

Journal Club Summary April 2019

“How to get away with debriefing a murder”



Expert Opinion: Dr Stuart Rose

“These events are an integral part of our professional life and while we are searching for ways to debrief that will ‘do no harm’, we should acknowledge that debriefing can change the culture of our workplaces”

The Article :

"Impact of child death on paediatric trainees "

HOLLINGSWORTH, C. E., WESLEY, C., HUCKRIDGE, J., FINN, G. M. AND GRIKSAITIS, M. J.

Archives of Disease in Childhood, 103(1), pp.14-18. 2017

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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.

The Case :

Nitin liked think that he had a strong growth mindset. He enjoyed unexpected challenges, and tried to extract a valuable learning point from any kind of challenge. But when he had received the formal invitation to start working at the sim centre, he hadn't expected to eventually learn that moving a real dead body was significantly harder than moving a Sim Man 3G back to the supply room. It was more slippery for one thing.

"So let me get this straight..." puffed Brad as they struggled with the weight. "We're moving Snythe's body into the supply room, tampering with the crime scene and potentially incriminating ourselves, all so that we can debrief his death in our standard debriefing room?"

"The roads are flooded, Brad. We could be stuck here for hours. Everyone is stressed, and we need a safe place to talk. And safe spaces don't usually feature the corpses of murdered intensivists." Said Nitin.

"Are you sure debriefing this is a good idea?" asked Brad, "I thought debriefing clinical events is associated with increased PTSD score?".

Nitin placed Snythe's shoulders on the floor for a moment. "You mean the Cochrane review from ages ago? It didn't seem that relevant to our population. And besides, Nimali is trying to look after our team. I'm not sure we need an evidence base to connect emotionally and support each other".

Brad frowned. "I'm serious Nitin, what if talking about this stuff in the wrong way makes the whole situation worse? We're all at serious risk of PTSD from this.". Together they picked up the body again and shuffled towards the supply room.

Nitin shuddered as he felt Snythe's cold hand drop out of position and onto his back. Something was... dripping on his shirt. An optimistic growth mindset was one thing, but if he was honest with himself, he'd had significantly better days. "To be quite honest Brad, I'm not sure it's the conversation afterwards that causes the complex psychological trauma."

He looked piercingly at Brad for a moment and scowled. "Besides. We both know why you're really worried."

Discussion :

As Clinical Event Debriefing gains traction in hospitals around the globe, some clinicians are warning us about the potential harms from having learning conversations in the context of patient death. In their article from 2017, Hollingsworth et al explore the psychological impact of child death on paediatric trainees, but in doing so come to the conclusion that Attending a debrief following child death may be associated with symptoms of ASR/PTSD.

What are your thoughts about this article, it's methods and its' conclusions?

Article Summary

In "Impact of child death in paediatric trainees", Hollingsworth et al report the findings of a large survey of 302 paediatric trainees that aimed to establish the point prevalence of symptoms related to acute stress reactions (ASR) and post-traumatic stress disorder (PTSD) following involvement in a child's death in hospital.

- In reporting the results of their survey, however, they note that there is little evidence regarding the safety of clinical event debriefing in paediatric mortality, and find that there may be an association between clinical debriefing and ASR or PTSD.

The team distributed 604 surveys to paediatric trainees in the UK and received a 50% response rate.

- In the survey they asked responders to report symptoms of ASR or PTSD, and then ask some questions about potential associated factors, such as participation in a clinical event debrief, exercise, whether they'd had any training on paediatric death etc.

When it comes to assessing the point prevalence of symptoms, the article finds that :

- 81% of trainees reported one or more symptoms or behaviours that could contribute to a diagnosis of ASR/PTSD.
- 9% of responders met the complete criteria for ASR and 5% for PTSD. (or as the authors put it, The authors argue that 14% of the trainees in this cohort could potentially meet a psychiatric diagnosis).

