Helping Without Harming
The Instructor’s Feedback Dilemma in Debriefing—A Case Study

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Introduction: Simulation instructors often feel caught in a task-versus-relationship dilemma. They must offer clear feedback on learners’ task performance without damaging their relationship with those learners, especially in formative simulation settings. Mastering the skills to resolve this dilemma is crucial for simulation faculty development.

Methods: We conducted a case study of a debriefer stuck in this task-versus-relationship dilemma. Data: The “2-column case” captures debriefing dialogue and instructor’s thoughts and feelings or the “subjective experience.” Analysis: The “learning pathways grid” guides a peer group of faculty in a step-by-step, retrospective analysis of the debriefing. The method uses vivid language to highlight the debriefer’s dilemmas and how to surmount them.

Results: The instructor’s initial approach to managing the task-versus-relationship dilemma included (1) assuming that honest critiques will damage learners, (2) using vague descriptions of learner actions paired with guess-what-I-am-thinking questions, and (3) creating a context she worried would leave learners feeling neither safe nor clear how they could improve. This case study analysis identified things the instructor could do to be more effective including (1) making generous inferences about the learners’ qualities, (2) normalizing the challenges posed by the simulation, (3) assuming there are different understandings of what it means to be a team.

Conclusions: There are key assumptions and ways of interacting that help instructors resolve the task-versus-relationship dilemma. The instructor can then provide honest feedback in a rigorous yet empathic way to help sustain good or improve suboptimal performance in the future.

(Sim Healthcare 8:304-316, 2013)

Key Words: Feedback, Debriefing, Faculty development, Debriefing the debriefer, Interprofessional education.

Debriefings are critical to health care simulation programs because that is usually where the critical process of feedback occurs1-7 and learning is often clarified, codified, and translated into guidelines to carry forward into future practice.8-10 Indeed, without an effective debriefing, the whole point of formative simulation education can be lost.5,11,12 Yet, when simulations reveal learners’ shortcomings, many instructors find debriefings exquisitely difficult to lead13 because of a classic instructor’s dilemma14-16: instructors rightly worry that critiquing task performance may damage the relationship or make learners so defensive or ashamed that they resist input or future training.7,13,17 On the other hand, obscuring important task-related critiques in the service of the instructor-learner relationship may leave learners without guidance on how to improve. Instructors often struggle to help learners perform better in the future without harming their self-esteem, confidence, or connection to the instructor. Simulation programs that invest significant resources to improve the quality and safety of health care need to help instructors resolve this “task-versus-relationship” dilemma18 so that they can provide effective feedback.

There are 2 frequent faculty responses to the common and challenging task-versus-relationship dilemma, one that emphasizes task and one that emphasizes relationship. In the “judgmental” approach, the instructor emphasizes task by directly chastising or subtly “pimping”19,20 the learner to improve their task performance. By impugning the learner’s character, judgment, intelligence, or competence, this approach can weaken the relationship between instructor and learner.17,21,22 While the direct chastising of the judgmental approach may sometimes be efficient, quickly and directly showing learners their errors in the task at hand, it can backfire when it degrades learner confidence in a way that impedes task performance,17 humiliates or shames learners in a way that prevents reflection,7 absorption, and retention of lessons,22-24 or weakens the pairs’ ability to discuss difficult topics in the future.14,25

The other response to task-versus-relationship dilemma is the faux nonjudgmental approach to feedback meant to protect the instructor-learner relationship. The goal of this...
approach is to help without harming. Using the veneer of kindly leading questions (eg, Did you have any concerns about the dose of epinephrine? Did it occur to you to double check?) this approach camouflages the instructor’s judgment.

In this intendedly nonjudgmental approach to feedback, also called “easing in” or “protective” conversational strategy, instructors seek to maintain the relationship by guiding the learner to a criticism the instructor holds but does not want to say directly. This pattern, while common, has several liabilities: 1) Because clear, actionable task feedback is obscured, the learner often does not or cannot guess the expected correction; 2) it is often experienced as manipulative, requiring the learner to play along if they are to be seen as a cooperative student. In the judgmental approach to feedback the instructor is like the proverbial wolf, harshly attacking the learner, while in the nonjudgmental approach to feedback, the instructor is like a wolf in sheep’s clothing, using a fleece of niceness to disguise the same harsh view of the learner.

Neither resolves the basic task-versus-relationship dilemma.

The purpose of this article is to show how the task-versus-relationship dilemma can undermine effective feedback in debriefing and suggest ways to develop faculty skills to resolve the dilemma. The task-versus-relationship dilemma is based in a crucial mismatch between many instructors’ espoused view of mistakes in simulation—that they are normal and expected—and their actual feelings in the moment—that mistakes are unacceptable. Many health care educators believe in the foundational tenets of patient safety described in reports like “To Err Is Human,” mistakes are normal; clinicians function in the context of imperfect systems; and vigilance alone is not enough to ensure high quality care. However, many instructors, like the instructor in the case we present here, struggle to apply these values in the practice of debriefing.

This inconsistency between espoused values and actual practice reveals that debriefers are human too: Like simulation participants, debriefers often err and it is important to understand why and what to do about it. Managing the internal conflict created by wanting to provide direct feedback on task performance while maintaining a positive relationship with learners drives many dysfunctional debriefing strategies. Although the type and impact of the task-versus-relationship dilemma will vary depending on the design of the simulation, the expertise of the debriefer, or the particular skill being taught, we believe the basic structure of the dilemma is universal enough that exploring an in-depth example will provide broader lessons.

