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Peer-Debriefing After Distressing Patient Care Events: A Workshop for Pediatric Residents

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Abstract

Introduction: When confronted with a distressing patient care event, physicians experience feelings of failure, inadequacy, and self-doubt that negatively impact emotional well-being and have been linked to burnout and premature exit from the medical profession. A need exists within the medical community for improved emotional processing of distressing patient care events, particularly for resident physicians at the beginning of their careers. **Methods:** To encourage physicians to communicate as a means of initiating emotional processing after a distressing patient care event, a workshop was developed for pediatric residents providing training on a peer-debriefing model taken from the bereavement counseling literature. The workshop is designed to take 60 minutes, including dedicated opportunities to observe and conduct debriefing sessions based on the residents' own distressing patient care experiences. Included are the workshop facilitation guide, the adapted peer-debriefing model, hypothetical patient care scenarios, and pre- and postsession survey evaluation forms. **Results:** Pre- and posttraining survey metrics revealed statistically significant and meaningful increases in pediatric residents' self-reported comfort with and likelihood of leading a peer-debriefing session in an appropriate clinical setting. **Discussion:** This workshop is a well-received, effective intervention that provides pediatric residents with a tool to aid in the timely emotional processing of distressing patient care events. It has been adopted into the standard educational curriculum of our home institution's pediatric residency program. This workshop may be extended throughout the field, helping physicians at all levels of practice process the inevitable distress inherent in caring for the sick.

Keywords

Debriefing, Pediatric, Support, Emotional Distress, Peer, Role-Play

Appendices

- A. Peer-Debriefing Training Presentation.ppt
- B. Peer-Debriefing Model .docx
- C. Baseline Survey.docx
- D. Workshop Facilitation Guide.docx
- E. Demonstration Debrief Script.docx
- F. Hypothetical Scenarios for Role-Play.docx
- G. Session Evaluation.docx

All appendices are peer reviewed as integral parts of the Original Publication.

Educational Objectives

By the end of this session, learners will be able to:

1. Describe an effective strategy for leading a peer-debriefing session after a distressing patient care event.
2. Apply the peer-debriefing model to their own distressing patient care experiences.
3. Formulate a plan for providing emotional support to a colleague experiencing emotional distress.
4. Justify the importance of provider emotional well-being in the offering of safe, high-quality patient care.

Introduction

When confronted with a distressing patient care event, physicians experience heavy emotional burdens and often report feelings of failure.¹⁻³ Debriefing, a well-known technique for the facilitation of emotional processing of negative events, is most frequently practiced by physicians in the setting of a code blue event to discuss the medical management and communication vital to the emergent resuscitative effort.^{4,5} Undoubtedly, reflection on the circumstances of a code event and resuscitative effort is imperative to

improving future medical practice.^{6,7} However, in this process, an important opportunity to address the emotional distress experienced by the provider in caring for a sick or dying patient is largely missed.

Such distressing events confer a particularly negative impact on trainees, augmenting feelings of inadequacy and self-doubt.⁸ Acknowledging this, the American Academy of Pediatrics, the Academic Pediatric Association, and the Institute of Medicine have all put forth statements recommending the incorporation of education on grief and loss in residency education.⁹⁻¹¹ Despite the vulnerable position in which trainees find themselves—at the front lines of care with far less experience to draw from than their attending counterparts—most residency programs provide little in the way of preparation for distressing patient care events prior to their occurrence.¹² Within the growing movement of physician wellness, some residency programs have begun to address physician emotional distress and have implemented programs to help trainees process the difficult emotional aspects of providing medical care.¹³⁻¹⁵ However, even the most robust formal training program for pediatric resident emotional processing of distressing events relies on a multitude of mental health and ancillary providers to facilitate debriefing sessions.¹⁶ In the quiet moments after a distressing patient care event, when there are a multitude of other clinical tasks and responsibilities to tend to and heavy emotional burdens to process but staffing of mental health providers is limited, trainees need to begin their healing processes. In their times of need, pediatric residents report leaning on their resident colleagues as a major source of support.⁸ Taken together, these notions sparked the concept of a peer-led debriefing workshop to provide pediatric residents with the tools and skills to initiate a debriefing session amongst colleagues in the immediate aftermath of a distressing patient care event. To date, no published peer-debriefing training programs exist in pediatric residency education. A search of MedEdPORTAL revealed no curricula focused on teaching the skills of debriefing outside of the clinical setting for any population of learners.

A needs assessment of the pediatric residents at Children's Hospital Los Angeles conducted in the spring of 2016 revealed that pediatric residents had participated in an average of 1.12 total debriefing sessions throughout their training ($n = 62$, response rate = 70%; Table). Only four (6.4%) respondents had ever led a debriefing session, having led one session each. The top three barriers hindering pediatric residents from debriefing after a distressing patient care event were a lack of experience, feeling as though someone more senior should lead the session, and a need to get back to work due to multiple time-sensitive responsibilities (Figure 1).