With regard to potential associations, the authors state *"There was no statistically significant association between developing symptoms ... and seniority, gender, age, working pattern, paediatric intensive care unit (PICU) experience, child death training or participation in exercise. However, our results do show that the development of symptoms of ASR/PTSD may be associated with feelings of guilt after the death of a child and with attendance at a debrief."*

- Their reasoning for this conclusion is that Eighteen (20%) of 92 trainees who attended a formal debrief displayed symptomatology that suggests a potential diagnosis of ASR/PTSD. Conversely, 16/155 (10%) of those who did not attend a debrief met the ASR/PTSD criteria (χ^2 , $p=0.036$).
- They do acknowledge that an ASR/PTSD diagnosis is not made without a full clinician assessment, and as such they are only reporting the point prevalence of symptoms.

There was some significant gender disparity in the population demographics with women accounting for 82% of respondents, although while this might sound like a non representative sample of the population, the study quotes that around 70% of paediatric trainees in the UK are women.

When it came to debriefing post paediatric death, about 50% of the time a debrief was organised. Interestingly when survey responders described why they didn't attend, nobody chose the option 'did not want to attend' but some couldn't make it for clinical commitments, leave, night shift etc.

They close the article by recommending that *"Clear recommendations need to be made about the safety of debriefing sessions after the death of a child as, in keeping with existing evidence, our data suggest that debrief after the death of a child may be associated with the development of symptoms suggestive of ASR/PTSD."*

Expert Opinion: Dr Stuart Rose



Stuart is an adult emergency room doc living and working in Calgary, Alberta, Canada. He loves the learning and understanding that comes from taking part in inter-professional simulations debriefings. He was trying to debrief as many of his own clinical cases as possible to take advantage of the lessons that can be learnt from real patient encounter but even though he had simulation debriefing training and was motivated to debrief it was just not happening on a regular basis. Since then he has developed an interest in finding ways to make debriefing part of the management of critically ill patients in the ED.

Currently, he is interested in showing that clinical debriefing can positively impact ED staff wellness and teamwork. He is also involved in helping health care teams outside the ED implement clinical debriefing.

"Primum non nocere... first, do no harm..."

April's Journal Club paper - Hollingsworth et. al. ⁽¹⁾ concludes that debriefing after the death of a child may be associated with the development of symptoms suggestive of ASR / PTSD. There were some great comments in response to the paper, reflecting many of the concerns that we have when it comes to debriefing in our workplaces. As an adult emergency medicine physician who tries to debrief as many of my resuscitations in the ED as I can, who has created a process that encourages others to do the same and is actively trying to increase the number of cases that get debriefed each month I have spent a lot of time reflecting on whether debriefing clinical cases could place myself or my colleagues in a position where we would intentionally be doing harm to our team members. I do not think this article provides evidence that I should not be debriefing or that I am putting my team in harms way if we debrief. In fact, its conclusions seem to be the opposite of what I see in my practice.

The effect of debriefing was not a stated objective of the paper and like Jesse I am not sure why the authors elected to add the conclusion they did to a paper that begins with an important question – what is the impact of child death on pediatric trainees? I assume that the authors goal was to draw attention to the needs of the trainees and highlight that debriefing did not appear to have the effect that was hoped for or anticipated and that debriefing in this setting may not have been safe for the trainees who responded to the survey. Whether it was the authors intent or not, I now hear the paper quoted in the context of providing evidence that all clinical event debriefing is potentially unsafe. Considering this, I have viewed the article though a PICO lens to help me answer my question about psychological safety when debriefing clinical events:

Population – Pediatric trainees in the United Kingdom. Similar to front line clinical staff in the ED, the trainees are secondary rather than primary victims of the trauma they have witnessed. However, they are at different levels of training and experience. The residents range in experience (from 1-8 years) and 74% were less than 35 years old. Most the respondents of this small study were female (82%) with an overall response rate to the survey of 50%. I wonder what might have been revealed if the other 50% had responded. The paper focuses on responses to pediatric death which fortunately is a rare occurrence for most health care teams to experience and my population of health care workers are more likely to be dealing with high stake events involving adults. I do share Sonia's sadness that these inexperienced trainees were not provided with the tools to manage the stressful situation that they found themselves in.