This article presents a case study of T.R., a seasoned instructor, and her attempt to debrief a simulated case of managing hemorrhagic shock in a young child. The case study is a rigorous yet empathic look at an instructor’s perceptions and feelings, her “subjective experience,” and its impact on her debriefing technique and her assessment of learning outcomes. Following the Action Science tradition of accentuating one’s own missteps in an ironic and bright light, the case study uses vivid characterizations of the instructor’s thoughts and actions to capture the instructional dilemmas in the case.

The debriefing we analyze was part of a larger crisis resource management (CRM) program within T.R.’s institution, but the focus of this article is not on the CRM program per se; instead, the article focuses on the subjective experience of a debriefer. This portrait depicts the dilemma of trying to help without harming: blaming the learners in her own mind for their poor management of the case poses an irresolvable task-versus-relationship dilemma for the instructor. She feels that if she is honest with learners, they will find out that she thinks they made major mistakes in managing the clinical task and this critique will jeopardize her relationship with them as they become demoralized or defensive. How she addresses this internal dilemma provides clues both on how instructors create a debriefing problem for themselves and how they can solve it.

To foreshadow the case study analysis we will present, there are 3 strategies we identified to escape the task-versus-relationship dilemma and debrief more effectively in the future: (1) make generous inferences about the learners, that is, assume learners were well-intentioned and acting rationally from their perspective; (2) normalize the challenges posed by the simulation; (3) distribute the “heat” of pointed individual critiques to the team level.

The rest of the article is organized as follows. We describe the methods used in this case study; the Results and Discussion sections present the case study; the Conclusions section summarizes the case study results and the faculty development impact.

**METHODS**

To analyze the debriefer’s subjective experience of the task-versus-relationship dilemma, we conducted a retrospective analysis of a difficult debriefing. The debriefing focused on a 15-minute simulation case on managing hemorrhagic shock in a young child. We used methods from Action Science. Action Science is an action research discipline that studies existing practice and attempts to transform it with the goal of closing the gap between the someone’s intention, such as what they hoped to achieve in the debriefing, and their impact, what they actually achieved or, as in the case reported here, their perception of what they achieved. We introduce 2 established Action Science methods for capturing and analyzing invisible thought and feeling processes: the 2-column case and the learning pathways grid.

The 2-column case presented here was drafted by one of the authors (T.R.) to recount a difficult debriefing she led at one of her hospital’s simulation programs. The analysis of 2-column cases is usually conducted either by a group of peers reflecting together on 1 group member’s 2-column case or by a group of peers working with a mentor. The analysis of a debriefing presented here emerged from a 90-minute mentor-led simulation instructor reflection group, using the learning pathways grid. Three of the authors (J.W.R., R.S., and T.R., the casewriter) were present for this initial meeting. All authors then worked together via electronic mail and conference call to streamline and clarify the
analysis and draft this article. We sought and were granted research ethics review board approval for this analysis.

The 2-Column Case: Capturing a Debriefing

The 2-column case introduced by Argyris and colleagues is part of a family of methods, such as cognitive task analysis, process tracing, and protocol analysis, which attempt to capture and display what professionals say and do as well as what they are thinking and feeling. The 2-column case is a representation of what the debriefer said in one column and what she thought and felt (but did not say) in a parallel, second column. The dialogue for a case can be recreated from memory, audio or video recording. Although recording simulations is common, it is used much less frequently for debriefings. The data in this case, because there was no recording of the debriefing, were recreated from memory. (Each method of capturing what was said has pros and cons. A recording might have provided a fuller picture of the dialogue and prevented the case writer from being either too lenient or too harsh on herself. Given our emphasis on the subjective experience of the debriefer, using her description written from memory is useful: although it is subject to a variety of memory biases, these biases tend to lead people to recall things in a way consistent with their perceptions of themselves. The way she remembers the conversation is the way she believes it unfolded in her head and, therefore, is a window into how she experienced the conversation in real time.) Generalizing from a single case has a long history in health care and in the social sciences. Clinical case reports shed light on unexpected effects and mechanisms of disease, but in other instances, they may suggest a new way of thinking about a common problem that could benefit from new approaches. Similarly, single-case studies are used in the social sciences to develop theory or to flesh out or refine existing theories using in-depth analysis. In this article, we flesh out the details of a supposedly nonjudgmental debriefing approach that, in fact, only camouflages the instructor’s judgment. Although the skeletal outlines and frequent use of this “nonjudgmental” approach are already documented in the organizational behavior and psychology literatures, this analysis continues an effort to illuminate its details in a health care simulation context. The “thick” description provided by an in-depth single-case study such as this is often a critical foundation for larger quantitative or qualitative studies.

Two-column cases are usually introduced by a brief written description of the context, and the case writer’s goals for the conversation. For simulation instructors, the goals often include learning objectives as well as relational factors such as building trust with the learners. Two-column cases are frequently presented with a wry sense of humor meant to highlight one’s own flaws as a practitioner. Using ironic or colorful language helps accentuate the dynamics of one’s own missteps and may help counteract self-serving memory bias when the case is recreated from memory. Evocative language that captures the feeling of the situation helps pierce the veil of unawareness that generated the case writer’s debriefing problems and can spur them to use humor and humility in changing his or her own practice.

