the table" conversation that can consist of confusing and complex non-verbal signals. Open negotiation reduces the potential for misunderstanding and confusion between co-debriefers, as the authors explain. But to me, it does something so much more: it models for our learners a way of interacting that we want them to adopt with colleagues, patients, and carers. Open negotiation models that we treat our co-debriefer as a colleague and an equal, and that the work of facilitating the debriefing together is important enough to take seriously and discuss explicitly. It models that it is appropriate and valuable to be explicit about our intentions, to professionally and courteously challenge each other, to admit when we get confused or lose situational awareness, to ask for help, and to ask if our colleagues need help. It models that complex and difficult situations—like simulation debriefing, and indeed like patient care—benefit tremendously from an open and explicit approach to communicating. And that by working together effectively, we can create a rich and valuable learning experience.

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Journal Club Summary September 2018 "Explicit Thoughts"

Summary of this Month's Journal Club Discussion :

Blog Contributors :

- Christina Choung, Ben Symon, Derek Louey, Ann Mullen, Susan Eller, Nemat Alsaba, Janine Kane
- Komal Bajaj, Vic Brazil, Daniel Lugassy and the NYSIM team journal club group

Comments this month were engaging and it was exciting to have comments from the NYSIM Journal Club group, who have 'read along' with us this month! Overall the article is well regarded, considered foundational by many educators, and is widely shared, with many stating it has helped them in the past.

Themes of the discussion this month were quite diverse, but prominent themes included :

1. Co-Debriefing can be hard
2. Interprofessional and expertise heirarchies appear to be frequent challenges
3. There is tension between consistency of debriefing styles and maintaining one's individual authenticity

Co-Debriefing can be hard.

Multiple journal clubbers noted the complexities of co-debriefing. Nemat Alsaba argued "*Co-debriefing is harder and more complex than solo debriefing. It requires being extremely good at reading facial expressions and body language of your co-debriefer and to know when to pick up the baton and when to hand it back again without disrupting the flow of the session.*". The NYSIM group identified some specific challenges they have experienced in the past, including mismatched agendass, content experts who "*went down a rabbit hole*", or when a co-debriefer is clearly making learners uncomfortable. Despite this though, many participants identified the positive aspects of co-debriefing as well. Komal Bajaj argued that co-debriefing is a separate and specific skill that needs to be taught.

Interprofessional and expertise hierarchies appear to be frequent challenges

While Susan Eller described a particularly confronting debrief where her colleague separated participants by profession, she was not the only one who reported challenges with hierarchical imbalance in debriefing. Vic Brazil described issues coming up *"when content experts participate as debriefers without training in group or debriefing process, and yet assume/claim a superior place as a result of content expertise."*. It was acknowledged however that the benefits from accessing expert knowledge likely outweighed the challenges in co-ordinating the conversation. A number of strategies were identified from the paper as being useful for this as well, particularly 'open negotiation', 'pre-briefing', and 'post debrief huddles'. Christina Choung described frequently using this article in advance of a debrief to orientate new debriefers to their local practice.

There is tension between consistency of debriefing styles and maintaining one's individual authenticity

An interesting issue came up when Derek Louey and Ann Mullen described the challenges that come up with trying to find consistency in debriefing practice without losing one's natural conversational tone in the process. Derek asked specifically *"Is it a problem that facilitators/debriefers have different 'styles'? Or should we have a consistent and unified approach to the way we run simulation? Is transfer of knowledge invariably worsened when styles or messages diverge?"*. Ann Mullen answered with her perspective : *"As long as you are using sound practices, i think not. On the contrary, it is important that we bring our authentic voice to a debriefing".*

Article Critique

A consistent critique of the paper was that people wanted more examples of phrases and techniques that can be used to negotiate the debrief as it happens.

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Thank you to all commenters this month for sharing your thoughts and allowing us to learn from you.
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