Intervention – Debriefing. Although the authors discuss the possible nature of the debrief there is no definition of the debriefing that occurred. Ian points out that one of the first problems we face when looking at the literature for evidence around debriefing clinical events is that there are many different terms used to describe the discussion that takes place after an unexpected clinical event. It is confusing at best. The World Health Organization recommends doing psychological first aid but is strongly opposed to psychological debriefing. Is it ok to huddle or recommend an

After Action Review? If we wait a while and have a "cold" debriefing will it open the wounds again or should we have a "hot" discussion immediately after the event where we may not know all the details yet? Do we need Critical Incident Stress Debriefing or Critical Incident Stress Management? Should we be creating some sort of mix of the concepts mentioned above? Hmm...

It seems that the intervention in this study was a single event facilitated by untrained facilitators that occurred in a random, unstructured and unsupported manner. I agree with the authors statement that "seemingly random and unmonitored nature of debriefing following the death of a child is a concern".

Comparison – To do nothing. This is the comparison for the study and what happens to many of us in our clinical environment after a high stakes event. However, as Farrukh and Shannon state, some of us need to and want to discuss the events. We need to validate our experience and make sense of what happened. When there is no structured debriefing, the discussion often takes place during a break and does not involve the whole team. Creating the expectation that we will debrief is part of creating a culture where all team members feel supported, valued and empowered to speak up and contribute to patient care. There seems to be evidence in the literature that debriefing, either in simulation or real life is associated with improved clinical performance and a better work environment ⁽²⁻¹⁰⁾. If we miss out on the opportunity to debrief, we miss opportunities to change our culture, celebrate what we do well and improve our clinical performance.

Outcome - ASR/PTSD. In this study, 18/92 participants (total response 303/604 with 118 participating in a debriefing), reported symptoms of ASR compared to 16/155 participants who reported symptoms of ASR but did not attend a debriefing. I am not a researcher but the numbers appear too small for me to make meaningful conclusions. The authors note that this is statistically significant but I am unclear on the clinical significance of the numbers because as Sonia points out the trainees have a lower overall rate of PTSD than the general population, and Ben reminds us that completing a PTSD scoring system does not mean that you have PTSD.

Pediatric death is a tragic event. Kate notes this and asks what our normal response to such a significant stress should be. No matter how much experience one has or where one practices, the unexpected death of a child could be classified as extremely stressful for almost all clinicians and the approach to the team involved in the event would need to be more comprehensive and individualized than a one-off debriefing by an untrained facilitator.

Several Journal Club respondents note the methodological weaknesses of the study. While the authors can comment on the symptoms described by the trainees, I do not think the results support the firm conclusions that they arrive at.

So, after the PICO look at this month's article, my take away is that a single debriefing by an untrained facilitator after a very stressful event is not adequate support for any clinician, especially for a trainee in the early stage of their career. I do not think it provides evidence that I should not be debriefing in the ED.

As Nitin points out there is another article that is often quoted when the risks of clinical debriefing are discussed and not surprisingly it is included in the references. The article by my namesake, Rose et al ⁽¹¹⁾ was a Cochrane review published in 2002. Sonia has done a great job of reviewing the paper. The conclusion drawn by the authors of the review is that, "There is no evidence the single session individual psychological debriefing is a useful treatment for the prevention of PTSD after traumatic incidents. Compulsory debriefing of victims of trauma should cease". After a UK radio show highlighted the "fact" that no psychological interventions worked at all following traumatic events the authors ask us and the general public not to "overgeneralize research findings (of this Cochrane review) beyond the particular situations or populations investigated"⁽¹²⁾. I think the authors advice is more relevant in 2019 than it was in 2003 as interest in debriefing events in our workplaces increases. The article selection for the review was controversial in 2003 and generated some debate ⁽¹³⁾. In 2011 Hawker et al ⁽¹⁴⁾ further attempted to clarify some of the issues that surround this "overgeneralization". The Cochrane review participants were primary victims of trauma, not health care workers who are secondary victims. The debriefings were single "cold" or delayed,

compulsory interviews conducted by untrained debriefers who were not known to the participants. The only study in the Cochrane review that included a "hot" or "warm" debriefing showed benefit⁽¹⁵⁾. My take away from the Cochrane review is that debriefing within 12 hours may be helpful but compulsory, delayed or "cold" individual debriefing conducted by a stranger with no follow up or support, has no benefit and may be harmful.