The Learning Pathways Grid
Analyzing and Recrafting a Debriefing

The learning pathways grid analysis is a way to identify what worked and what did not work during a debriefing and then to think through and rehearse alternatives to enhance future debriefings. The analysis is conducted by a group examining the data in the 2-column case and transferring insights cell-by-cell into the learning pathways grid. The simulation instructor peer group helps the case writer identify and then remedy the mismatch between what they hoped to achieve—the desired results—and what they perceive they accomplished with the learners in the debriefing—the actual results. When cases are based solely on the recollections of the case writer, the “actual results” are an inference made by the case writer or others helping them analyze the case.

The mismatch between good intentions of the debriefer and unwelcome impact on the learners represents the debriefing performance gap. The learning pathways grid helps reveal the invisible, sometimes ironic, sources of this discrepancy (Fig. 1).

Once the debriefing performance gap is clear, the learning pathways grid analysis reveals what led to the actual results, first by exploring the case writer’s actual actions—focusing primarily on her speech—and then her assumptions or patterns of beliefs, called frames in this context. Then the recraft begins, first by creating new, more effective frames, and then more effective actions, all with the goal of allowing the instructor to conduct a debriefing that more consistently achieves the explicit learning objectives and other implicit goals such as maintaining a good relationship with learners.

The “learning pathway” refers to a causal chain common to theoretical models used in cognitive science, linguistics, and organizational behavior. These models posit that people’s internal meaning-making processes, as represented by constellations of cognitive frames and feelings, drive what they
say, which, in turn, contributes to particular results or outcomes in a situation.\textsuperscript{16,26,56–59} Reverse engineering how certain outcomes were produced then allows a reflection group to help the case writer learn new, more effective ways of interacting.

We will use the term frame in this setting to refer to the invisible cognitive and emotional drivers of people’s actions. Also called mental models or schemata, frames refer to the assumptions, knowledge base, cultural or professional beliefs and feelings about the situation.\textsuperscript{16,57,60–64} Frames can take different forms. They range from if-then decision rules\textsuperscript{55,65} (if someone is yelling, then withdraw) to an amorphous sense, for example, of what is safe, right, rational, or polite behavior.\textsuperscript{58} In this analysis, we follow recent research in neuroscience\textsuperscript{61} and the psychology of emotion,\textsuperscript{66,67} emphasizing that cognition and emotion are inextricably bound together, and we will talk about “frames” as including both cognitive and affective dimensions.

Reflecting With a Peer Group

Previous research\textsuperscript{68,69} and the authors’ combined experience facilitating several hundred learning pathways grid analyses suggests that when the case writer works with a group of peers or with peers and a mentor, it catalyzes much greater learning. (The authors have been using the 2-column case and the learning pathways grid for 15 years both to study and improve the quality of their own teaching, debriefing, and management interventions and to help our students study and improve their own debriefing, management, or consulting interventions. Collectively, we have participated in or supervised more than 800 learning pathways grid analyses of 2-column cases.) This is because it is difficult or impossible to perceive the contribution of one’s own tacit assumptions and beliefs on one’s own.\textsuperscript{70–73} Organizational and individual defensive routines,\textsuperscript{74} double binds,\textsuperscript{41} well-established habits of mind,\textsuperscript{75} and existing immunity to change\textsuperscript{76} can all conspire to make it difficult to reflect on our own action, particularly when that reflection is focused on identifying our own shortcomings.

The learning pathways grid analysis for debriefing is therefore best accomplished by a small group of simulation instructors working together repeatedly over time. This is the sort of “supported, sequential process” that provides the continuity necessary for feedback to have an impact.\textsuperscript{7} Creating such a group is not always easy. It requires some individual reflection skill, commitment, as well as contextual support by the broader organization, all of which can be hard to find.\textsuperscript{71,77} Even when these factors are present, some topics can be particularly difficult to broach, such as power differences among professional groups. However, participants can gain valuable insights even without substantial experience. Several “how to” resources can guide instructors on core skills.\textsuperscript{41,71,78,79} Groups are likely to develop rapport and expertise more quickly if membership is stable and meetings are relatively frequent (eg, monthly). It helps if group members practice making generous inferences about each other and the case writer—assuming that their frames make sense to them and that they are capable, trying to do their best, and want to improve. Mistakes made by the case writer or unskillful help from the group members in analyzing the case can serve as a basis for learning, as long as they—like mistakes by participants in a simulation—are not condemned. This is a good practice for assuming the stance that “mistakes are opportunities for learning” when debriefing a simulation.

The reflection group provides instructors a chance to simulate holding new assumptions, examine their own inconsistencies with humor, and practice phrasing new statements and questions or other interventions for future debriefings. When such reflection groups are possible, they provide a powerful developmental context in which instructors can adopt new effective debriefing skills that feel authentic.\textsuperscript{41,71} By “authentic,” we mean that the instructor has a chance to practice new approaches enough so that they feel they could “own” them or at least try them in a new contexts.

RESULTS AND DISCUSSION

In this section, we describe and then analyze the debriefing case including mapping the pathway to improve it. Table 1 displays the data of the 2-column case. Figure 1 depicts the counter-clockwise analysis process of the learning pathways grid and Figure 2 summarizes the results of the analysis.

