



Implementing Emotional Debriefing in Pediatric Clinical Education

Amanda D. Osta, MD; Marta A. King, MD; Janet R. Serwint, MD;
Susan B. Bostwick, MD, MBA

From the Department of Pediatrics (AD Osta), University of Illinois at Chicago, Chicago, Ill; Department of Pediatrics (MA King), Saint Louis University School of Medicine, St. Louis, Mo; Department of Pediatrics (JR Serwint), Johns Hopkins University School of Medicine, Baltimore, Md; and Department of Pediatrics (SB Bostwick), Weill Cornell Medical College, New York, NY

The authors have no conflicts of interest to disclose.

Address correspondence to Amanda D. Osta, MD, University of Illinois at Chicago, 840 S. Wood, MC 856, Chicago, IL 60612 (e-mail: aosta1@uic.edu).

Received for publication March 22, 2018; accepted October 13, 2018.

ABSTRACT

Challenging situations and intense emotions are inherent to clinical practice. Failure to address these emotions has been associated with health care provider burnout. One way to combat this burnout and increase resilience is participation in emotional debriefing. Although there are many models of emotional debriefings, these are not commonly performed in clinical practice. We provide a guide for implementing emotional debriefing training utilizing the American Academy of Pediatrics Resilience Curriculum into clinical training programs, with a focus on preparing senior residents and fellows to act as debriefing facilitators. Senior residents and fellows can provide in-the-moment emotional debriefing which allows

for greater health care provider participation, including medical students and other pediatric trainees. Training of senior residents and fellows may allow more frequent emotional debriefing and in turn may help to improve the resilience of pediatricians when they face challenging situations in clinical practice.

KEYWORDS: clinical education; emotional debriefing; graduate medical education; pediatrics; residency; resilience; wellness

ACADEMIC PEDIATRICS 2019;19:278–282

CHALLENGING SITUATIONS AND intense emotions are inherent to clinical practice. Health care providers care for patients and families during high-stress situations, wrestle with uncertainty in medical decision making, disclose medical errors, discuss life-altering diagnoses, and experience the death of patients. These inevitable events impact not only patients and families but also their medical providers, including residents, fellows, and medical students,^{1–3} and have been associated with health care provider burnout.⁴

National organizations endorse the importance of acknowledging the emotional impact and supporting health care providers after challenging situations.^{5–7} Dedicated emotional debriefing is a technique that allows participants to work together after a challenging event to identify, reflect, organize, discuss thoughts and emotions, share perspectives, provide support, and decrease preoccupation with the event in a psychologically safe space.^{8–10} Unlike intellectual debriefing, where the focus is on critically reviewing the facts of the case, in emotional debriefing the primary focus is the impact of the encounter on the health care providers.

Emotional debriefings have been shown to benefit health care providers in both the shorter term, by helping them process the challenging event, and the longer term, by promoting resilience and reducing burnout.^{1,11–13}

Despite established benefits and models,^{13,14} formal emotional debriefing is not routinely practiced or taught.^{15,16} It may be difficult for teams to come together without a skilled facilitator to lead these discussions. Although attending physicians as medical team leaders might be expected to lead debriefings, many of those practicing in high-acuity settings are not prepared to do so. Eighty-eight percent of US pediatric emergency medicine fellows¹⁵ and 93% of pediatric trainees in the United Kingdom¹⁶ reported no formal debriefing training.

As authors of the American Academy of Pediatrics (AAP) Resilience Curriculum,^{17,18} we have led numerous national workshops on the topic of physician resilience and emotional debriefing. When workshop participants were asked to reflect on past experiences with grief and loss, they often brought up events that occurred during their training. Many workshop participants specifically commented on not discussing these events with anyone at the time and some reported never discussing these events at all.