Again, this does not help me answering my question: in my ED is a facilitated "hot" inter-professional discussion between qualified front line clinicians in a structured and supported system safe for participants? The American Heart Association advocates for clinical event debriefing⁽¹⁶⁾ and there are published suggestions on how to set up the process⁽¹⁷⁾ but we need further research to help us clarify the nuances of the best way to debrief clinical events safely in the manner and setting that we are currently practicing in.

Our unpublished post implementation survey is not high quality peer reviewed data but it does reflect staff responses to the clinical event debriefing process that we instituted in our ED. The debriefing, defined as "charge nurse facilitated inter-professional team reflection after a high stakes clinical event that focused on improving the system and the team's performance" involved training for the charge nurse facilitators and was part of a supported process. The survey took place 6 months after the implementation of the voluntary clinical debriefing program. During this time, 50 clinical event debriefings had taken place. 101 inter-professional staff completed the survey and results showed that staff felt safe in the debriefings, would recommend them to their colleagues and would take part in further debriefings. Comments such as, *"I think the INFO sessions have helped to create an environment where everyone's voice is valued, not just in these critical situations but in all situations. This is something incredibly valuable and makes for a more positive work environment"*, represented the general tone of staff responses.

The thoughtful comments in this month's Journal Club reflect that as front line clinicians we recognise the importance of debriefing after the high stakes events that we experience at work. These events are an integral part of our professional life and while we are searching for ways to debrief that will "do no harm", we should acknowledge that debriefing can change the culture of our workplaces, provide opportunities to support ourselves and our colleagues, celebrate the excellent care that we provide and identify areas to improve the care we deliver for our patients. We need to do this.

1. Hollingsworth CE, Wesley C, Huckridge J, Finn GM, Griksaitis MJ. Impact of child death on paediatric trainees. Arch Dis Child. 2018;103(1):14-8.
2. Weiner E, Bar J, Fainstein N, Ben-Haroush A, Sadan O, Golan A, et al. The effect of a program to shorten the decision-to-delivery interval for emergent cesarean section on maternal and neonatal outcome. American journal of obstetrics and gynecology. 2014;210(3):224.e1-6.
3. Wolfe H, Zebuhr C, Topjian AA, Nishisaki A, Niles DE, Meaney PA, et al. Interdisciplinary ICU cardiac arrest debriefing improves survival outcomes*. Crit Care Med. 2014;42(7):1688-95.
4. Bandari J, Schumacher K, Simon M, Cameron D, Goeschel CA, Holzmueller CG, et al. Surfacing safety hazards using standardized operating room briefings and debriefings at a large regional medical center. Joint Commission journal on quality and patient safety / Joint Commission Resources. 2012;38(4):154-60.
5. Patterson MD, Geis GL, Falcone RA, LeMaster T, Wears RL. In situ simulation: detection of safety threats and teamwork training in a high risk emergency department. BMJ Qual Saf. 2013;22(6):468-77.
6. Weaver SJ, Dy SM, Rosen MA. Team-training in healthcare: a narrative synthesis of the literature. BMJ Qual Saf. 2014;23(5):359-72.
7. Calhoun AW, Boone MC, Porter MB, Miller KH. Using simulation to address hierarchy-related errors in medical practice. Perm J. 2014;18(2):14-20.
8. Rose MaRK. Use of a Surgical Debriefing Checklist to Achieve Higher Value Health Care..pdf>. Am J Med Qual. 2018;33(5):514-22.
9. Brindle ME, Henrich N, Foster A, Marks S, Rose M, Welsh R, et al. Implementation of surgical debriefing programs in large health systems: an exploratory qualitative analysis. BMC Health Serv Res. 2018;18(1):210.