Two-Column Case

In this section, we present the 2-column case drafted by one of the authors (T.R.). The case is an example of the “nonjudgmental” approach to debriefing described in detail in the introduction. The article focuses on this approach because we estimate, based on our within-course formative assessments, that more than half of the 2000 simulation instructors-in-training in the Institute for Medical Simulation and 1000 masters-level management students the authors have trained use this approach de novo.

Although the focus of this article is on T.R.’s subjective experience as a debriefer and on the teaching-learning dynamic, it’s informative to know the context of the simulation. T.R. is an experienced emergency nurse with 20 years of clinical practice and a lead simulation instructor at a pediatric hospital that is a level 1 trauma center in its metropolitan region. T.R.’s simulation program prepares staff to manage high-consequence, low-frequency events as well as common clinical challenges that involve intense teamwork. The program is developmental and formative; it teaches CRM principles to both experienced and newly oriented staff as well as trainees from inpatient areas, critical care units, and outpatient clinics.

This simulation program is also one of the only opportunities for fellows in pediatric emergency medicine, and senior residents in anesthesia in their third to fifth year of training to get practice and get feedback leading a true interprofessional pediatric resuscitation team; they see this as a unique opportunity to challenge themselves to manage the case as best as they can on their own. In the real emergency department, attending physicians oversee fellows’ and residents’ clinical management of complex traumas. The scenarios are designed to be as realistic as possible; as in the real emergency department, the team is instructed that they can call for help at anytime. There is a senior physician as part of the teaching team who acts as the consultant, if requested by the team.
Nurse 1 is right the leader [a resident] was very ineffective, but nurse 1 has many years of experience. She should have helped! She should have asked the team leader to call out her assessment.

Oh, God, she is right. The leader should know you never give that amount of drug in a hypotensive patient.

But the nurses know this too! We just covered this in didactics. They know these drugs. It is just as much the nurses’ responsibility to be sure safe drugs are given as it is the leader’s. I have to stop this attack of the leader; she is about to cry.

Fluid resuscitation! They all missed this boat—stop blaming the leader. How do I let this conversation carry on but get the leader off the hot seat? In almost every scenario we do with shock, people are afraid to give fluids fast enough. This mistake would have been very bad news for a real patient. They all know this! Why don’t they give fluids faster? They don’t need a leader to tell them this child is in hemorrhagic shock and needs rapid fluids. I need to nail this point home.

I want to say, “Why didn’t you say something?! You have years of experience.” Of course, the patient needed to be intubated sooner. That poor leader...she is almost in tears, but we need to cover indications for intubation.

The team has responsibility here. They may not have been happy with the leader, but they have many years of experience and they did nothing to help.

Such was the situation in the simulation debriefed in T.R.’s case. The team was called to manage a trauma patient in the (simulated) emergency department, a 6-year-old pedestrian struck by a car, presenting with head and abdominal injuries. A group of nurses of varying experience from those newly orientated to the trauma room to those having 15 or more years of experience in the emergency department were led by a knowledgeable but relatively inexperienced resident. The nurses have all had previous education in CRM precepts and are expected to participate in interprofessional training sessions on a yearly basis to refresh these skills. In the simulation, the medical lead and nurses in a newly formed group did not find an effective way to work together, they did not call for help, and patient management suffered. This configuration of factors contributed to a challenging and conflictual debriefing situation.

As an experienced clinician and simulation instructor who had worked in the simulation program for 8 years at the time of this case, T.R. valued simulation training highly. Because of this experience, T.R. was sensitive to the potentially painful short-term, or worse, long-term effects of personal confrontation or criticism of participants in the simulation program. T.R. worried about the fallout of criticizing people too harshly—a too common practice, she felt, in her own education—and wanted to avoid making people reluctant to participate in future simulation training.

The right-hand column reflects what the dialogue the instructor recalls being said in debriefing, and the left-hand column depicts what T.R. recalls having thought and felt but did not say. (Although 2-column cases can include descriptions of nonverbal behavior, for example, “she rolled her eyes,” this particular case did not do so. Nonverbal expressions can offer excellent data, but we feel the dialogue in this case provides ample data of how things went awry during the debriefing process.)

**Learning Pathways Grid Analysis**

Desired Results—What the Debriefer Was Hoping For

If everything had gone perfectly in the debriefing, what would the participants have learned? What would the instructor have learned about the participants? How would everyone feel? The left-hand “What I Thought and Felt” column of the 2-column case provides clues about what the instructor wanted to achieve. There were 3 results T.R. seemed to care about in this debriefing: (1) that participants aren’t scared off of simulation training, (2) that the group members take responsibility for sharing their expertise and not just point blame at others, and (3) that there be real and lasting learning about management of a trauma patient in hemorrhagic shock.

**Desired Result 1: Do Not Scare Them Off!**

The left-hand column of T.R.’s “Is it Cruel to be Kind?” debriefing case indicates she saw some serious flaws in clinical
management by all participants. However, she is anxious to deliver the critique in a way that will not alienate participants, in particular the less experienced resident who led the team. She thinks it is important to cover what went wrong but asks herself, “How do I let this conversation [about mistakes] go on and yet get the leader off the hot seat?” At another point, she thinks, “I have to stop this attack of the leader; she is about to cry.” T.R.’s worry that learners would be frightened off by a too critical conversation, paired with her belief that significant mistakes had been made, left her feeling completely stuck—damned if she was honest about her critiques of clinical management, damned if she allowed the critique to continue.

