

## The Case of the Debriefing Debacle

Case Written by Joanna Bostwick

### Case

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### Objectives:

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### Expert Responses

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"Excuse me Dr. Berner. One of the nurses came to ask me if we were aware that there is a 20 year old guy in Resusc with a heart rate of 200," said Melanie nervously, a third year medical student who had just started her Emergency Medicine (EM) rotation.

"What!?! I didn't hear about that. Let's go over right away."

Dr. Berner sprinted ahead as Melanie grabbed her stethoscope. As Dr. Berner entered the Resus Bay he saw a young slender male who did not appear well with vomitus running down his cheek. He looked sonorous and diaphoretic and the monitor showed a heart rate now of 220 bpm. Two nurses were hard at work attempting to establish an IV and draw bloodwork

"Can anyone tell me about this patient?" Dr. Berner demanded.

"He was found slumped over at a house party tonight. The paramedics think he took a cocktail of drugs and alcohol," said one of the senior nurses while she primed an IV with normal saline.

Dr. Berner turned to Melanie, "Have you ever intubated before?"

"Ummmm... A few times?" Melanie stuttered, she had intubated a couple of times in the OR but never in the ER. "But I'm not even sure what's going on here."

"We can talk more about what's going on in a moment, first we need to secure the patient's airway."

"The O2 sats are starting to drop and I can't wake him up," said a nurse anxiously.

"Ok team, let's give the naloxone and get set up to intubate."

"The naloxone was given per protocol by EMS with no effect earlier," stated the charge nurse. "Alright then, I'm going to intubate right now." Let's get the crash cart at the bedside and page

RT stat." Dr. Berner turned to Melanie, "I will have you watch this one and you can attempt the next intubation."

The patient was intubated successfully and Dr. Berner sighed with relief. With the patient's airway secure, his oxygenation improved. He now turned to Melanie to ask about toxins that could cause tachycardia when suddenly the monitor started to beep as Dr. Berner looked in horror to see VFib.

"Melanie start chest compressions," ordered Dr. Berner, "Betty, can you give 1 mg of epi? Also, Sarah can you go get Dr. Takeda and his residents over in the Quick Care area?"

Melanie had never done CPR before in real life and shuddered in horror as she felt ribs breaking beneath her hands.

Her head was spinning. What had just happened? She was beginning to feel her arms fatiguing and didn't know how she could keep this up.

There was a flurry of people who suddenly appeared to help at the bedside.

"Ok stop CPR let's check the rhythm and pulse," said Dr. Berner.

"Asystole," said several in unison.

"Resume CPR," Dr. Berner said and then turned to Melanie, "you can switch off with Joe. He's right behind you, ready to take over CPR."

"Dr. Berner the family has arrived they would like to find out what's happening and want to see their son," said the social worker quietly from the doorway. I have tried to prepare them for what they are about to see." Dr. Berner nodded his assent, and the social worker disappeared momentarily. A few minutes later, she returned with a middle-aged couple, both clinging to her for support.

"Another round of Epi please, Betty?" (cont'd)

# Expert Response

"How long has the code been going on?" asked Dr. Takeda as he arrived. He and Dr. Berner turned to each other to discuss the proceedings on the code, just out of Melanie's earshot. Dr. Takeda then went over to talk to the parents of the patient, talking to them somberly for several moments.

A few moments later, the couple looked to him and said: "Please stop."

Dr. Takeda then nodded at Joe, who had the bedside ultrasound set up, and ready to use at the next rhythm check.

"Rhythm and pulse check please," ordered Dr. Takeda.

"No pulse... Asystole..."

"Bedside echo shows no cardiac activity."

"Let's call the code," sighed Dr. Berner. "Time of death..."

There was a large wail as patient's mother fell to the ground. Melanie tried to hold back her own tears.

