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The clinical debriefer: is experience necessary?

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ABSTRACT

Introduction: Clinical debriefing (CD) has been established as a powerful tool to improve clinical outcomes and staff wellbeing. Despite this, multiple barriers to widespread implementation have been identified, most notably a perceived deficiency of skilled facilitators and a lack of debriefing experience. This raises an important question: who should lead a CD?

Main body: Arguments supporting the importance of experience for clinical debriefers include the perceived necessity of training for effective debriefing, the difficulties in cultivating psychological safety and the possibility of debriefings causing harm. Arguments against this viewpoint include practical limitations in accessing experienced debriefers, the availability and utility of debriefing tools and the opportunity to learn through different forms of facilitation. There is a relative paucity of research in this area, and we draw upon evidence from the simulation literature as there are key parallels between debriefers in both contexts.

Conclusions: In this debate, we have explored a variety of relevant considerations, although evidence is mixed and it remains unclear whether experience is necessary to facilitate CDs. We believe that for the potential of CD worldwide to be realized, compromise must be reached. For particularly challenging debriefings, such as in exceptionally distressing scenarios or critical incidents, experience may be essential. Fundamentally, we hope to have enabled readers to reach their own verdicts.

Introduction

The evidence is compelling: clinical debriefing (CD) works [1,2]. A CD is a group learning conversation, which attempts to bridge the gap between the experience of a clinical event and making sense of it [3]. Typically initiated and led by a member of the team itself, a CD represents an opportunity for all members of a clinical team to share their experiences and learn from them. This may be undertaken after specific clinical events or as part of routine practice [4]. CD has become established as a powerful tool to improve clinical outcomes, inform systems improvement and support team working and staff wellbeing [5,6].

Despite this, a significant evidence–practice gap exists, and the potential of CD worldwide remains broadly unrealized [7–9]. Multiple barriers to its widespread implementation have been described [10], most notably a perceived deficiency of skilled facilitators and a lack of debriefing experience [8,11,12]. This raises an important question: who should lead a CD? There is no clear consensus on whether training is required to lead a CD, nor how this affects outcomes for participants [13]. Exploration of whether experience is required to lead a CD is clearly necessary, both to describe effective and safe practice, and to identify and empower debriefers. Most importantly, we believe that clarity on this issue may promote uptake of CD among clinicians.

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Although there is limited published research focusing on the debriefer within CD, there is a wealth of literature regarding the debriefer within simulation-based education (SBE) [3,14–17]. Originating in the military and aviation industries [18,19], debriefing practices were first adapted for use in healthcare within SBE [20]. In this context, a debriefing is defined as a guided conversation among participants that aims to explore and reflect on the experience of a simulated scenario, and draws upon experiential learning theory [21,22]. CD has much in common with SBE debriefing, and there are many parallels – but also important differences – between debriefers in both contexts. We will draw on literature within the field of SBE throughout this debate to help to explore this complex and thought-provoking issue.

Aim of the debate

This debate will examine whether prior experience is necessary to facilitate CDs, presenting arguments both for and against. In doing so, we hope to allow readers to reach their own conclusions about the approach best suited to their practice. Drawing on the literature, this article will specifically explore debriefing effectiveness and use of tools, psychological safety and the relevance of content expertise, and finally the risk of harm. For consistency, we have defined an 'experienced' debriefer as someone who has undergone formal CD training and has practical experience in facilitating debriefings.

Debriefing effectiveness

Research shows that effective CDs can improve team performance [23,24]. Keiser and Arthur have published two meta-analyses [25,26] identifying characteristics that contribute to debriefing effectiveness. Important factors include debriefing structure and the facilitation approach. This is the crux of this debate: does an experienced debriefer facilitate a more effective debriefing?

It is well recognized that training is essential to develop effective medical educators [27]. While the impact of debriefing training has not been extensively assessed in the clinical setting, literature exploring CD implementation references the importance of an educated and experienced debriefer [11]. Some publications associate a lack of debriefing training with poorly organized or ineffective debriefings [12], while others have presented data from debriefing participants, who themselves felt that specific expertise is required to lead these discussions [8].