**Desired Result 2: Hold People Accountable for a Successful Resuscitation**

T.R. observes that the leader was indeed very ineffective, as the nurses keep pointing out, but thinks, “You [nurses] should have taken more of a lead.” One issue was how the resident led the trauma management, but another equally important issue was how the nurses handled working with a leader who needed their help. So when they discuss the late and problematic intubation of the patient and nurse 1 says, “I felt like she [the resident] struggled with the airway and didn’t recognize the need to intubate soon enough,” T.R. thinks, “Why didn’t you say something!” The left-hand column of the case reveals that T.R. wanted the nurses to take responsibility for speaking up, sharing their expertise to support the leader, and ensure that clinical management of the trauma was successful. Given that they were working as a team to resuscitate the patient, T.R. wanted to ensure that everyone saw how they contributed to both the problematic management of the patient and how to achieve better collaboration on the team.

**Desired Result 3: Apply Clinical Knowledge in a Demanding Trauma Resuscitation**

In her experience, T.R. has observed that teams, regardless of experience, often struggle with application of seemingly basic medical knowledge. T.R. is very frustrated during the
debriefing, thinking to herself, “They know this; they don’t need a leader to tell them this child is in hemorrhagic shock and needs rapid fluids.” In this case, she wants the learners to manage the airway and fluid resuscitation effectively, something she believes they know, in principle, how to do. The team seems unable to work through known algorithms, however, in practice.

**Actual Results**

As in any simulation debriefing, there are a host of actual result here, but several are critical for understanding the instructor/case writer’s dilemma, namely, an emotional standoff that leaves one participant near tears while others feel self-righteous, a missed opportunity for instruction in clinical practice, and lack of comprehension about joint responsibility for the case.

**Actual Result 1: Emotional Stalemate**

From statements in both the right- and left-hand columns, a picture emerges of an emotional standoff among T.R., the nurses, and the resident. Three times, the nurses describe the weaknesses of the team leader, and each time, T.R. tries to head off escalating criticism, while the resident remains silent. In this, T.R. thought she was reducing the participants’ fear of simulation, one of her desired results. However, in fact, participants seem to be retreating to their corners, one fearful and closed up, others argumentative and vocal. It seems impossible for any of them to break out of their current positions to take a broader view of how they might have collaborated to handle the scenario.

**Actual Result 2: Little Guidance on Clinical Management**

T.R.’s attempt to tamp down discord comes at the expense of meaningful dialogue on clinical management of the patient. With preserving her relationship with the learners and their psychological safety foremost in her mind, T.R. did not explore the best clinical or teamwork practices for handling the case. The result, in-depth conversation about fluid delivery in the context of hemorrhagic shock, indications and drugs for rapid sequence induction, and communicating effectively to accomplish these tasks, fell by the wayside.

**Actual Result 3: People Do Not Understand Their Joint Contribution**

The right-hand column statements suggest that the nurses may have felt little responsibility for the poor resuscitation of the patient. They seemed to blame the resident, leaving them unable to understand how they also contributed to the problem or how they could have been part of the solution with a better outcome for the simulated patient. Conversely, the resident did not ask for help when she needed it, and her near-tears silence suggests that she may have felt primarily responsible for the poor clinical management of the case.

**The Debriefing Performance Gap**

Comparing the desired results with what actually happened elicits a clear picture of the debriefing performance gap. What T.R. wanted and what she reports actually happened are almost diametrically opposed. T.R. worries that she did not succeed in maintaining or strengthening her relationship with learners or in creating a safe yet challenging environment.

She thinks the group walked away without clear messages on how to manage the task at hand, hemorrhagic shock. Furthermore, she believes that the group members do not see clearly how their actions contributed to the poor clinical management of the patient or how they could have worked as a team to turn it around.

**How did this happen?**

**Actual Actions**

Step one in solving the mystery of how the intent of T.R.’s debriefing could be so different from its impact involves documenting the actions she did take, primarily the patterns in what she did or did not say.

**Actual Action 1: T.R. Lets the Nurses Off the Hook**

To blunt critiques of the resident yet try to get the nurses to see how they contributed to the quality of the resuscitation, T.R. uses the strategy of transforming highly specific critiques of the resident, for example, “She kept changing her mind and I had no idea what she wanted,” into generalities, “So there was trouble communicating.” She pairs these generalities with questions that provide what she hopes will be nonthreatening hints of her own point of view that they should have helped more: “How do you think your experience could have helped here?” or “How do you think she could have handled the communication differently?”

**Actual Action 2: T.R. Withholds Her Expert Judgment**

When the nurses do not follow her hints to arrive at the conclusions T.R. holds yet does not say directly, T.R. backs off. She does not share her expert opinion that they should have helped the resident more because she thinks they know the drug doses and that no one provided fluids fast enough. Instead, she attempts to defend the resident by tamping down the psychosocial impacts of the nurse’s specific, accurate, but relentless critique. The irony is that the nurses are providing the very critiques T.R. might offer, if she felt she could do so without scaring people away from simulation. The specificity of the critiques, “She didn’t communicate her assessment;” “She kept changing her mind about [rapid sequence induction (RSI) drugs];” “I had no idea what she wanted;” and “She wasn’t clear on the fluids. I wasn’t sure how much to give or how fast,” provide highly pertinent feedback to the resident on what nurses need from their trauma resuscitation team leader. In contrast, T.R.’s own approach to the topic disguises her point of view in vague inquiries: “How do you think your experience might have helped here?”