For the next few minutes, Melanie felt like she was walking through a daze. Had that really just happened? She felt like it had just been a few minutes since she had seen arrive with the paramedics! He had groaned when she tried to do a sternal rub... He had been alive. What had happened? Maybe her compressions weren't forceful enough? What if it was her fault?

## Questions for Discussion

1. How do you debrief this case with Melanie?
2. How do you address her fears that she did something wrong?
3. What is a general approach to debriefing a medical student after a bad outcome in a young patient?
4. What is the role of the family's presence during a resuscitation?

## Competencies

ACGME	CanMEDS
Professional Values (PROF1) Patient Centered Communication (ICS1) Team Management (ICS2)	Professional Communicator Collaborator

## Intended Objectives of Case

1. Describe a method framework for debriefing.
2. List and describe various types of debriefing activities.
3. Discuss the concept of the 'second victim'.
4. Elucidate linkages between the following topics: post-traumatic stress disorder, debriefing,, compassion fatigue and burnout.

## 3 Steps for a Smooth Debriefing

by Hans Rosenberg MD, CCFP(EM)

In the field of Emergency Medicine most of us would have encountered a similar experience as that of Melanie. Our work can be often seem like the routine intermixed with moments of chaos that can leave us in a fragile emotional and psychological state. A case such as the one described is capable of doing just that. So as an attending/supervising physician there is a clear role in this case for debriefing with our learner. I'll briefly discuss a suggested approach to debriefing and how it could play out in real life.

Debriefing is an integral process in learning which allows for discussion and analysis of an experience, evaluating and integrating lessons learned into one's cognition and consciousness. (1)

The debriefing approach that I prefer to use is a 3-step approach described by experts from The Center for Medical Simulation in Cambridge, Massachusetts (2):

### Step 1 - The reactions phase

At this point it would be important to allow Melanie, as well as any other participants in the case who would like to participate, to be able to "blow off" some steam and let out their emotions about the case. In our particular scenario there are appears to be a mix of shock, sadness and perhaps feelings of inadequacy. This is the time to "normalize" both the emotions that Melanie is experiencing, as well as the case that she had just seen. If applicable, this would be the time when the supervisor can share a similar experience they had at some point in their training as part of the normalization process. Additionally, the facts of the case should be explicitly reviewed at this time.

### Step 2 - The understanding phase

This step is when Melanie would be given the opportunity to describe her frame of mind, how that led to a certain action and what the results were. For example, Melanie may mention that although she had previous knowledge of how to perform Cardio-Pulmonary Resuscitation (CPR) she had never performed it on a person. The resulting sensation of ribs fracturing under her hands led to a distinctly negative

experience and did not yield the results she may have hoped for or expected (ie. successful return of spontaneous circulation). This is also a time when the debriefer would make explicit what's on their mind in order to clarify certain points and encourage discussion. In our case, a statement such as "I was pleased to see that you had excellent technique during your performance of CPR, it was at the appropriate rate of 100 per minute and the ideal depth." This has a two-fold effect of letting Melanie know what she did correctly and the rationale behind it.

### Step 3 - The summary phase

At this final step, it is time to allow Melanie to tell me what she thought she did well, what she would do differently and how she might implement it in the future. It is a simple, but often overlooked skill to be able to reflect on actions and make a plan which they can be acted upon if a similar scenario were to arise.

This approach would be helpful in dealing with the debriefing of a young learner such as Melanie being exposed to what can be a very traumatic experience. However, that should not be the end of the discussion. It would also be important to gently remind her what a profound effect these types of cases can have on health workers and that she is not alone. There is clear evidence that exposure to critical incidents is associated with post-traumatic stress symptoms, anxiety and depression. (3) As such, it would be wise to ensure that there can be some follow up in the near future to see how Melanie is doing. It doesn't have to be formal, but support from colleagues/supervisors can have a protective effect when it comes to the negative outcomes associated with critical incidents. (4)

### References

1. Lederman LC. Debriefing: towards a systematic assessment of theory and practice. *Simulations Games*. 1992;23(2):145-160.
2. Gardner R. Introduction to debriefing. *Seminars in Perinatology*. Elsevier; 2013 Jun 1;37(3):166-74.
3. de Boer JC, Lok A, Verlaat EV, Duivenvoorden HJ, Bakker AB, Smit BJ. *Social Science & Medicine*. Social Science & Medicine. Elsevier Ltd; 2011 Jul 1;73(2):316-26.



