Caring for Each Other: A Resident-Led Peer Debriefing Skills Workshop

Grace S. Lee, MD
Samantha E. Dizon, MD
Colby D. Feeney, MD
Yu-Lin Amy Lee, MD
Megan Jordan, MD
Anthony N. Galanos, MD
Jane V. Trinh, MD

ABSTRACT

Background Inadequate time and space to process critical incidents contribute to burnout. Residents do not regularly participate in emotional debriefs. An institutional needs assessment revealed only 11% of surveyed pediatrics and combined medicine-pediatrics residents had participated in a debrief.

Objective The primary objective was to increase resident comfort in participation in peer debriefs after critical incidents from 30% to 50% with implementation of a resident-led peer debriefing skills workshop. Secondary objectives included increasing resident likelihood of leading debriefs and comfort in identifying symptoms of emotional distress.

Methods Internal medicine, pediatrics, and medicine-pediatrics residents were surveyed for baseline participation in debriefs and comfort in leading peer debriefs. Two senior residents became trained debrief facilitators and led a 50-minute peer debriefing skills workshop for co-residents. Pre- and post-workshop surveys assessed participant comfort in and likelihood of leading peer debriefs. Surveys distributed 6 months post-workshop assessed resident debrief participation. We implemented the Model for Improvement from 2019 to 2022.

Results Forty-six (77%) and 44 (73%) of the 60 participants completed the pre- and post-workshop surveys. Post-workshop, residents' reported comfort in leading debriefs increased from 30% to 91%. The likelihood of leading a debrief increased from 51% to 91%. Ninety-five percent (42 of 44) agreed that formal training in debriefing is beneficial. Almost 50% (24 of 52) of surveyed residents preferred to debrief with a peer. Six months post-workshop, 22% (15 of 68) of surveyed residents had led a peer debrief.

Conclusions Many residents prefer to debrief with a peer after critical incidents that cause emotional distress. Resident-led workshops can improve resident comfort in peer debriefing.

Introduction

Residents are at risk for processing critical incidents in maladaptive ways.[1] A survey of pediatric residents found that while 90% experienced a patient death, 40% did not feel prepared to deal with it.[1] More than 80% experienced at least one symptom or behavior associated with acute stress reaction or post-traumatic stress disorder.[1] Inadequate time to reflect on such events contributes to harmful coping mechanisms and burnout.[1,2]

Debriefing is an intervention distinct from mental health counseling. Debriefs provide reassurance, reaffirm competence, and facilitate a sense of community.[2,3] In 2013, a palliative care physician and licensed clinical social worker started monthly debriefs for our internal medicine residents after residents expressed a need for formal debriefing after difficult patient deaths.[4] Though the debriefs helped residents develop resiliency strategies, its frequency did not allow for timely emotional debriefs.[4] Many residents "sought instruction on how to initiate debriefing with their teams."[4]

Even when institutional resources for prompt debriefs are available, residents underutilize them and prefer to debrief with colleagues.[5] In 2019, 92% of surveyed residents agreed there is a need for debriefs to process the emotional impact of critical events, but only 11% had participated in one. The Caring for Each Other Response team is available to debrief staff at our institution at all hours. Despite high resident awareness (74%) of this team, only 5% of residents had contacted them.

Based on the voiced need for emotional debriefing and limited use of institutional resources, we deployed a peer debriefing model for timely emotional debriefs. At baseline, 30% (15 of 49) of residents felt comfortable leading a debrief. Inadequate time, lack of experience, and discomfort in leading debriefs were barriers. More than 80% (38 of 46) agreed that formal debriefing training would be beneficial. Using the Model for Improvement,[6] through a resident-led initiative to equip residents with peer debriefing skills, we aimed to increase comfort in and occurrences of resident emotional debriefing after critical incidents.

DOI: http://dx.doi.org/10.4300/JGME-D-22-00513.1

Editor's Note: The online version of this article contains further data from the study and the curriculum and surveys used in the study.

Downloaded from http://meridian.allenpress.com/jgme/article-pdf/15/2/248/3208573/i1949-8357-15-2-248.pdf by Duke University user on 18 April 2023

TABLE
Peer Debriefing Skills Workshop Outline

Time	Tasks
5 minutes	▪ Pre-workshop survey completion. ▪ Silent personal reflection on a recent critical incident at work that caused distress.
10 minutes	▪ Interactive discussion about how to identify a distressed peer who may benefit from a debrief and why debriefs can be beneficial.
10 minutes	▪ Discussion on components of a peer debrief, including an adapted reference Pocket Card[9] and a list of available institutional support resources. ▪ Review of the 6 components of a peer debrief: (1) ground rules; (2) case review; (3) emotional response; (4) effective ways to cope with grief; (5) lessons learned; and (6) conclusion. ▪ Review of what a debrief should not include and examples of what debriefers should not say or do during a debrief.
10 minutes	▪ Peer debrief leaders incorporate the components of a peer debrief into a discussion of a critical event in a role-play.
10 minutes	▪ Participants split into groups of 2 to 3 and role-play a peer debrief using the previous reflection on a critical incident. At 5 minutes participants switch roles between the debriefer and the person being debriefed.
5 minutes	▪ Participants reconvene into the larger group to reflect on the practice of peer debriefing. ▪ Post-workshop survey distributed.

