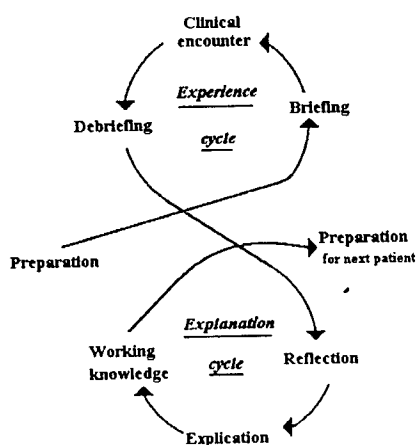


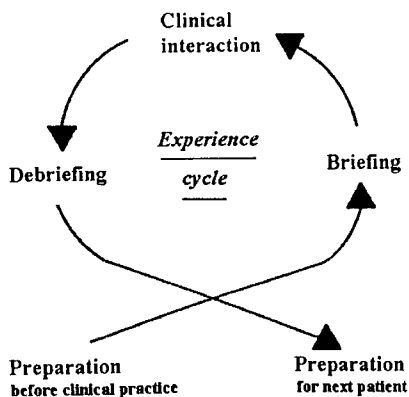
THE MEDICAL TEACHER

Planning bedside teaching – 5. Debriefing after clinical interaction

Ken Cox



Debriefing allows the teacher to review with students what went on at the bedside. Debriefing also provides an opportunity for the student to talk about the experience, to express to the teacher how the clinical interaction was understood, and to raise questions about what wasn't understood. Just as briefing anticipates what is expected in the clinical experience so that the student is prepared sufficiently, debriefing checks what has been recognised and interpreted accurately. Debriefing can also review the clinical performance of the student or graduate trainee.



What actually happens in your debriefing? What aspects do you foster? What do you care about?

Planning

What can you achieve in a debriefing? What are your purposes?

You could check what the students recognised and what they missed, what they understood and what they misinterpreted. You could use their responses as a form of assessment. If you were focusing on their clinical performance, you might include observations on:

- the appropriateness of the student's approach to the patient
- the structure and content of the consultation process
- the quality of the communication skills
- the appropriateness of the student's responses to issues or questions raised by the patient
- the safety of the activity to the patient
- the technique of interruption used by the teacher
- the aspects of the consultation which may be enhanced at a later date.

As you plan it, you recognise that debriefing needs the following.

Allotment of **time**. The description and clarification of complex interactions take time to recount (and even a mundane clinical encounter is complex). The commitment of time by a teacher makes a clear statement that you are doing it thoroughly. You are demonstrating that you are more interested in hearing their understandings and helping them clarify their ideas than in hurrying on to the next patient.

Immediacy after the clinical events while the facts and the impressions are still vivid in everyone's minds.

A private place (not at the bedside or in the corridor) which acknowledges that these are matters for this group which has interacted with this patient. The discussion needs a "safe

house" where all can trust that their airing of any uncertainty or confusion won't be ridiculed.

Chairs, arranged in a circle, which make a different statement about the learning process from briefly leaning against a wall in the corridor, or from chairs in rows facing one presenter in front.

Rules

Your expectations of the students reflect your implicit rules. One may be that you will direct the debriefing with the trainee responding to your questions. Or that, in reviewing what happened, they will stick to **accurate description** of the clinical events, seeking external verification of what everyone saw and what actually happened.

Another rule may be about the **agenda** to be dealt with. Some focus on associations and interpretations of the clinical findings in disease terms. Others look at implications and meanings.

If debriefing progresses more deeply into meanings which flow from an individual's personal life, the rules reinforce **respect** for those beliefs, grateful acknowledgment for the self-disclosure, and total **privacy** of the matters discussed.

Roles

If debriefing focuses on checking what was seen and its correct interpretation, then the teacher's roles may be as:

- **Clinical expert** who extracts clinical lessons from the student's experience and weaves those lessons into clinical working knowledge.
- **Critic** who challenges the student's assumptions and reasoning, requiring rigor in any argument or justification.
- **Planner** who prescribes further learning for the student, arranges more clinical experiences, and identifies resources for the student to turn to.

If debriefing is a time for students to talk, then some possible teacher roles are as:

- **Supportive facilitator** who is attending to the description of the clinical data collected, sharing ideas about the possible diseases, about the illness, about the patient, and about

management procedures.

- **Listener** who is acceptant of the student and non-judgemental about any feelings expressed.

Debriefing has relatively low psychological threat because the interaction is over and you are inspecting the past, but the teacher's posture can raise the threat level and block students' readiness to express ideas and feelings if the debriefing is all about "getting it right".

Who are you during debriefing? What are your concerns? What do you wish to happen? What posture(s) will make that most likely?

Steps

Debriefing has many possible steps. Too often, clinical teachers hurry on to the excitement of demonstrating the next patient or task without ensuring full use of the learning experience in the last clinical encounter. Debriefing reviews everyone's memory of what actually happened, strengthens later recall of the clinical picture, adds the observations of the others who were there, and fosters analysis and synthesis of the clinical data.