### About the Expert

Dr. Hans Rosenberg (@hrosenberg33) is an Emergency Physician in Ottawa, ON, Canada. He is an Assistant Professor, and the IT director of the University of Ottawa's Department of Emergency Medicine. He is a contributor to EM:RAP. His interests are in medical education and web 2.0 tech.

## Debriefing Models

by Tessa Davis MBChB, MA, FACEM

This is an emotional and difficult situation whether you have been working in medicine for 2 days, 2 years or 20 years. However, as a medical student Melanie is in a particularly vulnerable position because she has no previous experience or preparation.

A debrief is needed to allow staff to feel comfortable opening up about their reflections. This might include practical points such as finding a private area to debrief; making sure all the staff have space to sit and are facing each other; and noting that everyone in the team is a potential valuable contributor (1).

### Debriefing Models

There are several models for debriefing. The most common is the Critical Incident Stress Debriefing (CSID) model, created by Mitchell in 1983 (2) and elaborated on by Dyregrov (1997) (3), which includes 7 stages:

Stage	Description
Introduction	Introduce the team members, set out some guideline for the debriefing conduct
Facts	A very brief overview of the facts
Thoughts	"What was your first thought?"
Reactions	Aiming to transition from 'thoughts' to 'symptoms' by asking "what is the worst thing about this for you personally?"
Symptoms	Team members listen to other people's emotional or physical symptoms and contribute theirs
Teaching	Normalising symptoms, explaining reactions and teach about stress management and any topic relevant to the specific case
Re-entry	An opportunity for any other questions or statements. The team summarises the discussion.

Others include Kinchin's emotional decompression model (4), which uses a diving analogy (the stages are diving in; deep water; middle water; breaking the surface; and treading water) and the SHARP medical model (5 stages: Set learning objectives; How did it go; Address concerns; Review learning points; Plan ahead) (5).

The General Concepts

All of the above models (and there are plenty more) encompass the same key points:

### 1. Establish the facts

Outline what happened with this patient, the medical elements of the resuscitation, and how the case progressed. Often in times of high stress, the facts can get blurry in our minds. Stating the facts out loud at an early stage can help provide an accurate memory of the situation.

### 2. Address thoughts and feelings

It is important to discuss people's thoughts and worries. This medical student is having the same reaction we all do when faced with death: Did we do something wrong? Could we have done something differently that would have led to a different outcome? Often, a specific element of the resuscitation can become the focus. A senior doctor may worry about his intubation skills and if he could have been faster; a junior doctor may worry about the time taken to recognize how unwell the patient was; a medical student may worry that she wasn't doing the CPR correctly and that her fatigue brought about the patient's death.

It would be more helpful for Melanie to be allowed discuss her specific worries openly rather than just giving her a dismissive 'of course you didn't do anything wrong'. Asking what her concerns are, and perhaps even discussing the role she played throughout the resuscitation, will help her to decompress.

### 3. Discussing our own symptoms

I think we all have a patient that suddenly flashes into our mind in the middle of the night, or even in the most unexpected situations. That's a normal part of being human and coping with our day-to-day working lives. However, if these thoughts or feelings are affecting our work, sleep or personal life then they may need some additional support. Post-traumatic stress disorder is described in healthcare professionals after witnessing stressful events and the healthcare team needs to be vigilant to the signs and symptoms.

