Debriefing and Feedback

Two Sides of the Same Coin?

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Debriefing is a key part of simulation. Whether it occurs at the end of a simulation or is woven into the simulation itself, debriefing is the time and space where learners "reflect on action, identify performance gaps, discuss areas for improvement, and consolidate knowledge and skills so that the latter can be applied in real practice to improve health care and patient outcomes."[1] As a critical element of simulation education, it is interesting that debriefing poses such a challenge for even the most seasoned educators—"Even after 23 years, the most experienced of us are still learning to debrief."[2]

Recently, there has been an inclination to pursue research questions that address the "technical" aspects of debriefing, in an effort to determine what combinations of duration, timing, use of video, and so on lead to the greatest educational benefits. An excellent systematic review by Cheng et al[1] highlights that although these debriefing features may influence learning outcomes, the effect sizes are notably small and inconsistent. We are left to wonder whether there are other "technical" issues that need to be looked at further or whether the keys to better debriefing might instead come from thinking about debriefing in an entirely different way.

An example of rethinking the debriefing problem is addressed by Rudolph et al.[3] They describe how to establish a psychologically safe context for learning using a set of educational practices to create the conditions where learners "feel safe enough to embrace being uncomfortable" in the simulated environment.[3] In fostering the "safe container," the instructor (among other things) conveys a commitment to respecting the learner and understanding the learner's perspective. The establishment of this safe container for learning is done before the simulation session, in a prebriefing. The ideas put forward by Rudolph et al speak to a much deeper reality in simulation education—no matter how technically sound a debriefing is, there are social and interpersonal matters that need to be addressed if the debriefing is to have its desired impact. This is true in simulation and is equally true in the broader context of medical education.

We come at this issue as medical educators and see many parallels between simulation-based debriefing and feedback in clinical education. Similar to the simulation community's struggles with debriefing, the medical education research community has been working on the "feedback problem" for a long time. Most educators agree that feedback is the information provided to a learner on the gap between their performance and a standard, with suggestions on how the gap might be bridged.[4] In parallel with debriefing, feedback is recognized as an important component of effective education. How to give and receive meaningful feedback, however, remains a hot research topic. Similar to the many models of debriefing that are outlined in the Concepts and Commentary article by Cheng et al[1] in this issue of *Simulation in Healthcare*, many feedback models have been proposed, but in practice, each one falls short—feedback remains an often challenging, uncomfortable part of clinical education.

Recently, several medical education research groups have begun to pay closer attention to the broader sociocultural and interpersonal elements that shape any feedback exchange. As an example, Watling et al[5] have proposed that for feedback to have a meaningful impact on performance, it must originate from a credible source. Credibility, in this context, is determined in many ways and includes

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judgments such as "Do I respect this person?" and "How has this person come to make this assessment of me?" In this light, recipients of feedback are seen not as passive vessels, taking in all feedback equally, but instead as filters of multiple sources of feedback, picking and choosing among the varied sources of available information.

Qualitative work by Mann et al[6] has described a number of tensions that influence an individual's receptivity to feedback during assessment of clinical performance. These include tensions within the individual (wanting but fearing feedback), tensions between individuals providing and receiving feedback (where credibility may have a role), and tensions in the learning environment (how behavior changes when being observed). Within the individual, there are complex interactions among fear, confidence, and clinical reasoning that may influence the receptivity to feedback.[7] Although we have only highlighted a few of the medical education studies in this regard, it is evident that important insights are being gained, which influence how we think about feedback.

What does this mean for debriefing and simulation? The good news is that simulation educators are already in a great position to provide meaningful feedback to learners by virtue of a number of features that should positively influence the exchange of meaningful feedback. Simulation sessions typically begin with a prebriefing, and as outlined by Rudolph et al,[3] this can be a very effective approach for establishing a safe learning environment; in clinical education, the clinical context is not always as clearly "safe" for education. Simulation also provides the opportunity for direct observation of the performance of a clinically relevant task, enhancing credibility in a way that is often lacking in clinical settings where learners are seldom directly observed. Finally, simulation settings provide supportive learning environments where learners can make mistakes without causing real harm.

The better news is that there is a clear way forward for research in debriefing. Simulation education researchers might borrow from the broader medical education literature the set of new insights into the sociocultural and interpersonal contexts that shape feedback (and debriefing) interactions. Complementing many of the faculty development issues in debriefing identified by Cheng et al,[1] these recent insights into the sociocultural aspects of feedback might form the basis of entirely new faculty development strategies, ones that focus not only on the technical aspects of the debriefing but also on creating the conditions necessary for meaningful debriefing to take place. Research suggests that these contexts and conditions are highly influential, and there is every reason to believe that they may also have a role to play in shaping debriefing. Effective debriefing in simulation has many parallels to meaningful feedback in clinical education, and the 2 worlds have a lot to offer each other.

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