

The Meta-Debrief Club: an effective method for debriefing your debrief

Chris Iain O'Shea ¹, Christopher Schnieke-Kind,¹ Dan Pugh,¹ Evie Picton²

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¹Medical Education Directorate, NHS Lothian, Edinburgh, UK

²Edinburgh Medical School, University of Edinburgh, Edinburgh, UK

Correspondence to

Dr Chris Iain O'Shea, Postgraduate Education Centre, Royal Infirmary of Edinburgh, Edinburgh EH16 4SA, UK; chris.o'shea@nhs.net

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INTRODUCTION

The application of simulation as an educational tool within medicine is increasing. In immersive simulation, it is widely accepted that the post-scenario debrief is a critical component for learning.¹ Effective faculty development is therefore required to preserve the quality of debriefing.

Though clear standards have been set out by the Association of Simulated Practice in Healthcare (ASPiH),² there is little in published literature describing faculty development. NHS Lothian has established a 'debriefing the debrief' programme, called 'The Meta-Debrief Club' or 'MDC'. It is available to staff from all backgrounds and levels of experience. Through group reflection, debriefers take part in a regular evaluation of their practice, with constructive feedback from peers.

Here we describe the founding of the MDC, its current format, factors contributing to a successful session, and results achieved. We hope this article and the accompanying online supplementary video will stimulate further discussion regarding faculty development methodology.

ORIGINS OF THE MDC

The MDC had simple beginnings, with a group of novice debriefers meeting to critically review footage of their debriefing. Over time, a standardised format emerged guided by our core belief that theories and practices applied to simulation participants are equally applicable to faculty learning. Two concepts, in particular, were influential.

First, we considered Ericsson's technique of 'deliberate practice'.³ The group had ample opportunity for practice, with responsibility for over 600 simulated scenarios per year. However, simple repetition does not continue to yield improvements in performance. Instead, a process of focused reflection was employed, leading to regular, deliberate refinements.

Second, Kolb's theory of experiential learning portrays a continuous cycle of reflection, conceptualisation, experimentation and experience.⁴ Our development would not be achieved by approaching each session in isolation but rather as part of a continuous cycle of development.

SESSION FORMAT

The only requirements for an MDC session are access to debrief footage, a suitable venue and enthusiastic participants. While viewing and discussing footage, the aim is to create a list of 'take-home messages'. These must include a few small, deliberate changes for the debriefer to incorporate into their practice.

Sessions are typically held weekly with up to 10 attendees who sign up electronically. Anonymous feedback following sessions is managed through the same online system. Collection of debrief footage requires appropriate consent from simulation participants who are also asked to avoid using patient identifiable information. Footage is transported and stored securely to ensure the privacy of the participants.

Each session begins with the allocation of a session chair, who also controls playback of the debriefing footage, and a scribe, who documents discussion and potential action points.

After the debriefer provides some background information about the scenario and participants, their footage is reviewed using a 'pause and play' style. Each member of the group can, at any time, interject with a comment, question or suggestion. Ideally, a debrief is played in its entirety, particularly for novice debriefers. More experienced debriefers may have specific areas on which they wish to focus, and sessions can be tailored accordingly. The time-consuming nature of reviewing an entire debrief has been a challenge since its inception. More targeted sessions for experienced debriefers have been introduced to increase efficiency.

The aim is to construct a number of actionable take-home messages for the debriefer. However, just as with simulation participants, discussion includes exploring the debriefer's mental frame and both theoretical and practical learning points such as questioning style, phrasing, or body language. We are, literally, debriefing the debrief.

ENCOURAGING SUCCESSFUL SESSIONS

Critical to the success of the MDC has been the focus on open, inclusive and constructive discussion within a safe learning environment.

A casual and relaxed atmosphere is encouraged, beginning each session with introductions and setting ground rules. Participation is treated as confidential, inviting open discussion. Traditional medical hierarchies are deliberately set aside, empowering junior staff to speak and enabling senior colleagues to share areas of weakness.