Be cognizant of humanity and grief. ED staff have a tendency to just 'grab a coffee and pull themselves together', and many find it challenging to confront emotions during debriefs. However, there is clear evidence of the psychological effects of resuscitations on doctors (6), so it's essential to acknowledge this.

# Expert Response

## 4. Learning from our mistakes.

As doctors we are always learning from our patients – we can always do better next time and identify learning points. Resuscitation scenarios can often highlight systemic flaws in the department: equipment that is not available or complete; problems with drug access; or difficulties with communicating with other staff members. The debrief helps to establish whether there are changes that can be made to improve the system in the future.

However, as a medical student who is not expected to have expert resuscitation skills, the main purpose of the debrief for Melanie is emotional support.

## 5. Summary and follow-up.

A debrief usually happens pretty close to the event (although the CSID guide reference above suggests 24-72 hours post-event). This is often for practical reasons – getting together the same staff at another time in a shift-working environment is near impossible. It is useful to talk about the resuscitation while it is fresh in everyone's mind.

Follow-up is also important. After time for reflection, Melanie may have other questions and other thoughts and it's essential to address these. Arrange to meet Melanie again and let her know of any follow-up case meeting, for example if the case is being presented at an M+M meeting.

## References

1. Salas et al, Debriefing medical teams: 12 evidence-based best practice tips, *The Joint Commission Journal on Quality and Patient Safety*, 2008, 34(9):518-527. [http://www.wpahs.org/sites/default/files/file/DebriefingMedicalTeams\\_000.pdf](http://www.wpahs.org/sites/default/files/file/DebriefingMedicalTeams_000.pdf)
2. Mitchell, JT, When disaster strikes...The critical incident stress debriefing, *Journal of Emergency Medical Services*, 1983, 13(11):49-52.
3. Dyregov, A. The process of psychological debriefing, *Journal of Traumatic Stress*, 1997, 10:589-604.
4. Kinchin, David (2007). *A Guide to Psychological Debriefing: Managing Emotional Decompression and Post-Traumatic Stress Disorder* London, UK and Philadelphia, PA, USA: Jessica Kingsley Publishers.
5. Ahmed, M., Arora, S., Russ, S., Darzi, A., Vincent, C., & Sevdalis, N. (2013). Operation debrief: a SHARP improvement in performance feedback in the operating room. *Annals of surgery*, 258(6), 958-963.
6. Dyer, K. The potential impact of CODES on team members: examining medical education training, *American Academy of Experts in Traumatic Stress*, accessed online on 27th March 2014, <http://www.aaets.org/article95.htm>

## Other Resources

7. The London handbook for debriefing, Imperial College, London, 2010, accessed online on 26th March 2014 at [http://www1.imperial.ac.uk/resources/EE125DD5-63D9-48AB-8A77-F2951610CD83/lw2222ic\\_debrief\\_book\\_a5.pdf](http://www1.imperial.ac.uk/resources/EE125DD5-63D9-48AB-8A77-F2951610CD83/lw2222ic_debrief_book_a5.pdf)
8. May, N, It's good to talk – debrief in the emergency department, *St Emlyn's Blog*, accessed online on 26th March 2014 <http://stemlynsblog.org/good-to-talk-debrief-in-the-emergency-department/>



## About the Expert

Tessa Davis (@TessaRDavis) is a Pediatrics Registrar at Sydney Children's Hospital. She is the founder and genius behind Don't Forget the Bubbles blog and the director of iClinicalApps.

# Curated Community Commentary

By Teresa Chan MD, FRCPC, MHPE(c)

*A qualitative methodology was used to curate the community discussion. Tweets and blog comments were analyzed, and four overarching themes were extracted from the online discussions.*

This week, we had a similarly significant online discussion about this case. As I read, there were a number of themes that emerged from your comments. We have chosen to highlight some key issues for learners and faculty members to consider when you encounter a situation that may require a debrief.