Note: Due to the COVID-19 pandemic, the workshop was presented in 3 different formats: virtually using the Zoom platform; in-person outside without access to audiovisual technologies, such as PowerPoint; and in-person with access to audiovisual technologies. Workshop materials and online Pocket Card were made available to participants after completion of the workshop.

Methods

This resident-led quality improvement project occurred at an academic institution within a tertiary care hospital from 2019 to 2022. It included pediatrics, internal medicine, and medicine-pediatrics residents. At the project's initiation, residents had no debriefing training.

The initial plan-do-study-act (PDSA) cycle aimed to increase the percentage of pediatrics, internal medicine, and medicine-pediatrics residents who agreed that they felt comfortable leading a peer debrief from 30% to 50%. Additional aims were to increase resident likelihood to lead a peer debrief and comfort in identifying symptoms of emotional distress.

Two residents completed an hour-long Caring for Each Other Response debrief facilitator training. They adapted this training and existing peer debriefing curricula into a 50-minute resident-led skills workshop (TABLE).[7-9] The adaptation and piloting process took approximately 10 hours. There were no production, implementation, or distribution costs.

From 2020 to 2022, the resident leads implemented the workshop during existing rising senior resident development sessions. Participants were asked to complete pre- and post-workshop surveys about the project's aims.

Follow-up surveys were distributed to all residents in the 3 residency programs 6 months post-workshop. Surveys asked about participation in debriefs, including resident-led debriefs, and experience leading peer debriefs. Residents were asked to rank with whom they would most prefer to debrief. Surveys were voluntary and anonymous.

The Duke University Health System Institutional Review Board determined this project exempt.

Results

PDSA Cycle 1: Resident Comfort With Peer Debriefing

Forty-six (77%) and 44 (73%) of the 60 residents who participated in the workshop completed the pre- and post-surveys, respectively. The percentage of residents who felt they were comfortable leading peer debriefs, likely to lead a peer debrief, and comfortable identifying signs of distress increased post-workshop (FIGURE). Pre-workshop, lack of experience leading debriefs was the primary barrier to facilitating peer debriefs. Post-workshop, the leading barrier was lack of time due to clinical responsibilities.

PDSA Cycle 2: Frequency of Peer Debriefing Among Residents

Sixty-eight (26%) of 266 total residents completed the follow-up survey, with 68% (46 of 68) having participated in a debrief after a critical incident. Thirty-five percent (23 of 65) had participated in a debrief led by a peer, and 22% (15 of 68) had led a debrief. Of those, 54% (7 of 13) felt they had adequate skills to lead the debrief.

Forty-six percent (24 of 52) preferred to debrief with a co-resident or senior resident after experiencing a critical incident, followed by an attending,

Downloaded from http://meridian.allenpress.com/jgme/article-pdf/15/2/248/3208573/i1949-8357-15-2-248.pdf by Duke University user on 18 April 2023