Institutional culture, lack of trained facilitators, and the perception of inadequate time likely contribute to the problem. Although employment of bereavement facilitators trained in debriefing and group processes¹⁴ is one potential solution, it is likely not feasible for most

programs. It also does not serve the need for immediate in-the-moment discussion. In this paper, we aim to address this gap and provide an overview of emotional debriefings, discuss their risks and benefits, review various formats, outline key steps, and highlight resources for further training. Additionally, we propose a model to incorporate emotional debriefing into pediatric training that utilizes senior residents and fellows as skilled debriefing facilitators, which allows for peer-led, timely emotional debriefings and may begin to change expectations in the medical culture. Training senior residents and fellows gives them the skills to perform emotional debriefings in their future practice.

BENEFITS AND RISKS OF EMOTIONAL DEBRIEFING

Multiple studies demonstrate that emotional debriefing can reduce medical provider burnout and promote resilience.^{1,11–13} Bateman et al¹³ reported that Wrap-ups, which included multidisciplinary debriefing after a pediatric patient death, alleviated the stress of providers involved. A survey of 755,000 providers in the United Kingdom showed that debriefings in the medical and pediatric intensive care units decreased rates of physician and nurse burnout.¹¹ Medical students who debriefed with a supervisor following a patient death were more likely to integrate lessons learned.¹ Staff who participated in bereavement sessions focusing on emotional debriefing indicated via self-report that they were better able to manage grief.¹⁴ Internal medicine residents at Memorial Sloan Kettering Cancer Center found debriefing sessions to be educational and specifically commented on appreciating senior physician leadership.¹⁹

Although the literature largely supports emotional debriefing, some studies that have shown no or a negative impact deserve consideration. A Cochrane review²⁰ evaluated the association of a single debriefing session for victims and first responders involved in events associated with post-traumatic stress disorder (PTSD) and found no correlation between the single-session debriefing and decreasing PTSD incidence.²⁰ A second Cochrane review²¹ found that multiple individual trauma-focused cognitive behavioral interventions were most effective for individuals with acute traumatic stress symptoms as compared with other types of supportive counseling interventions, such as one individual or group emotional debriefing. Similarly, a cross-sectional survey of pediatric residents in the United Kingdom showed an association between debriefing and development of PTSD following a patient death, but those who led the debriefing did not have any training in emotional debriefing.¹⁶ Perhaps more than anything, these studies support that participation in debriefing should be a personal choice, that participation should be voluntary rather than mandated, and that skill is required to recognize when additional mental health or spiritual resources are needed in selected cases. The need for these additional resources may become apparent during the debriefing, which allows for open discussion of the impact of the event.

EMOTIONAL DEBRIEFING FORMATS

Numerous emotional debriefing formats and models exist, ranging from impromptu immediate discussions among peers to more formal, large, multidisciplinary sessions facilitated by trained mental health professionals.^{13,14,19,22} Learner-centered debriefing practices developed in the field of medical simulation should be applied.^{23,24} Debriefings can occur immediately following an event, the next day, or days to weeks later. Advantages of performing debriefings immediately after the event include a brief time for reflection and acknowledgment that the event occurred when it is fresh in everyone's mind. If patient acuity and/or clinical responsibilities do not allow for immediate debriefing, it is critical to briefly acknowledge the event and its emotional impact and to make plans for later discussion. Such a discussion may take place up to several weeks later and has the added benefit of allowing time for personal reflection, but it may be logistically difficult to gather all team members back together to participate. Another approach is to have regularly scheduled debriefings (such as monthly) in high-acuity settings such as the emergency department, neonatal and pediatric intensive care units, or the oncology floor to discuss multiple patients.

In the model of regularly scheduled debriefings, health care providers collect and reflect on a number of events knowing they will have an opportunity to discuss them with peers and facilitators. This option allows for reflection on several weeks of clinical experience and can include both the emotional challenges and the celebrations of patients who improved which can reinforce some of the joys of our work. As with any well-being strategy, one size does not fit all, and a hybrid of the above strategies is likely necessary to meet individual needs and situations.²⁵

Although participation in debriefing should be voluntary, making this a routine part of the educational programs reinforces emotional support for trainees and the importance of reflective practice. The participants who are invited may vary, and debriefings should be individualized to the situation and participant preferences. In some circumstances, debriefing within a team and including the medical students, residents, and faculty may be optimal. A multidisciplinary approach may be appropriate if all can share their own emotions and hence gain a better understanding of the perspectives of others, although one must consider if the participants will be comfortable being vulnerable across disciplines.