10. Tannenbaum SI, Cerasoli CP. Do team and individual debriefs enhance performance? A meta-analysis. *Hum Factors*. 2013;55(1):231-45.
11. Rose S, Bisson J, Churchill R, Wessely S. Psychological debriefing for preventing post traumatic stress disorder (PTSD). *Cochrane Database Syst Rev*. 2002(3):CD000560.
12. Rose S, Bisson J, Wessely S. Counselling and psychotherapy: media distortion. *The British journal of psychiatry : the journal of mental science*. 2003;183:263-4.
13. Wessely S, Deahl M. Psychological debriefing is a waste of time. *The British journal of psychiatry : the journal of mental science*. 2003;183:12-4.
14. Hawker DM, Durkin J, Hawker DS. To debrief or not to debrief our heroes: that is the question. *Clin Psychol Psychother*. 2011;18(6):453-63.
15. Campfield K. Effect Of timing Of Critical Incident Stress Debriefing on Posttraumatic Symptoms. *Journal of traumatic stress*. 2001;14(2):327-40.
16. Bhanji F, Donoghue AJ, Wolff MS, Flores GE, Halamek LP, Berman JM, et al. Part 14: Education: 2015 American Heart Association Guidelines Update for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care. *Circulation*. 2015;132(18 Suppl 2):S561-73.
17. Kessler DO, Cheng A, Mullan PC. Debriefing in the emergency department after clinical events: a practical guide. *Ann Emerg Med*. 2015;65(6):690-8.

Summary of this Month's Journal Club Discussion :

Blog Contributors :

- Farrukh Jafri, Ben Symon, Paul Elliott, Sonia Twigg, Vic Brazil, Katie Reeves, Ian Summers
- Noel Roberts, Jesse Spurr, Kate Bassett, Joy Domingo-Bates, Shannon McNamara

There was appreciation for the intent of the study but concern about the extent of the conclusions made.

Multiple journal clubbers expressed delight at the questions being raised but there was disappointment with the methods used. As Sonia Twigg put it : *"I was annoyed and intrigued by this study. I like the questions it poses. I applaud the authors for their efforts in answering them. But I did not think their measures or the survey method used in their study could answer these interesting questions."* Issues raised included concern regarding linking association with causation, the selection bias that will come from more activated staff filling out this kind of voluntary survey, the 'chicken and the egg' question regarding whether symptoms of ASR affecting debriefing attendance as well as the fact that the DSM V is not designed as a survey, but a set of diagnostic criteria that require clinical assessment.

Ian Summers discussed the inherent dangers of lumping all types of debriefing into one research category :

"The risk of bundling immediate and delayed, hot and cold, psychological first aid, quality improvement and raw emotional events together as one overarching "debriefing" is tempting, but ultimately misleading.

They exist on a spectrum of emotional charge, risk, availability, duration post event, in-team lead vs outside provider, facilitator comfort, training and expertise and rather than lump them all in together, we should see them as an overlapping continuum we can divide up to add a little more meaning to the discussion."

Despite misgivings regarding the methods used however, people were alarmed by some of the data that was revealed, particularly regarding the lack of debriefing training for many facilitators, the lack of structure that was being reported in debriefing programs, and the perceived lack of support many paediatric trainees reported post paediatric death.

This stuff is nuanced and important

Many responders flagged how important they felt clinical event debriefing was to their departments, but also how important staff wellbeing was in general. The challenges it seemed, are that such issues require nuance and a variety of approaches, and that we lack evidence about which approach works best for specific situations.

Kate Bassett argued that we cannot have a single solution to such complex issues :

"I worry that in our desperate search for wellness we seek a one size fits all solution to the psychological traumas we encounter. Where I work – all streams are invited to the debrief and I worry that times when our medical minutiae focus has offered me comfort; it has done little to help our operational colleagues. Surely a debrief can only offer a reflection on the events and a reminder to practice whatever we have in our resilience toolkit. We need to be given that toolkit early. Our work lives are a continuum of micro traumas that build up in our psyche: the professional discourtesy from an overworked and angry colleague, a failed procedure, heaven forbid the harsh words of a loved one who craves more time from us. We must learn and teach methods of managing the small things so the muscle memory kicks in and help us when the tidal wave crashes over us in difficult clinical situations."

Despite this complexity, Shannon McNamara closed this month's discussion with this :

"These conversations are risky, and deeply important. They should be optional and treated with respect and reverence. I used to avoid them due to fear of causing harm. Now I realize that people often need to talk about these cases in the moment. I think it's better to lean in and try to talk about them as best we can, even if it's not perfect."

Acknowledgements :

Thank you to Stuart Rose 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. Hollingsworth, C., Wesley, C., Huckridge, J., Finn, G. and Griksaitis, M. (2017). Impact of child death on paediatric trainees. *Archives of Disease in Childhood*, 103(1), pp.14-18.