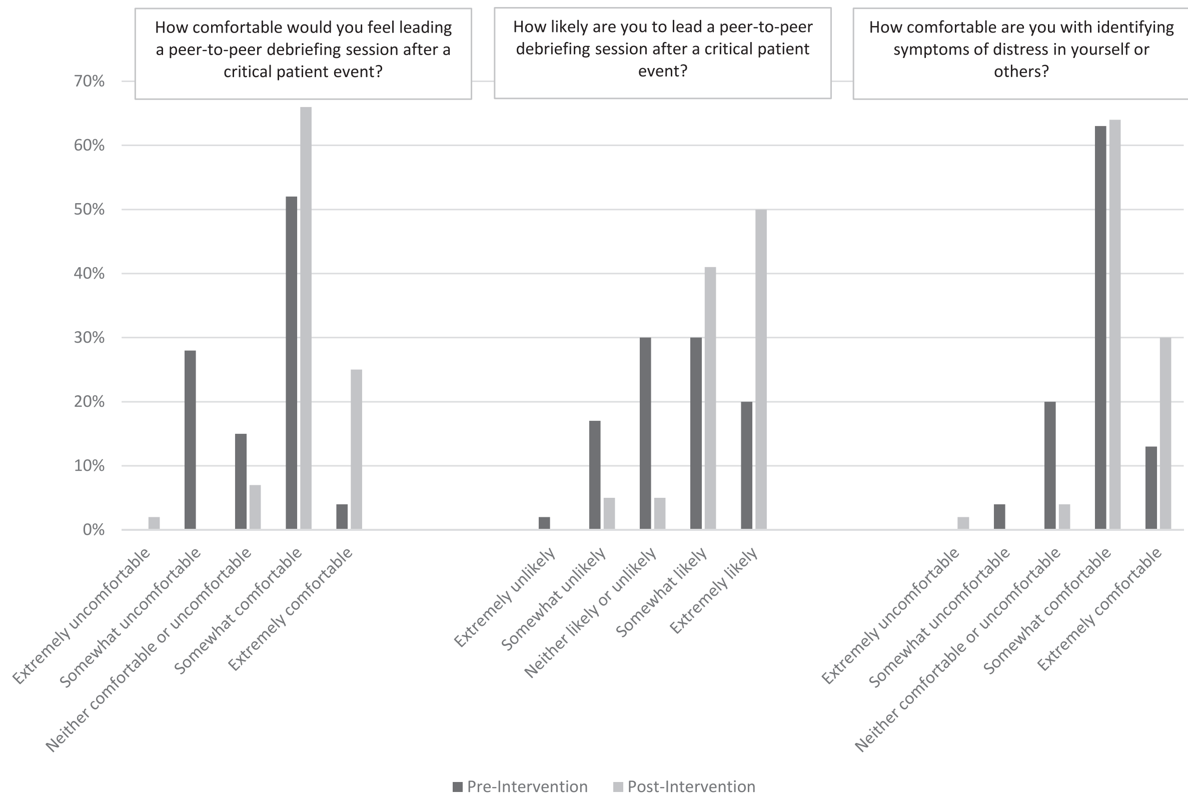

FIGURE
Comparison of Survey Results Pre- and Post-Intervention

fellow, chief resident, program director, hospital debrief team, and mental health professional.

PDSA Cycle 3: Resident Comfort With Peer Debriefing

We implemented the workshop the following year. Again, residents reported improved comfort in leading peer debriefs, likelihood in leading peer debriefs, and identifying signs of distress. Lack of experience was the leading barrier pre-intervention. Lack of time was the leading barrier post-intervention.

PDSA Cycles 1 and 3: Qualitative Feedback

Residents described the workshop as "great" and a "fantastic experience." One wrote it was "very helpful to have this time to. . .role-play and talk about real cases that were distressing." Another commented, "Walking through [my experience] was very healing." This intervention had no reported adverse events.

About 90% (60 of 67 in 2021 and 63 of 67 in 2022) of the rising senior residents across the 3 programs had completed the workshop. After 2 years of implementation, 123 residents had been trained in peer debriefing.

Discussion

We improved resident comfort in leading debriefs and increased the occurrences of peer debriefs through an annual skills workshop. The project's success stemmed from addressing a practice gap in acknowledging emotional needs after critical events and incorporating resident preferences to peer debrief.

The resident-led aspect was integral to this initiative's acceptance. Similar trainings led by program leadership were discontinued due to limited resident engagement. Medical education literature attributes the effectiveness of peer teaching programs to social and cognitive congruence among peers.[10,11] Peer debriefing leverages the power of shared experiences. Resident-led workshops demonstrate another opportunity to optimize resident engagement.

This study has limitations. Discussion during the workshop revealed many had participated in clinical debriefs, but few had participated in emotional debriefs. This may have resulted in an over-estimation of resident participation in emotional debriefs in pre-intervention surveys, which did not specify the type of debrief. The lower response rate in the PDSA cycle 3 post-intervention survey is another limitation possibly leading to an over-estimation of the intervention's impact.

Downloaded from http://meridian.allenpress.com/jgme/article-pdf/15/2/248/3208573/1949-8357-15-2-248.pdf by Duke University user on 18 April 2023

Additional investigation is needed to understand the quality of peer-led emotional debriefs and its impact on resilience and mitigation of burnout. Qualitative feedback from workshop participants, however, signals a potential positive and meaningful impact. We are unaware of the number of emotional debriefs that may have occurred with non-peers or the perceived differences in the impact of such debriefs.

This workshop was successfully incorporated into development sessions for rising senior residents. Senior residents were recruited to continue this initiative in its third year of implementation. Additionally, residents who did not attend the workshops may benefit from the training through peer debriefing with trained residents or seeing peer debriefing modeled by others.