**Actual Action 3: T.R. Implies Performance Is Unacceptable**

Although T.R. desperately wants people to feel good about the simulation, paradoxically, the opposite message leaks out. The content of her statements hints something is awry, and the repetition of these vague hints sends a metamessage—you messed up so badly I cannot even talk about it directly:

T.R.: That is interesting. You have a lot of experience; how do you think your experience could have helped here? (Implying the nurse should have used her experience to help).
T.R.: So there was trouble communicating. How do you think she could have handled this differently? (Implying how the resident handled it was not optimal).

T.R.: Fluids were an issue here. What happened? (Implying fluid management was a problem).

T.R.: What were your thoughts on why the patient needed to be intubated? (Implying—in the context of this debriefing—that the patient should have been intubated sooner.)

In summary, T.R.’s nonjudgmental approach to feedback has the following characteristics: T.R. repeatedly uses vague paraphrasing and open-ended inquiry that fails to address the clinical objectives of the simulation while implying that the team’s performance was not up to par.

Why does T.R. rely on this ineffective intervention strategy? Her cognitive and emotional framing of the situation offers some clues.

**Actual Frames**

**Actual Frame 1: If I Say Critical Things People Will Feel Bad and Be Scared of Simulation**

This frame relates to how T.R. understands the nature of criticism and her role. She never offers her own views despite her stated desire to generate real clinical learning. This frame is central because it indicates that T.R. was holding one of her aims—protecting her relationship with participants and their willingness to participate in simulation—above her goals related to the task of appropriate clinical practice and team responsibility. She did not know how to critique the clinical management without putting learners on the spot. This overall frame had several important elements as follows:

- Criticism will make people feel bad, and feeling bad will make them hate simulation;
- It is my responsibility to protect everyone;
- I remember my days as a learner, and I will never make anyone feel as incompetent as I was made to feel.

**Actual Frame 2: They Did Not Handle the Clinical Intervention Well and That Is a Crime**

T.R.’s frustration with the team suggests that she also held another often problematic frame, namely, the learners were wrong in their clinical intervention and that is itself wrong.26 The “It’s wrong to be wrong” frame can be gleaned from T.R.’s left-hand column, for example, “The leader should know you never give that amount of drug in a hypotensive patient, but the nurses know this too! We just covered this in didactics, and she knows these drugs.”

There is an irony here. Hospitals (including T.R.’s) as well as medical and nursing schools all devote significant resources to simulation so people can learn how to handle complex clinical challenges, yet here was T.R. rebuking the learners in her own mind for not being masters of something they were there to practice.

Holding the frame that “a mistake is a crime,” although it sounds exaggerated, is a normal emotional reaction; people do it all the time.14,26 In their frustration, instructors feel it is a “crime” to make a mistake. This puts instructors in an irresolvable dilemma: if they are honest about what they are thinking, it is likely to discourage or anger the learners. Learners will rightly perceive that the instructor has condemned them. This is the crux of the nonjudgmental debriefer’s double bind: either the instructor tells the learners they committed the “crime” of clinical mismanagement, potentially causing emotional distress and discouraging their participation in future training, or the instructor can withhold the judgment, hoping and hinting that they will see things her way or leaving the group without the knowledge of how to perform better in the future.

**Actual Frame 3: Everyone Knows What It Takes to Be an Effective Team**

In the left-hand column, T.R. repeatedly thinks that the nurses should have “stepped up to the plate” when they saw the resident struggling. Implicit in her frustration is the belief that others share her view that they have expertise to share that is valuable. At the end, she makes it very clear: “The team has responsibility here.” However, “team” is an abstract concept that can be understood in many different ways, and it can be further complicated in interprofessional settings. In T.R.’s mind, it is clear that all the learners have joint responsibility for the case and therefore should speak up if things are not going as they think they should or should ask for help when they need it. Because she holds this assumption so strongly, it does not occur to her that others may understand their roles, responsibilities, and constraints in the team quite differently. Because she is so frustrated that they did not speak up, she worries that her feelings might “leak” if she tries to say anything directly, triggering defensiveness or embarrassment among the participants. These frames help us understand why T.R. chose to downplay her own expertise, relying instead on broad generalizations and vague inquiry.

Alternate ways of framing her challenge could release T.R. from her double bind and greatly enhance the learning that took place in the debriefing. We now discuss these alternatives.

**Desired Frames—Reframing the Debriefing**

Fortunately, many frames are malleable. By surfacing one’s embedded mental and feeling processes and examining their impact, we can determine whether our current ways of thinking are enabling or inhibiting our effectiveness. We can then decide what other ways of thinking might be more likely to lead to the outcomes we want, a process called reframing,36,80 reflection-on-action,36,80 or double-loop learning.26

The learning pathways grid provides a compelling opportunity to reframe. This can mean a relatively minor change—taking a current frame and changing it slightly—or a more substantial change in which we reverse a frame or create entirely new ways of viewing a situation. This is not easy, but it is possible with the help of others and especially if an instructor is motivated to transform his or her areas of ineffectiveness. Later, we describe reframes for each of the actual frames T.R. held.