Within simulation, many consider debriefing effectiveness to be reliant on the training and experience of the debriefer [3,17]. In this context, debriefing has been described as a 'complex, dynamic skill that typically requires hours of practice and thoughtful reflection to achieve proficiency' [28]. Simulation educators are often expected to understand educational theory and utilize pedagogical techniques in their practice. Fernandez et al. proposed guidance for debriefing healthcare teams in simulation, stating 'debriefing facilitators should be appropriately trained and utilize evidence-based methodology' [29].

Given this evidence, it is the opinion of some that an effective CD must always be facilitated by an experienced debriefer. However, even within simulation this notion is being increasingly challenged [30]. Using a simulated crisis scenario, Boet et al. reported that interprofessional within-team debriefing was as effective as instructor-led debriefing in improving leadership, teamwork and performance [31]. Other studies have gone a step further and investigated the power of self-debriefing. In a study of nursing students who undertook a simulated clinical decision-making exercise, Verkuyl et al. found that there was no difference in self-efficacy and knowledge among nursing students who participated in self-led debriefing compared to instructor-led debriefing [32]. Similarly, Svendsen et al. found that self-debriefing interprofessional *in situ* simulations promoted team reflexivity and team members' interprofessional feedback skills [33]. A recent debate article extracted the learning from these studies and explored the potential of self-led versus facilitator-led debriefing in a simulation context, encouraging readers to challenge the *status quo* [30].

Lack of skill and experience are persistently quoted barriers that prevent healthcare professionals from engaging in debriefings within their own context [10]. However, the effect of training on debriefing effectiveness is uncertain, and there is limited direct evidence of the impact of debriefing experience in a clinical setting. The literature referenced herein includes both examples of the perils and possibilities of debriefing without the presence of an experienced debriefer. While further research is undoubtedly needed to explore this further, the positive examples in an SBE setting may indicate that debriefings do not always require experienced faculty to be effective. In our experience – as others have found [5,12] – it is unrealistic for many clinical settings to have trained or experienced facilitators readily available at all times of day. If clinicians without debriefing experience can be supported to deliver effective CDs, this offers huge potential for an increase in uptake of CD worldwide.

Clinical debriefing tools

The advent of CD tools and scripts has improved uptake and educational outcomes among clinicians [34], providing a promising way to mitigate for lack of debriefer experience. These tools provide a structured approach to CD and are a means of improving accessibility while simultaneously empowering inexperienced debriefers to lead safe and effective CDs. In a systematic review of 21 tools used for CD, none of the tools stated a prerequisite for debriefing experience [13]. For instance, the TALK© tool prides itself on being designed to be used 'with or without expert facilitators' [35]. Indeed, the inherent design of debriefing tools enables inexperienced debriefers to start somewhere.

INFO is the epitome of such a tool: it has been designed specifically to address the lack of skilled facilitators. Rose and Cheng recognized that debriefing facilitation often defaulted to the most senior physician on duty – even if they lacked debriefing experience. Using INFO, they have empowered multidisciplinary team members, particularly

nurses, to facilitate debriefings [36]. As a result, they have shifted leadership accountability to all team members, providing learning opportunities and simultaneously validating the concept of a team approach to patient care and quality improvement [9]. With the same idea, Rousseau et al. implemented a debriefing programme in their intensive care unit that was led entirely by junior team members utilizing the DISCOVER-PHASE tool [37]. The intervention was deemed feasible and well-received. It also offered an opportunity to strengthen interprofessional relationships, as one of the collateral benefits of CD is fostering collaboration [6]. These studies provide examples of how CD tools enable all members of a team to facilitate a debriefing. As a result, they serve to bring cohesion to a fragmented area of practice and encourage the uptake of CD across different settings.

Psychological safety

Psychological safety is the sense of safety that enables effective learning conversations [38], and is accepted as an important prerequisite for learning via CD [39]. A CD offers the opportunity for participants to unite as a collective, analyse their experiences and identify areas for learning and improvement [24]. For this to be effective, participants must feel able to contribute freely and openly, without fear of reprisal [38]. Failure to create a 'safe container' for participants is likely to undermine efforts to foster group learning and reduce the effectiveness of the debriefing for process or systems improvement [40].