Resident peer debriefing initiatives can augment existing institutional resources for debriefing, well-being, and mental health. We recommend continued development of resident-led debriefing interventions focused on peer support. Other programs can integrate resident-led peer debriefing workshops into resident education by similarly adapting existing curricula at minimal to no cost. While workshop leaders do not require formal peer debrief training prior to implementation, they may benefit from mentors with debriefing experience.

Next steps include integrating the workshop earlier in training and expansion of peer-led training to fellows, attendings, and other disciplines.

Conclusions

Many residents prefer to peer debrief after critical incidents. Peer debriefing workshops can improve resident comfort in leading structured and timely peer debriefs.

References

1. Hollingsworth CE, Wesley C, Huckridge J, Finn GM, Griksaitis MJ. Impact of child death on paediatric trainees. *Arch Dis Child*. 2018;103(1):14-18. doi:10.1136/archdischild-2017-313544
2. Schmidt M, Haglund K. Debrief in emergency departments to improve compassion fatigue and promote resiliency. *J Trauma Nurs*. 2017;24(5):317-322. doi:10.1097/JTN.0000000000000315
3. Newman MC. The emotional impact of mistakes on family physicians. *Arch Fam Med*. 1996;5(2):71-75. doi:10.1001/archfami.5.2.71
4. Leff V, Klement A, Galanos A. A successful debrief program for house staff. *J Soc Work End Life Palliat Care*. 2017;13(2-3):87-90. doi:10.1080/15524256.2017.1314234
5. Hu YY, Fix ML, Hevelone ND, et al. Physicians' needs in coping with emotional stressors: the case for peer support. *Arch Surg*. 2012;147(3):212-217. doi:10.1001/archsurg.2011.312
6. Langley GJ, Moen RD, Nolan KM, Nolan TW, Norman CL, Provost LP. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*. 2nd ed. Jossey Bass Wiley; 2009.
7. Serwint JR, Bostwick S, Burke AE, et al. The AAP resilience in the face of grief and loss curriculum. *Pediatrics*. 2016;138(5):e20160791. doi:10.1542/peds.2016-0791
8. McDermott A, Brook I, Ben-Isaac E. Peer-debriefing after distressing patient care events: a workshop for pediatric residents. *MedEdPORTAL*. 2017;13:10624. doi:10.15766/mep_2374-8265.10624
9. Govindan M, Keefer P, Sturza J, Stephens MR, Malas N. Empowering residents to process distressing events: a debriefing workshop. *MedEdPORTAL*. 2019;15:10809. doi:10.15766/mep_2374-8265.10809
10. Yew EH, Yong JJ. Student perceptions of facilitators' social congruence, use of expertise and cognitive congruence in problem-based learning. *Instruction Sci*. 2013;42(5):795-815. doi:10.1007/s11251-013-9306-1
11. Lockspeiser TM, O'Sullivan P, Teherani A, Muller J. Understanding the experience of being taught by peers: the value of social and cognitive congruence. *Adv Health Sci Educ Theory Pract*. 2008;13(3):361-372. doi:10.1007/s10459-006-9049-8

Grace S. Lee, MD, is a Chief Resident, Department of Pediatrics, Duke University School of Medicine; **Samantha E. Dizon, MD,** is a Cardiology Fellow, Department of Medicine, Columbia University Irving Medical Center; **Colby D. Feeney, MD,** is Assistant Professor, Department of Medicine and Department of Pediatrics, and Program Director, Internal Medicine and Pediatrics Residency Program, Duke University School of Medicine; **Yu-Lin Amy Lee, MD,** is Assistant Professor, Department of Medicine and Department of Pediatrics, Duke University School of Medicine; **Megan Jordan, MD,** is Assistant Professor, Department of Medicine and Department of Pediatrics, Duke University School of Medicine; **Anthony N. Galanos, MD,** is Professor of Medicine, Department of Medicine, Duke University School of Medicine; and **Jane V. Trinh, MD,** is Associate Professor, Department of Medicine and Department of Pediatrics, and Chief, Division of Med-Peds, Department of Pediatrics, Duke University School of Medicine.

Funding: The authors report no external funding source for this study.

Conflict of interest: The authors declare they have no competing interests.

Corresponding author: Grace S. Lee, MD, Duke University School of Medicine, grace.s.lee@duke.edu

Received July 5, 2022; revision received October 21, 2022; accepted January 9, 2023.

Downloaded from http://meridian.allenpress.com/jgme/article-pdf/15/2/248/3208573/i1949-8357-15-2-248.pdf by Duke University user on 18 April 2023