## What might you actually say?

Dr. Woods suggests that attendings can facilitate debriefing by asking a simple question: '[T]hat was a tough shift, is there anything you want to discuss?' Letting, the conversation, thereafter, be steered by the learner (Melanie) and her needs.

Dr. Loice Swisher outlined her actual answer to the question of how one might approach Melanie:

*"If you do this long enough you will make decisions that cause a patient pain, suffering and death- probably more than once. It is even more problematic in emergency medicine where we have to make rapid decisions with inadequate and incomplete data often having no established prior rapport with the patient or family. Yes, to err is human. Medical mistakes are now thought to be the 3rd leading cause of death in the US. However, Melanie, for you this is not one of them. You acted admirably at the level of your training. The outcome is not your fault. At this stage you need to recognize the difference of sick and not sick and when you are in over your head needing help. You did that."*

Jeffery Hill suggests starting with something akin to: "No matter how long I'll work in this job, I'll never get used to the death of a young patient." He then described how he would reaffirm the things that Melanie did very well: First, she recognized sick versus not sick and second, she realized that the resources present in the room weren't sufficient to care for the patient.

Others spoke in more general terms about their approaches. Some would provide Melanie with a break, while others suggested they would explicitly ask Melanie how she was doing (to create a safe space for disclosure). A key in this process seemed to be to normalize that emotions and responses were a natural part of post-resuscitation proceedings.

The importance of debriefing to prevent the 'Second Victim' effect: Learners, attendings, and everyone involved  
The concept of the 'second victim' was introduced to our conversation by Dr. Chris Merritt, who worried that we often downplay (or forget altogether) the healthcare practitioners that are involved in the resuscitation. Junior colleagues, nursing, clinical staff, and non-clinical staff alike may need support after experiencing a 'tough' resuscitation.

Many learners disclosed during the discussion that they often feel alone during the post-resuscitation period. Several noted that it is important for learners to feel supported and discuss cases of importance whenever possible. As Dr. Lockett-Gatopoulos states:

*"I suspect that experienced clinicians know when they are and are not to blame, but learners nearly always feel that they have had something to do with the outcome, especially since we often do not understand the intricate details of the situation."*

Several participants pointed to the concept of post-traumatic stress disorder, and how it might be important to institute ideas around critical incident stress debriefing (CSID) Of critical importance is the need to debrief with the entire resuscitation team, and provide follow-up. The worry, however, was that in having a standing CSID procedure that occurs immediately after every resuscitation, team members themselves may not be ready to perform this task in the immediate future. As Loice Swisher notes,  
*"Looking at the case, I don't think that Dr Berner could do a great clinical/cognitive debrief anytime in the near future. I think it will take some time to work this through himself and then decide how to incorporate what is learned into a their own clinical framework."*

The idea of a CSID team was a novel idea that not many commenters had experienced. Both Drs. Robert R. Cooney and Dr. Teresa Chan described the idea of a bare-bones debrief after a code, asking a few key questions:

- 1) Is there anything we missed?
- 2) Is there anything we could have done better?

More constructive and larger avenues would be to use a more systems-level thinking via an M&M case. Dr. Cooney suggested the Vanderbilt matrix to facilitate this (1,2). Dr. Merritt describes how their team uses both an 'in-shift' debriefing and then an organized session several days or even weeks later - but then describes how the temporally distanced debrief may lose impact.

# Curated Community Commentary (continued)

## The importance of being earnest... and having empathy

Empathy is a critically important skill in the setting of debriefing and bad news. Dr. Rob Woods (U of S, @RobWoodsUofS) highlighted that if a case seems clinically 'clear-cut' (e.g. an elderly patient, with significant co-morbid disease), we might overlook how stressful that can be for a trainee. Dr. Stella Yiu similarly highlighted the need for experienced clinicians to listen and normalize feelings, since junior colleagues may not have a large body of experiences to draw from.