Psychological safety is also key to facilitating effective debriefing within the simulation setting [39], and simulation educators typically take immense care throughout the development and delivery of a simulation to cultivate an experience that is optimally psychologically safe [41]. This includes efforts in 'pre-briefing' and when driving a scenario, but is most evident during the debriefing, where technique, choice of language and non-verbal communication are considered crucial to a productive learning conversation [3]. Importantly, this is recognized to be both critical to success and challenging to achieve. As such, psychological safety tends to be a key focus during simulation faculty development training and is considered an essential skill in the educator's repertoire [39,42].

However, many of the techniques used to foster and maintain a psychologically safe environment within simulation are increasingly difficult to apply in the clinical setting [39]. CD is more nuanced, as real-world experiences are not designed and there is rarely an opportunity for a 'pre-briefing' that might set the required tone before an event. Organizational culture is another powerful influencer [43]. The stakes are much higher within the workplace: participants are required to process real-life encounters, and any actions or comments are likely to have consequences and the potential to affect patient safety. A failure to achieve requisite psychological safety among participants may undermine any positive impact of the CD, and the experienced debriefer is likely to be better equipped to navigate these challenges [44].

The position of the debriefer within the team is also relevant. In the clinical setting, the debriefer is typically a member of the clinical team and has experienced the event themselves. This contrasts with SBE, where debriefers are usually positioned externally to the scenario and act as a guide to facilitate group progression through discussion [28]. The clinical debriefer may be fairly considered as *both* debriefer and participant, and it may be challenging for a clinical debriefer to move beyond their own reactions and motives to facilitate an open discussion. Clinical teams also have their own complex histories and established relationships between team members, which can affect the dynamics of the debriefing and have the potential to impact working practices in the future [43]. Given these challenges, an experienced debriefer is likely to be invaluable in navigating these complex interprofessional relationships and balancing facilitation and contribution.

In clinical settings, it is often senior members of staff who possess the most experience with debriefing [45]. However, restricting the facilitation of debriefings to this cohort may lead to unintended negative consequences. Hierarchies are ever-present within healthcare and have been demonstrated to impede patient safety by contributing to a reluctance to speak up [46,47]. Furthermore, they can obstruct interprofessional teamwork and impact individual and team psychological safety [48,49]. Defaulting to the most senior clinician to lead a CD may contribute to a hierarchical culture, undermine the aims of the debriefing and risk hindering team performance by compromising psychological safety [50,51]. It is also easy to falsely conflate seniority with experience: those who are perceived to be 'leaders' due to their hierarchical standing may not have undergone any training in CD facilitation and so they – by default – are inexperienced clinical debriefers. Research suggests that they may also inhibit or bias the discussion [52].

CD requires genuine, open dialogue and is challenging in the presence of established hierarchies within healthcare [53]. If choosing to prioritize an experienced facilitator limits CD to senior staff, there is a risk to this open discussion which may undermine psychological safety. Promoting active involvement from all team members – irrespective of seniority – validates the concept of a team approach to patient care, and may enhance both the learning and feasibility of CD in practice. Widening access to debriefing training and choosing to compromise on debriefer experience may offset these issues.

Debriefer background and content expertise

Within our clinical teams, uncertainty remains regarding which professional groups are best placed to lead a debriefing, and whether content expertise is necessary. In our experience, CDs are disproportionately led by medical staff, but we acknowledge that this can vary depending on context. Does a debriefer need to have deep knowledge of the topic being discussed?

Most useful evidence on this topic is found within SBE, where opinion is divided on whether expertise on clinical subject matter is required to conduct an effective debriefing.

Many simulation educators argue that clinical background and knowledge is secondary to debriefing skill, and is not compulsory in order to deliver an effective debriefing [54]. Indeed, in their randomized controlled trial Diaz et al. found that content expertise did not affect the participant perception of scenario effectiveness [55]. However, this opinion is not universal, and other simulation educators report that debriefing is most effective when delivered by a content expert [56,57]. Practice varies among simulation centres, and may depend on the style or approach to the debriefing. The importance of expertise is contentious in a variety of other educational contexts, most notably problem-based learning [58].