The steps depend on the agenda. Some have an orientation to "the facts", some to performing the clinical tasks accurately, some to the understanding of the process. None is better than the others; all may be included.

Review of clinical findings

These may be measurement of the clinical evidence, or of technique in revealing or describing them. Clinical discussion is more likely to be limited to disease-related rather than illness-related events. Most of the interpretation is likely to be about objective evidence associating the clinical findings with the disease.² That discussion will be about severity and extent and effects of the symptoms and signs, about pathophysiological mechanisms which relate them, and about frequencies of association with various diseases (which nowadays may be expressed more quantitatively as sensitivity, specificity and predictive value).

Description of observable evidence provides a non-threatening and factual basis, and ensures all are working with a common starting point of the same set of data. If you're lucky, you may elicit different descriptions of the same interaction from among the group, revealing multiple perspectives on the same set of clinical manifestations. This can lead on to different descriptions by the students or you of parallel events and other clinical experiences, which allows comparison of samples of each individual's slice of life.

Each of our experiences is true for us, but each experience is only one sample of possible similar experiences of the same malady. Patients differ, diseases differ in extent, effects, severity and impact. We differ in what we select to look

for, what we avoid, and what we remember. Our true experience from our sample does not allow us to deny the validity of any description or interpretation of the experiences of others.

Any ambiguous data may need some verification, which may lead into review of the process of collecting those findings.

Review of the clinical process between teacher, student and patient

Such review invites discussion of the interaction more than the findings. What happened? What did you see going on? Did anyone else notice that? How do you interpret that? How does that fit with the diagnosis or definition of the patient's problem? Why was that done?

The discussion is then likely to centre on illness-related events and on the interpretation of what was said and done — the effectiveness of communication and the handling of tasks. Some may also use the clinical process to assess deviations of the clinical state of the patient from the patient's norms, and be more concerned about the impact of the illness on the lifestyle, work, or social well-being of the patient in the family.

Students are, or can be, shrewd observers. Are they allowed to express what they saw, and what it means to them? These more subjective components are dealt with within the explanation cycle, under the heading of "reflection", in the next paper in this series.

Skills

Managing the debriefing calls on many teaching skills, and high sensitivity to nuances. The skills include the following.

Control in structuring description of the clinical events, allowing open-ended discussion but with control of the direction and maintenance of its effectiveness.

Reasoning in recognising students' assumptions, misinterpretations, flawed reasoning, and aspects of the illness or disease avoided. The teacher is setting standards of critical thinking, finding deeper explanations for the students to ponder, and synthesising the clinical picture and explanations of its components.

Listening closely, fostering trust, exposing the students' blocks to self-knowledge, encouraging expression of feelings, and perhaps with some self-disclosure by the teacher. The teacher is modeling the clarification of values and attitudes of both clinician and patient.

Managing the patient, perhaps expanding the management options, balancing trade-offs of possible gains and losses, ensuring the patient's participation in the process of negotiation, if appropriate, and exercising judgment. Sometimes, this task entails resolving conflict over the management plan.

Closing the debriefing by synthesising the learning from the case, giving the students a

sense of achievement, ensuring resolution of any feelings aroused during the clinical encounter and its debriefing, and devising individual or group learning plans for the future.

Evaluation

Whether the debriefing seems successful or not depends on what you were trying to achieve. Debriefing is not just a chat about what happened, but a purposeful and structured review aimed at clarifying, interpreting and explicating the pathophysiological and psychological events. Such intentions can be agreed upon with the students when the rules are discussed.

Having set the rules, however, the teacher's skill is to maximise the students' freedom to express what is uppermost in their minds. Were students invited to comment freely on the interactions? What happened if they took that risk? Were they rewarded by compliments for doing so? Or were their comments diverted on to "more important" matters, that is, your agenda? Could assumptions be spelled out, including cultural differences from the patient, and the sub-cultural assumptions of the clinical professions?

Did the clinical discussions encourage students to express and explore broader aspects, such as ethical issues or health services issues and their own attitudes? Did you allow them to reveal all of their insights, not just the disease or procedure-related ones? If not, why not? Remember that if students seem too stunted interpersonally, the responsibility may rest principally with you! These matters are explored further within the reflection component of the explanation cycle in the next paper.

Time is always short. Teachers face difficult decisions about how much time to allow for somewhat unstructured exploration of insights that the student is struggling to articulate and express. However, not providing time may be perceived as disapproval of such issues, which may inhibit the students' expression for the rest of their clinical career. Don't underestimate the socialising power of what is attended to, and what is not.

References

1. Pearson M, Smith D. The development of the skills of debriefing. In: Boud D, Keogh R, Waler D, editors. Reflection: turning experience into learning. London: Kogan Page, 1985: 77-79.
2. Patel VL, Evans DA, Groen G. Reconciling basic sciences and clinical teaching. *Teach Learn Med* 1989; 1: 116-121.

Debriefing examines what happened at the bedside. Some teachers question students to ensure they "got it right". Some elicit questions from students to gauge their depth of understanding.

The next article addresses reflection, the first step in the explanation cycle.