FORMAT HIGHLIGHTED IN AAP RESILIENCE CURRICULUM

A debriefing framework developed by Keene et al¹⁴ outlines important components of emotional debriefing. We recommend starting the emotional debriefing with welcomes and introductions, a review of the purpose of the session, and each participant taking turns describing their involvement in the care of the patient. Following introductions, there is a review of the circumstances surrounding the event, and the facilitator elicits participants' physical, emotional, and behavioral grief responses.

Participants are also asked the important question, “How are you taking care of yourself so you can continue to provide care for other patients and families?” During the debriefing, strategies and local resources for coping with grief are also reviewed; for example, many hospitals have an employee assistance program that provides confidential counseling for trainees if needed. The session concludes with a discussion regarding lessons learned from caring for the patient and family—for example, learning that getting palliative care services involved early can add support for a family and the care team, or that different members of a family can experience grief at different points, thus affecting their emotional responses at the time of death.

INCORPORATING EMOTIONAL DEBRIEFING IN PEDIATRIC TRAINING

Although some programs may have the benefits of dedicated faculty or staff to lead timely debriefings, this is not the case at every institution. We recommend training senior residents and fellows to lead debriefings. This will ensure that the debriefings occur in a timely fashion and will allow more trainees to participate. We provide the full resources for the debriefing process itself in the AAP Resilience Curriculum,¹⁸ but below we briefly outline how a program can implement this trainee-led emotional debriefing approach (Figure).

STEP 1. CHOOSE A DEBRIEFING MODEL AND EQUIP CHAMPIONS

Training programs interested in incorporating emotional debriefing should start by selecting a debriefing model and seeking resident, fellow, and faculty debriefing champions. Faculty champions can be role models and debriefing facilitators until residents or fellows are trained. We have included a “train the trainer” section on implementing emotional debriefing using the framework developed by Keene et al¹⁴ in the AAP Resilience Curriculum,¹⁸ which includes a facilitator’s guide, didactic slide sets, journaling exercises, role plays, and a facilitator assessment form. Champions can then incorporate this teaching through a variety of venues: residency lecture series, class retreats, or specific clinical rotations, such as intensive care rotations, where triggering events are more likely to occur.

STEP 2. MODEL INITIAL SESSIONS

Initial emotional debriefing training sessions should incorporate all levels of learners led by faculty champions, with planned transition to resident and fellow leaders. Sessions should focus on the introduction of emotional debriefing and its importance in promoting physician resilience. In addition, by using journaling or small-group work, trainees can identify situations where emotional debriefing might have been helpful or situations that might arise in the future. Reflecting back and thinking about the future, trainees can begin to identify their own and others’ emotions. The initial session can

teach the trainees that they may never come to full closure, but rather they may begin to integrate the experience into their future practice of medicine. And, importantly, they can be made aware of available resources in the institution and how to access those resources to support one another’s emotional needs.

STEP 3. PROVIDE ADVANCED TRAINING

Advanced debriefing training sessions should target senior residents and fellows. These sessions focus on recognizing struggling colleagues and helping team members understand and integrate their experience. The free AAP Resilience Curriculum¹⁸ contains modules that can be used by residency and fellowship programs to provide advanced training. We recommend the inclusion of role-play in the training, which allows learners to practice emotional debriefing skills in a supportive environment to decrease their discomfort and to increase their future skill utilization. The senior residents or fellows are taught common grieving practices but are made aware of additional available resources when more advanced support for themselves and their colleagues may be needed.