**Reframe 1: Learners Are Resilient; They Can Tolerate Direct Feedback Shared in a Respectful Way**

Replaces Actual Frame 1: If I Say Critical Things People Will Feel Bad and Be Scared of Simulation. T.R. knew that to
discuss the case comprehensively would mean pointing out the mistakes of all participants. She anticipated that having those errors discussed in a group would make individuals feel bad. This was a self-fulfilling prophecy: understanding individuals as defensive and fragile can often lead to ways of talking that make individuals feel defensive and fragile.\textsuperscript{51} In the first of several frame changes that make generous inferences about learners, T.R. reframes her view of the learners as resilient and capable (rather than defensive and fragile). Generous inferences, in contrast to uncharitable inferences, are positive assumptions about learners. Examples include the following: they mean well, they are trying to do their best. She also reframes her critique as positive and useful rather than negative and damaging, which frees T.R. to state her concerns clearly, both about the clinical practice and about the need for teamwork. However, to have confidence that this direct critique will not demoralize or antagonize the learners, T.R. has to reframe her deeper beliefs about the mistakes that were made.

**Reframe 2a: There Is a Good Reason They Did Not Handle the Clinical Intervention Well**

*Replaces Actual Frame 2: They Did Not Handle the Clinical Intervention Well and That Is a Crime.* The key to providing a respectful yet direct critique lies in reframing T.R.'s view of her colleagues. Rather than focusing only on their mistaken actions, she shifts to a focus on them as competent meaning makers.\textsuperscript{14} She reframes her debriefing task as discovering the thoughts and feelings that led her intelligent, capable, and well-meaning learners to do what they did.\textsuperscript{16,26}

This is not simply a rose-tinted reframe. It is consistent with a range of research in experimental economics and social science indicating that even when people make mistakes or appear to act against their own best interests, they are intending to accomplish something they perceive as valuable.\textsuperscript{81,82} Generous inferences, in contrast to uncharitable inferences, are positive assumptions about learners. Examples include the following: they mean well, they are trying to do their best. She also reframes her critique as positive and useful rather than negative and damaging, which frees T.R. to state her concerns clearly, both about the clinical practice and about the need for teamwork. However, to have confidence that this direct critique will not demoralize or antagonize the learners, T.R. has to reframe her deeper beliefs about the mistakes that were made.

**Reframe 2b: They Did Not Handle the Clinical Intervention Well and That Is Normal**

*Replaces Actual Frame 2: They Did Not Handle the Clinical Intervention Well and That Is a Crime.* In the context of health care simulation, debriefers can also rely on another reason to reframe mistakes as an important source of learning. Simulation programs are funded and staffed precisely because it is difficult to apply knowledge, skills, or attitudes, no matter how obvious and straightforward they seem in theory, on tests, or in lecture.\textsuperscript{83,84} If the simulation evokes stress or appears as a threat to learners, their usual routines or the didactic, knowledge-based instruction offered in undergraduate or continuing nursing and medical education is unlikely to prepare them.\textsuperscript{85–87} If the team could already collaborate to handle hemorrhagic shock perfectly under stress and time pressure, it would not need an expensive simulation program to develop skills, although it might need training in other areas or expert-level simulation challenges to keep its skills sharp. The same holds true for novice and intermediate learners facing simpler procedural or communication challenges that challenge them at the edge of their expertise.

**Reframe 3: We May Have Different Understandings of What It Means to be a Team**

*Replaces Actual Frame 3: Everyone Has the Same Understanding of What it Means to be a Team.* Although many nursing as well as medical and allied health education programs increasingly espouse the importance of teamwork and interprofessional collaboration, the challenges of communicating in the context of professional and hierarchical differences are difficult to overcome.\textsuperscript{88–90} Therefore, it is helpful for the debriefer to reframe the learners’ performance as the result of legitimately difficult teamwork and communication issues that they may not see the same way she does. This reframe makes T.R. less likely to blame the participants for abdicating their responsibility and more likely to wonder how they understand their responsibility. This reframe also has an interpersonal benefit: it allows her to feel more comfortable holding the team to a standard of care because she focuses on the team’s performance rather than focusing on 1 or 2 individuals. This would open up the possibility of having a meaningful conversation about the team-level factors that facilitate or prevent asking for and offering help.\textsuperscript{91} It would also allow her to discuss other challenges clinicians face in making sure their interprofessional team manages clinical aspects of the case well.

**Desired Actions—I mprovement Techniques for This Instructor**

We have diagnosed some of the obstacles T.R. faced in achieving outcomes she wanted and suggested some prescriptions about ways she might reframe the debriefing challenges she faced. We now turn to the process of crafting new ways for...
T.R. to act, that is, talk during the debriefing. The goal is to devise debriefing moves that are more likely to lead to the results T.R. hoped to achieve, namely, that learners feel safe, although challenged; that they take away clinical learning; and they understand their joint responsibility for effective clinical management of hemorrhagic shock.

**Normalize the Challenges of Trauma Resuscitation in a Team**

Ironically, T.R.’s left-hand column reveals that difficulties are common, “In every scenario we do with shock, people are afraid to give fluids fast enough... We just covered this in didactics.” Normalizing the group’s performance might have reduced their defensiveness and paved the way for a productive discussion of how to do better in the future. There are four ways to normalize the team’s performance:

1. Most teams handle this as you did. A well-designed simulation puts team after team into the same dilemmas. Telling the team that most other groups did no better than they did with fluid resuscitation and communication—if true—can be reassuring.