Less experienced debriefers may not feel qualified to comment on the performance of others. The Observational Structured Assessment of Debriefing tool is often used to address this discrepancy, acting as a guide to observable behaviours, allowing novice debriefers to contribute constructively.⁵

Several discussion topics, such as questioning style, were found to frequently recur. A range of 'prompt cards' was created, each representing



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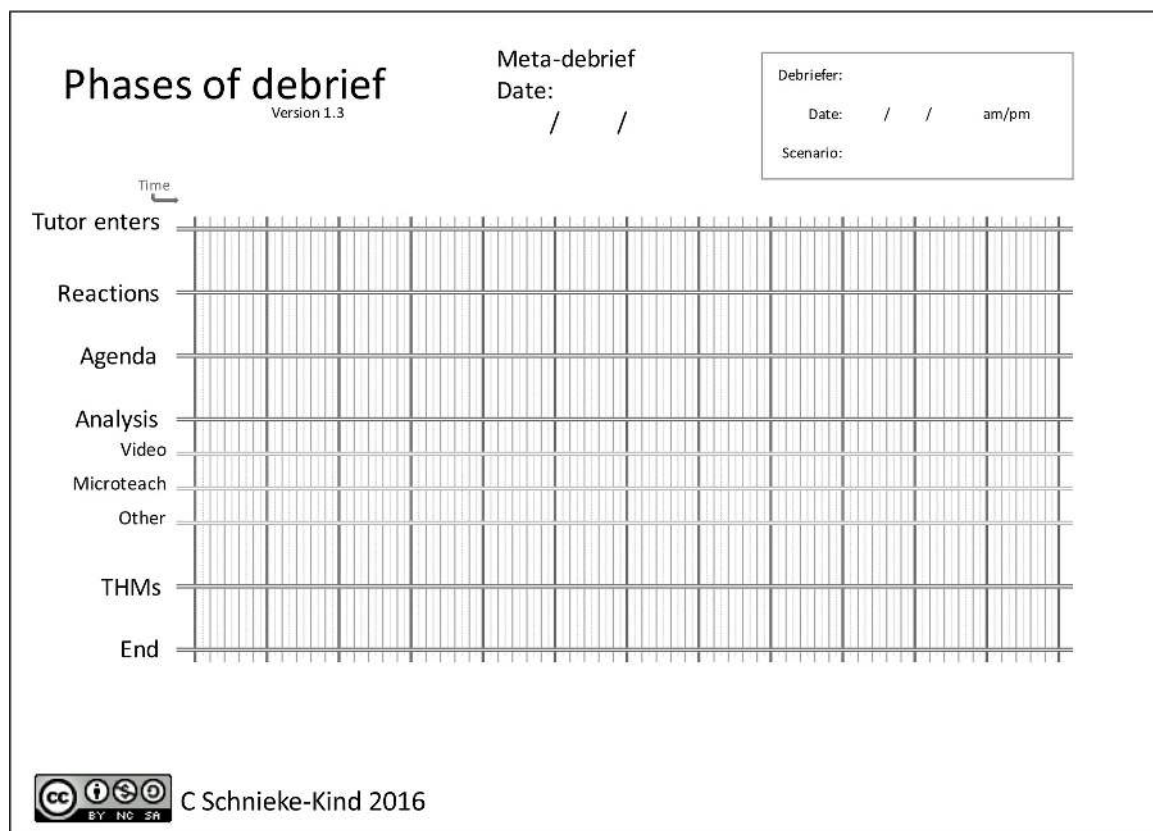


Figure 1 'Phases of Debrief' chart. Using this provides a graphical plot of the various debrief phases against time.

a particular topic, to act as a focus of discussion and an aide memoir.

As footage plays, the session chair completes the 'Phases of Debrief' chart (figure 1), a graphical plot of the debrief phases against time. This simple, visual overview of each debrief acts as a powerful aid to reflection. As demonstrated in the accompanying online supplementary video, this tool also provides some objective measure of debriefing practice.

OUR EXPERIENCE

ASPiH Standards recommend regular evaluation and reflection on learning.² The cyclical nature of the MDC makes regular attendance critical to learning. In practice, participants are repeatedly attending sessions and giving universally positive feedback. This suggests that efforts to create a safe and constructive learning environment have been successful.

Another key recommendation in the ASPiH Standards is the involvement of both faculty members and their peers in the evaluation of performance. We have found that a critical factor in the success of the MDC has been the process of reflection as a group activity. In a given session, a maximum of three debriefs are reviewed, so the majority of attendees are not discussing their own footage. However, as the challenges encountered are rarely unique, the process of shared problem solving is beneficial for all. Indeed, when surveyed, participants report sessions being useful regardless of whether their own debrief was featured.

Finally, the programme has undoubtedly had a beneficial effect on the local simulation faculty as a community. Attendance is increasingly diverse, resulting in greater sharing of experience and practice between faculty who may otherwise have remained isolated.

It is hoped that this account will encourage others to share their faculty development methods. The authors would be interested

in corresponding with any centres with similar programmes or who wish to emulate the MDC.

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Collaborators Simon Edgar; Hannah Monaghan; Gillian Nelson; Nathan Oliver; Joe Roberts.

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ORCID iD

Chris Iain O'Shea <http://orcid.org/0000-0001-8230-0151>

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