STEP 4. INITIATE TRAINEE-LED DEBRIEFINGS

When these advanced training sessions have been performed, senior residents and fellows should begin conducting debriefing sessions using the chosen model. Senior residents and fellows who are often in a position to facilitate debriefing sessions in the moment or soon after an event occurs will now have the skills, experience, and confidence to conduct them. Given that medical students switch rotations often, an in-the-moment debriefing led by a senior resident or fellow might allow for greater student participation. Students and junior residents may learn to expect debriefing sessions following difficult events and to trust colleagues to provide emotional support. The faculty and resident champions of emotional debriefing should remain an available resource to all senior residents and fellows conducting debriefings. Programs should also consider adding emotional debriefing facilitation skill items to rotation and/or senior resident expectations and assessments. Adding these items might help program directors assess several pediatric-specific Accreditation Council for Graduate Medical Education reportable milestones,²⁶ including 1) a sense of duty and accountability to patients, society, and the profession; and 2) demonstrating the insight and understanding into emotion and human response to emotion that allow one to appropriately develop and manage human interactions.

STEP 5. GATHER FEEDBACK AND OPTIMIZE THE PROCESS

We suggest setting up feedback mechanisms that will allow for continual process optimization. This could include routine educational activity assessment for both the initial and advanced emotional debriefing training sessions. The AAP Resilience Curriculum¹⁸ includes an assessment of debriefing session facilitation that could be employed with both simulated and real sessions. Faculty or resident