Table. Needs Assessment Baseline Debriefing Experience^a

Question	% Responses
What is your current level of training?	
PGY 1	33.9
PGY 2	24.2
PGY 3	40.3
PGY 4	1.6
Have you ever participated in a debriefing session after a distressing patient care event?	
Yes	71.0
No	29.0
Have you ever led a debriefing session after a distressing patient care event?	
Yes	6.4
No	93.60

^aResponse rate was 62 out of 89 (69.7%) after two email requests.

The needs assessment demonstrated that pediatric residents desired a training in peer-debriefing that provided opportunities for gaining experience, that empowered the trainee physicians to demonstrate leadership amongst peers, and whose skills could be utilized efficiently and effectively in a busy clinical setting. The majority of residents (84%) felt that the addition of a formal peer-debriefing training would be beneficial to their education; the remainder were neutral.

Figure 1. Percentage of residents ($n = 62$) identifying particular barriers as limiting to their ability to lead debriefs after distressing patient care events.

This peer-debriefing workshop was created to align with the main principles of adult learning and experiential learning theories.^{17,18} These theories were selected as a conceptual model for the workshop to maximize pediatrics residents' buy-in and stimulate active learning through an experiential process, drawing from the trainees' own experiences as a guide. Welcoming to all learning styles, the workshop encompasses opportunities for transmission and conceptualization of information, as well as experimentation with and reflection on the process of debriefing.

Methods

This workshop was designed by a team of physician-educators with specialties in general pediatrics, pediatric hospital medicine, and pediatric palliative care as a guide to conducting a peer-debriefing session for pediatric residents of all levels of training. It was held as part of the regularly scheduled educational curriculum of the pediatric residency program at Children's Hospital Los Angeles in May 2016. All pediatric residents were invited to participate in the workshop regardless of study participation, which included survey metrics pre- and postworkshop. The study received exempted review status from the Institutional Review Board of the Children's Hospital Los Angeles.

The workshop is designed to be completed within a 60-minute time frame, keeping with the standard educational curriculum of the Children's Hospital Los Angeles pediatric residency program. The workshop utilizes a PowerPoint presentation (Appendix A) for reinforcement of the discussion using graphics, and thus, audiovisual capabilities and a facilitator familiar with the presentation are required.

The suggested time line of the workshop is as follows:

- 0-5 minutes: Introduction of facilitator, workshop goals, review of agenda.
- 5-8 minutes: Presurvey completion (if utilizing presurvey metrics).
- 10-25 minutes: Facilitator reviews didactic slide presentation.
- 25-30 minutes: Mock peer-debriefing demonstration.
- 30-50 minutes: Partner role-play peer-debriefs (two at 10 minutes each).
- 50-57 minutes: Large-group discussion debriefing the debriefing process.
- 57-60 minutes: Distribution of session evaluation/postsurvey.

The workshop was facilitated by the physician by whom it was developed; a facilitator familiar with the workshop materials is required. A packet containing the adapted peer-debriefing model¹⁹ (Appendix B), an index card, and a writing instrument should be made available to all attendees. If utilizing presurvey metrics, the presurvey (Appendix C) should also be administered at the beginning of the session.

Following the PowerPoint slides (Appendix A), the facilitator begins the didactic portion of the workshop. Further information for the didactic portion of the workshop, as well as highlighted opportunities for personalization of subject matter, is available in the workshop facilitation guide (Appendix D). Due to the emotional nature of the topic being presented, making a connection with participants using real experiences of distressing patient care events lends authenticity and meaning to the didactic portion, which should certainly vary by individual experience. With the facilitator setting this tone of openness and support, participants are encouraged to be open to sharing emotional thoughts and feelings with one another.

After the peer-debriefing model has been thoroughly explained, the observational portion of the workshop begins. Participants are invited to think about a particularly powerful distressing patient care event and jot down any meaningful phrase on their index cards to connect them to that experience. It should be reinforced that all index cards will be kept confidential and be disposed of appropriately and in compliance with patient confidentiality. After approximately 5 minutes to allow trainees to identify and contemplate this distressing event, the trainees are invited to observe a model peer-debriefing session conducted by the facilitator and a volunteer, preferably one with a similar level of training to the facilitator so as to reinforce the peer relationship. A script is provided to both parties (Appendix E). As the demonstration debriefing is occurring, the trainees may follow along with the presentation and/or their handouts (Appendices A & B), keeping their own distressing patient care experiences in mind.