Unlike simulation, there is little published work on the background and clinical expertise of the debriefer in a clinical setting. In their 2021 concept analysis, Toews et al. outlined evidence to support a need for the debriefer to be 'educated', but this evidence focused on debriefing training and practical preparedness for the debriefing rather than specific clinical knowledge [11]. Healthcare professionals from a variety of backgrounds were noted to be capable of leading a CD, but significantly they found 'uncertainty as to the discipline that is best positioned to lead a debrief'. Clearly further research into the background and clinical expertise of potential debriefers will be valuable and exactly who is best positioned to lead a debriefing within a specific team may vary with context.

Risk of harm

While the benefits of CD have been robustly demonstrated, recent literature exposes the limitations of poorly facilitated debriefings, and even presents the possibility of causing harm when a debriefing goes wrong [59]. CDs represent exploration of real-life events and can cover unanticipated and potentially sensitive or distressing topics. Indeed, the stereotypical perception of CD among clinical staff is a group discussion following an emergency, with a focus on managing staff wellbeing [11]. These discussions can be unpredictable, even when CD is a routine part of practice, and it is common for participants to be distressed or, less commonly, for conflict to occur within the team. Facilitation of these discussions can be challenging as a result [5,8].

This raises concerns about the possible unintended negative impact that could occur following a poorly facilitated CD. Recent literature on this topic highlights the need for debriefers to screen participants for negative reactions and to judge the emotional temperature in the room in order to avoid exacerbating psychological distress [43]. It is also recommended that debriefers understand the intention of debriefing, and focus on debriefing for education or improvement ('debriefing-to-learn'). Debriefing to avert or manage potential post-traumatic stress disorder ('debriefing-to-treat') is not recommended without specific training as it can cause harm for participants [6]. The impact on the debriefer themselves is not inconsiderable, and emotionally charged discussions on distressing topics can negatively impact their wellbeing [11].

These considerations broaden the responsibility of the debriefer, and there is growing consensus that for critical incidents or particularly distressing scenarios it is essential that the debriefer has undergone training in managing challenging debriefings [60]. For example, the TALK© tool, while stating that any team member can initiate a debriefing, recommends that 'emotionally complex' scenarios should be debriefed by an experienced facilitator, psychologist or critical incident stress debriefing expert [35]. Other debriefing tools now incorporate emotional screening, aiming to aid the debriefer in identifying and preventing debriefings that could cause harm [13]. While some of these situations are difficult to predict, debriefings that risk exacerbating psychological distress clearly require debriefer experience.

Concluding remarks

The ability of CDs to facilitate team learning and create positive change for our systems is indisputable [7,15]. Also self-evident, however, is the difficulty in doing this effectively and safely; navigating the complex histories, hierarchies and relationships within our clinical teams and responding to the complicated and unpredictable challenges posed by healthcare environments. Exactly *who* leads a CD and whether this role should be restricted to experienced debriefers is unclear, and published work on this topic is scarce. The literature primarily explores the benefits and barriers to CD, with much less consideration of implementation and sustainability. Beyond the published work on CD, key lessons can be taken from literature on SBE and translated, when appropriate, to the clinical workplace.

A perceived deficiency of skilled facilitators and a lack of debriefing experience remain significant barriers to widespread uptake of CD. While there are many strong arguments as to the benefits of debriefer training and importance of experience, in many healthcare contexts an experienced debriefer is not always readily available. It is our belief that a compromise must be reached, and that all healthcare professionals are provided with the opportunity and empowered to debrief their own teams safely. This should include promotion of CD tools and widening access to basic debriefing training. However, significant caution should be advocated in 'emotionally complex' scenarios or critical incidents, when training and experience are indispensable.

In this article, we have attempted to explore this debate, presenting the arguments and evidence whilst highlighting the many and varied challenges involved in choosing an appropriate facilitator to lead a CD. While there remains a variety of opinions on this topic, we hope to have equipped readers to reach their own verdict, and to develop a method of CD that fits within their local context, to make debriefing the norm rather than the exception.

Declarations

Authors' contributions

CJD and SW are joint first authors and co-led the conception and design of this article. Both authors contributed to the writing and editing of this manuscript and have reviewed and approved the final article.

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