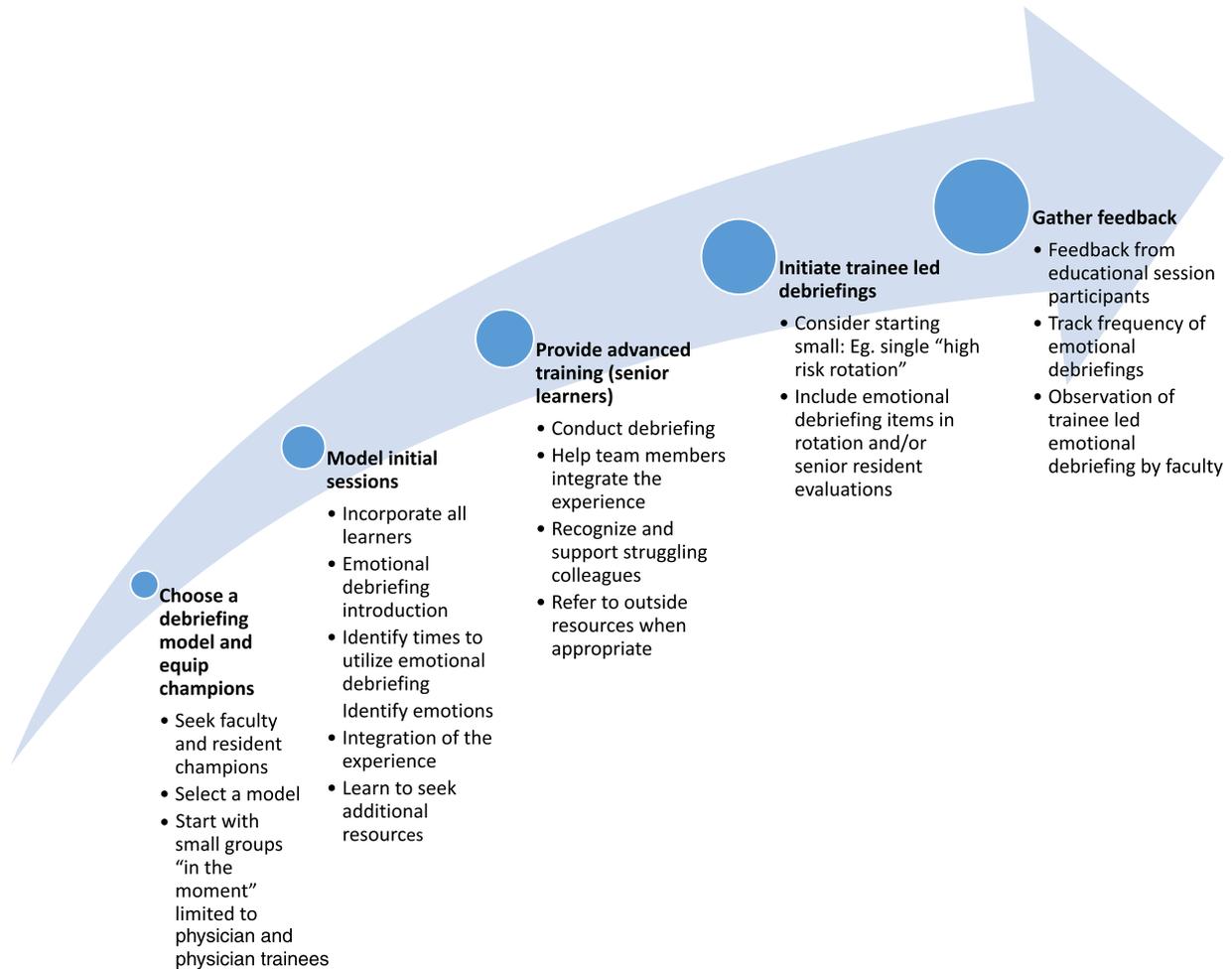


Figure. Steps to implementation of emotional debriefing in pediatric training.

emotional debriefing champions can observe the emotional debriefing led by senior residents and give real-time feedback. On rotations where emotional debriefings commonly occur, tracking the frequency of debriefings led by senior residents or fellows is critical. With feedback on the training process as well as the quality of debriefings led by senior residents or fellows, resident, fellow, and faculty champions will continue to improve the process of teaching and performing emotional debriefings. From our experience, residents who participated in trainee-led debriefing programs found that they were better equipped to lead a debriefing in the moment and had obtained the skills necessary to support their colleagues in real time. In addition, they felt empowered by gaining a future valuable skillset to take to the next phase of their practice.

OTHER CONSIDERATIONS

Although this article has focused on emotional debriefing following stressful and challenging events, we also propose that there are potential benefits of debriefing following positive emotional experiences. These events may include the birth of a healthy child whose prenatal course was uncertain, the unexpected recovery of a critically ill child, or the successful discharge of a child who has had a prolonged hospitalization, to name a few. We are not aware of any studies that have reviewed debriefing

following positive experiences, but we propose that the same process would allow a team to celebrate the joy of medicine, reflect and reinforce the meaning of our work, and strengthen a sense of community.⁴ All of these factors have been associated with enhanced physician engagement and well-being.⁴ We encourage physicians to include both intellectual and emotional debriefing in their clinical practice, teaching, and educational programs. We hope that by having a process and resources available for emotional debriefing training led by residents and fellows, programs will be able to support their current trainees while also training future facilitators for this work.

ACKNOWLEDGMENTS

The authors acknowledge Ann Burke, MD; Annamaria Church, MD; Albina Gogo, MD; Dena Hofkosh, MD, MEd; Jennifer Linebarger, MD, MPH; Megan McCabe, MD; Margaret Moon, MD; Deborah Rana, MD; O.J. Sahler, MD; Keely Smith, MD; Florence Rivera, MPH; and Constance Baldwin, PhD, who are members of the working group that developed the American Academy of Pediatrics Resilience in the Face of Grief and Loss Curriculum.