After the conclusion of the demonstration peer-debrief, trainees are invited to participate in the experiential portion of the workshop. In pairs, participants alternate between playing the roles of debriefing leader and distressed physician, utilizing their own distressing patient care experiences, identified on their index cards as the basis for discussion. This allows for the most authentic role-play simulation scenario. If a trainee has not been able to identify a particularly impactful experience, hypothetical scenarios are available for distribution (Appendix F), though participants should be strongly encouraged to draw from their own experiences when possible. Role-play should be allotted a total of 20 minutes to allow participants to fully engage one another in meaningful discussion. The use of a timer may help trainees self-regulate the pace of their discussions. Alternatively, the facilitator can provide a verbal prompt to switch roles at the midway point.

Once all pairs have completed both roles, the trainees regroup to reflect on their experiences using the peer-debriefing model in a large-group setting. The participants are called to provide comments on two thought-provoking, call-to-action questions, designed to reinforce the applicability of this peer-debriefing model to the clinical setting. At the conclusion of the session, participants are invited to complete an anonymous session evaluation, consisting of simple nonidentifying demographic information and Likert scale and free-response options (Appendix G).

Given the potentially distressing nature of the subject matter of this workshop, facilitators should have readily accessible information about resources for further emotional support available for all participants. Participants should also be informed that at any time, they are free to break from the session if the subject matter is too difficult for them, returning only if they feel comfortable doing so.

Results

All pediatric residents at Children's Hospital Los Angeles were eligible to participate in this workshop regardless of study participation. The session, offered as part of the standard educational curriculum of the residency program, was attended by 31 residents, which is typical of other similarly timed educational activities at this program. In total, 25 out of 31 (80%) pediatric residents in attendance at the session participated in providing survey responses. The pediatric residents were surveyed on Likert scale measures of self-reported comfort with leading a debriefing session and likelihood of leading a future debriefing session. Due to the small sample size, responses were dichotomized as affirmative (comfortable or likely) versus nonaffirmative (uncomfortable or unlikely) to allow for comparison of

attitudes pre- and postintervention. Chi-square analyses of proportions were conducted using $p = .05$ for significance and a 95% confidence interval.

Analyzing the pre- and postworkshop data, a statistically significant increase in self-reported comfort with leading a debriefing session was observed, $\chi^2(1) = 13.0, p = .0003$, 95% CI, 21.5-71.8. Prior to the workshop, only 32% of trainees reported that they were comfortable leading a debriefing session. At the conclusion of this workshop, 83% of trainees rated themselves as comfortable leading a peer-debriefing session (Figure 2).

Figure 2. Residents' ($n = 25$) self-reported comfort level leading a peer-debriefing session pre- and postworkshop training. All comparisons with statistical significance at $p < .001$ are denoted by an asterisk.

Improvement in self-report measures of pediatric residents' perceived likelihood of leading future peer-debriefing sessions in an appropriate clinical setting was both statistically significant, $\chi^2(1) = 11.6, p = .0006$, 95% CI, 18.6-64.9, and meaningful. Before the workshop, 36% (nine out of 25) of trainees felt that they were at all likely to lead a future debriefing session. At the conclusion of the workshop, the number of pediatric residents who rated themselves as likely or very likely to lead a future debriefing session increased to 88% (22 out of 25; Figure 3). One hundred percent of residents felt that this workshop was beneficial to them and should be added to the formal curriculum.

Figure 3. Pediatric resident self-report of likelihood of leading a peer-debriefing session after a distressing patient care event. Comparisons of all likely and all unlikely responses significant to $p < .01$ are denoted by an asterisk.

Free-response reflection comments regarding the peer-debriefing workshop included the following:

- “I will reach out and *offer* help rather than ask if help is needed.”
- “I will check in more frequently with my colleagues.”
- “I will take the structure of the model and question prompts with me in my future clinical practice.”

Suggested opportunities for improvement in the workshop, as provided by anonymous survey comments, included the following:

- “[When asking trainees to reflect on a distressing patient care event they have experienced,] allow more time for trainees to process their emotions prior to moving on with the workshop.”
- “Fully script the demonstration peer-debriefing session to sound organic and supportive.”
- “Utilize the model as a guide for, not in place of, an organic, supportive conversation amongst peers.”

Discussion

We offer a workshop that is effective at providing pediatric residents with training in peer-debriefing through the use of didactic, observational, experiential, and reflective learning processes. Participants in the workshop gained knowledge and skills that led them to be more comfortable with and likely to lead a peer-debriefing session after a distressing patient care event. The workshop was an exceptionally well-received addition to the educational curriculum. It demonstrated significant and meaningful achievement of its objectives to increase pediatric residents’ comfort with and likelihood of leading a peer-debriefing session after a distressing patient care event. Additionally, the perceived value of the session to the standard educational curriculum was universally endorsed, indicating improved awareness of the importance of emotionally processing distressing patient care events to physician wellness.