An underlying tone of some of the comments was that sometimes we, as emergency practitioners, treat death and dying a bit mechanically - as a code to be run. Dr. Loice Swisher explained how a personal friend and situation helped her remember the impact of your words on your patient's family:

*"I had a good friend whose mother and brother were killed in a motor vehicle accident after leaving his house for Thanksgiving dinner. I wasn't even in medical school at the time when he told me how "the ER doctor came in and quietly tore his life apart". I think of my friend and that phrase every time that I notify a family of a death. That is my private moment of silence and reflection."*

Dr. Nadim Lalani, explained his technique for holding a moment of silence at the termination of a resuscitation. This seems to have been taken up well by the team in his department, and may be of benefit to other teams.

Many participants also endorsed the involvement of family presence during the resuscitation. As has been described in the literature previously (3), this technique does help with the family's grieving process. But, as Dr. Lockett-Gatopoulos noted, it is quite unfair to ask those without specific training to support a family through a resuscitation. If we are to care all members of our team, we should equip them with the skills to be able to handle the family presence. As such, Dr. Robert R. Cooney noted that he is only able to provide the family the opportunity to be present during resuscitation if there are trained individuals present that can carefully facilitate this process.

## That awkward moment when you realize you need to talk and no one is around

Many participants noted that this case seemed to have affected both Dr. Berner and Melanie significantly. As such, it was agreed that both needed to talk about this case with someone.

Some learners perceived that they have had to request debriefing, and still others noted that they have felt the need for one, but didn't know how to ask. In fact, some participants noted that Dr. Berner (the attending for the code) may be in need of a good debrief, too. As such, would he even serve as a good 'debrief' for Melanie? This issue was left unresolved by our discussion, but highlights an important issue for discussion: What debriefs the lead clinician?

A few participants highlighted the need to create a supportive network, people with whom you will discuss cases that bother you most. Some found their friends to be of importance in their personal debrief, others debrief openly in formal settings (e.g., Morbidity and Mortality rounds), whereas others found that discussing cases with a mentor helped. Drs. Yiu and Swisher both described how they had a few choice colleagues (e.g. 'work spouses') that serve to support them.

## A call to action:

### Training learners and staff to debrief

Many participants noted that they had little formal training in debriefing, but have learned on the job, or by an apprenticeship model (e.g. viewed others' and emulate). As stated before, though there is evidence (3), that family presence during CPR has benefit for the family members, there may not be capacity in your local milieu to provide this service.

At least one medical school (Queen's University, Kingston, ON) seems to have a narrative medicine course (Medicine and Literature) that serves as a platform to discuss learners' feelings, concerns and uncertainties. Indeed, it seems the fictional works they discuss precipitate reflection, and perhaps the MEdIC series itself is a proof of this method. Regardless, the avid discussion this month is testament that this is critical issue that needs to be discussed and then acted upon.

So, I leave you with this - what's your local plan for debriefing critical incidents? Do you have one? If not, is it time to think about it?

# Curated Community Commentary (continued)

## References

1. Bingham JW, Quinn DC, Richardson MG, Miles PV, Gabbe SG. Using a healthcare matrix to assess patient care in terms of aims for improvement and core competencies. *Jt Comm J Qual Patient Saf.* 2005 Feb;31(2):98-105.
2. Cooney, R. Making M&M Better: The Healthcare Matrix. From the Better in Emergency Medicine blog. Accessed last on Oct 30, 2014. Available at: <http://www.betterinem.org/?p=44>
3. Jabre et al. Family presence during CPR. *N Engl J Med.* 2013 Mar 14;368(11):1008-18. doi: 10.1056/NEJMoa1203366.

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*Thanks to the participants (in alphabetical order) for all of their input:*

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## About

The Medical Education In Cases (MEiC) series puts difficult medical education cases under a microscope. We pose a challenging hypothetical dilemma, moderate a discussion on potential approaches, and recruit medical education experts to provide their insights. The community comments are also similarly curated into a document for reference.

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