REFERENCES

1. Kelly E, Nisker J. Medical students' first clinical experiences of death. *Med Educ.* 2010;44:421–428.

2. Serwint JR, Rutherford LE, Hutton N. Personal and professional experiences of pediatric residents concerning death. *J Palliat Med.* 2006;9:70–81.
3. Serwint JR. One method of coping: resident debriefing after the death of a patient. *J Pediatr.* 2004;145:229–234.
4. Shanafelt TD, Noseworthy JH. Executive leadership and physician well-being: nine organizational strategies to promote engagement and reduce burnout. *Mayo Clin Proc.* 2017;92:129–146.
5. Accreditation Council for Graduate Medical Education. Improving physician well-being, restoring meaning in medicine. Available at: <http://www.acgme.org/What-We-Do/Initiatives/Physician-Well-Being>. Accessed November 5, 2018.
6. Committee on Bioethics. Committee on Hospital Care. Palliative care for children. *Pediatrics.* 2000;106:351–357.
7. National Academy of Medicine. Action collaborative on clinician well-being and resilience. Available at: <https://nam.edu/initiatives/clinician-resilience-and-well-being/>. Accessed November 5, 2018.
8. Mitchell JT, Everly GS. *Critical Incident Stress Debriefing (CISD): An Operations Manual for CISD, Defusing and Other Group Crisis Intervention Services.* 3rd ed. Ellicott City, Md Chevron; 2001.
9. Granek L, Bartels U, Barrera M, et al. Challenges faced by pediatric oncology fellows when patients die during their training. *J Oncol Pract.* 2015;11:e182–e189.
10. Pettker CM. Systematic approaches to adverse events in obstetrics. Part II. Event analysis and response. *Semin Perinatol.* 2017;41:156–160.
11. Colville GA, Smith JG, Brierley J, et al. Coping with staff burnout and work-related posttraumatic stress in intensive care. *Pediatr Crit Care Med.* 2017;18:e267–e273.
12. Delacroix R. Exploring the experience of nurse practitioners who have committed medical errors: a phenomenological approach. *J Am Assoc Nurse Pract.* 2017;29:403–409.
13. Bateman ST, Dixon R, Trozzi M. The wrap-up: a unique forum to support pediatric residents when faced with the death of a child. *J Palliat Med.* 2012;15:1329–1334.
14. Keene EA, Hutton N, Hall B, et al. Bereavement debriefing sessions: an intervention to support health care professionals in managing their grief after the death of a patient. *Pediatr Nurs.* 2010;36:185–189; quiz 190.
15. Zinns LE, O’Connell KJ, Mullan PC, et al. National survey of pediatric emergency medicine fellows on debriefing after medical resuscitations. *Pediatr Emerg Care.* 2015;31:551–554.
16. Hollingsworth CE, Wesley C, Huckridge J, et al. Impact of child death on paediatric trainees. *Arch Dis Child.* 2018;103:14–18.
17. Serwint JR, Bostwick S, Burke AE, et al. The AAP resilience in the face of grief and loss curriculum. *Pediatrics.* 2016;138:e20160791–20160791.
18. Serwint J, Bostwick S, Burke A, et al. Resilience in the face of grief and loss. Available at: <https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/hospice-palliative-care/Pages/Resilience-Curriculum.aspx>. Accessed March 1, 2018.
19. Eng J, Schulman E, Jhanwar SM, et al. Patient death debriefing sessions to support residents’ emotional reactions to patient deaths. *J Grad Med Educ.* 2015;7:430–436.
20. Rose S, Bisson J, Churchill R, et al. Psychological debriefing for preventing post traumatic stress disorder (PTSD). *Cochrane Database Syst Rev.* 2002(2):CD000560.
21. Roberts NP, Kitchiner NJ, Kenardy J, et al. Early psychological interventions to treat acute traumatic stress symptoms (review). *Cochrane Database Syst Rev.* 2010;(3):CD007944.
22. Hough CL, Hudson LD, Salud A, et al. Death rounds: end-of-life discussions among medical residents in the intensive care unit. *J Crit Care.* 2005;20:20–25.
23. Rudolph JW, Raemer DB, Simon R. Establishing a safe container for learning in simulation: the role of the presimulation briefing. *Simul Healthc.* 2014;9:339–349.
24. Cheng A, Morse KJ, Rudolph J, et al. Learner-centered debriefing for health care simulation education: lessons for faculty development. *Simul Healthc.* 2016;11:32–40.
25. McClafferty H, Brown OW. Physician health and wellness. *Pediatrics.* 2014;134:830–835.
26. Accreditation Council for Graduate Medical Education, American Board of Pediatrics. The pediatrics subspecialty milestone project. Available at: <https://acgme.org/Portals/0/PDFs/Milestones/PediatricsMilestones.pdf>. Accessed November 5, 2018.