In conceptualizing this peer-debriefing workshop, it was clear that by its very nature, the topic was emotionally charged. During the design and development of this workshop, buy-in of the pediatric residents for the role-play aspect of such a difficult topic was uncertain. Simulation teaching, the most experiential and active method of classroom-based instruction, always faces the challenge of authenticity. Role-playing, a very low-technology version of simulation, often garners comments about inauthenticity and difficulty getting into the character or mind-set required for the session. To achieve maximal authenticity, it was apparent that the workshop required participants to leave the physical setting of the classroom and reenter the reality of caring for a patient who experiences a distressing patient care event. The ability of the workshop facilitator to convey his or her own experiences with distressing patient care events with a combination of seriousness, support, and positive outlook is essential to obtaining residents’ interest in this important topic. However, the distressing nature of this type of experience must be balanced with levity and practical tools for dealing with emotional distress that empower the participants. Providing a balanced outlook on a largely negative experience invites learners to participate in something that is viewed as beneficial and not emotionally overwhelming. With this foundation set, the pediatric residents recognize they are in a safe space to explore their own experiences, learn new skills for emotional processing, and continue a journey of physician wellness.

Despite concerns over the emotionally charged nature of this workshop, and acknowledging the varied methods of emotional processing employed by individuals in times of distress, it was unclear how deeply participants would emotionally engage in the activities. Rather surprisingly, transporting the trainees to a space of contemplation and reflection was not difficult. It was as though their experiences were just below the surface, waiting to be discussed. The fact that these negative experiences were vivid and ready to be addressed made it easier for residents to be forthcoming and increased the authenticity of the role-play aspect of the workshop. However, when residents were mentally transported to a memory of a distressing patient care event, it was difficult to continue with didactic teaching. This prompting was intended to provide residents with a direct example from their own experiences that they could apply to the role-play

demonstration by the facilitator and volunteer. To help keep this reflection from flooding participants' minds, workshop facilitators should deliberately pause to acknowledge the emotions that have resurfaced and directly address the purpose of the reflection in helping with the authenticity of the role-play.

It is important to discuss several limitations with this workshop. As designed, the debriefing training occurs outside of the clinical realm, which may limit authenticity when attempting to recall a prior event. The emotional reaction to the distressing event is likely blunted or otherwise altered with the passage of time. This may make it more difficult for learners to place themselves in the mind-set of a distressed resident. Learner buy-in and perceived usefulness of the workshop may be reduced for those learners who are further removed temporally from distressing events because the immediacy and intensity of the experience may fade, leading these learners to unintentionally downplay prior distress. Alternatively, the intense emotional nature of the workshop topic may limit learner engagement if participants make an effort to not relive or reinvigorate an upsetting memory. It is important to emphasize that the participants are gaining skills in learning to perform a peer-debriefing session, not necessarily finding emotional relief from their own distressing experiences. Also, the survey metrics provided in this workshop did not measure baseline levels of emotional distress, conflict-management styles, or preexisting coping skills that may inform how learners respond to self-report measures of comfort with and likelihood of using peer-debriefing in clinical practice. Future iterations of this workshop may wish to supplement the baseline survey with validated measures assessing burnout or coping styles, for example. Finally, this workshop was conducted at a large tertiary care pediatric children's hospital on one cohort of pediatric residents, whose experiences may not generalize to all pediatric residents due to differences in patient acuity, complexity, and educational background. As the workshop is given to additional cohorts of residents, the increased sample size will allow for more robust analysis of changes in attitudes toward debriefing, as well as behavioral changes in resident peer-debriefing practices.

Ideally, pediatric residents would be exposed to this workshop near the start of their clinical rotations to provide a foundation for future experiences. Further, the workshop would be repeated yearly to refresh skills as the trainees' repertoire of distressing patient care events grows. To enrich the learning experience for our participants, future iterations of the workshop will be provided earlier in the academic year and occur on an annual basis.

The Children's Hospital Los Angeles pediatric residency program has continued to provide this workshop on a yearly basis for pediatric resident trainees. Opportunities for implementation with other medical groups within the institution are currently in discussion. A study of higher level outcomes, such as behavioral change and implementation of this model as part of the residency program workflow, is currently in progress. Future studies should apply this model to other groups of medical providers at different levels of training and specialties to determine its generalizability.

In conclusion, this peer-debriefing workshop demonstrates a well-received instructional tool that can be used to educate pediatric residents in peer-debriefing, imparting skills that pediatric residents felt they would be very comfortable with and likely to utilize in busy clinical practice to improve their own wellness. This workshop has the potential for extension throughout the field, helping physicians at all levels of practice process the inevitable distress that is inherent in caring for the sick.

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Ethical Approval

This publication contains data obtained from human subjects and received ethical approval.

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