2. Knowledge versus application. If she believes that the group is familiar with principles of identifying and managing hemorrhagic shock, she could discuss the difficulties many clinicians face in translating knowledge into action. It is one thing to know, in principle, that giving fluids rapidly is important; it is another to actually do it in practice.

3. Practice, practice, practice: clinical. Alternately, she could discuss that aviation, wildland firefighters, military services, and health care all use simulation to practice complex, high-consequence clinical events. The point is to help learners appreciate that they are in a simulation program precisely because the skills are challenging and require practice.

4. Practice, practice, practice: interpersonal. The debriefer could point out that interpersonal challenges of interprofessional communication are notoriously difficult and require both practice and, once learned, a real-world environment supportive of such communications.

**Pair Critique With Inquiry to Hold People Accountable and Provide Needed Support**

Instructors who choose a “nonjudgmental,” pseudo-Socratic approach to feedback, like T.R., often do so at the expense of direct, actionable feedback that clearly lets learners know where they went wrong and how to improve. This analysis shows that T.R.’s kind inquiry alone was probably not sufficient to help learners improve. Instead, a judicious combination of advocating what the instructor sees as important and inquiring into the learner’s point of view would allow T.R. to share her expertise and diagnose the learner’s needs efficiently. She can then match discussion and teaching to what they need to know. For example, after one nurse complained that the resident did not know what she was doing regarding the RSI drugs, T.R. says to herself in her left-hand column that she believes nurse knew the right drugs. T.R. could have said,

“It sounds like it was difficult that Sally (a pseudonym for the resident) kept changing her mind about the RSI drugs. I’m thinking that sharing your knowledge of the drugs might have helped the team get on the right track. I’m wondering how you see this?”

This phrasing allows T.R. to both take a stand on what constitutes effective teamwork action and also invites the learner’s perspective on the challenge.

**Move the “Heat” to the Team Level**

As attacks on the resident surfaced, T.R. could shift the focus of the dialogue from individuals to how the team as a whole can function better to achieve effective clinical management. Using a brief verbal preview, a sentence or two that could signal where she wants the conversation to go, she could provide concrete observations about the team’s performance and inquire about what nurse 1 and the others see as facilitating or constraining effective action by the team. By normalizing the difficulties of effective interprofessional communication—the normalizing “inoculates” people from the intensity of a pointed critique—she could pose tough questions without harming her relationship with the learners.

Preview: “I’d like to talk about what helps or hinders a team surfacing and sharing information that could help the patient.”

“Nurse 1, it sounds like you were concerned about fluids. As I watched the simulation, I too, was thinking, ‘Give them faster!’ But I didn’t hear you or anyone else state this concern during the case. Many teams struggle with this sort of communication challenge, which makes me think there is something hard about speaking up with ideas that could help each other and the patient. I wonder how you see this?”
Or “It looked like the team was having some trouble getting on track with the RSI. I don’t think it is news to any of you that getting the airway squared away quickly is beneficial. But I didn’t hear you, Resident, ask for help, or you Nurse 1 or 2, offer it. I think asking for or offering help can be hard on an interprofessional team. I’d be curious to know your thoughts.”

This approach shifts the focus to communication patterns within the whole team, helping both team leader and others see what prevented them from offering or asking for the help. It assumes that there are often complex reasons behind something as simple as reticence to ask for or offer help9¹,9² and asks for the learners’ analysis while being direct about her own point of view. It encourages open discussion and invites a look behind actions to motivations.

In addition to asking about specific moments, T.R. could widen the focus and explicitly raise the teamwork issue more broadly:

“Today, we had an interprofessional team with different levels of experience, a common challenge. Sometimes, the doctor is the expected leader but needs help, and sometimes, nurses with lots of experience aren’t sure how to offer this help. I think this poses a tough challenge for many teams. Let’s see if we can work out some ways to help each other in this context. I would be curious to hear about approaches to this dilemma any of you have seen work?”

Provide an Expert Opinion

After gathering any techniques for communicating in this awkward situation, she could add her expert view to the situation. This view might be based on the evidence base in the literature, her own experience, or both. For example, she could describe theory and best practices such as there are “fault lines” in many professional groups such as between physicians and nurses, and these require practice to traverse.9³,9⁴ She could describe and teach the steps of methods such as developing shared agreements in advance on how we support each other in stressful situations1⁴,9⁵; graded assertiveness; the 2 challenge rule for health care9⁷; the importance of the leader expressing openness to input early and often9⁴; or team organizing principles such as “take 10 seconds to plan for the next 10 minutes.”9⁶

CONCLUSIONS

This article presented a detailed portrait of the “task-versus-relationship” dilemma—how to provide accurate, specific, and timely feedback about task performance without demoralizing learners—and a path to transcend this dilemma. Focusing on the subjective experience—thoughts and feelings—of one debriefer, we have described what creates this dilemma: assuming that learners are fragile and cannot tolerate fair and accurate feedback; assuming it is bad, even a “crime” to make mistakes in simulation; and, in this specific case, assuming team members understand team performance in the same way the instructor does. We show how instructors can resolve the task-versus-relationship dilemma by (1) holding generous inferences about learners—that the learners are resilient and capable and even their mistakes are a reflection of rational, well-meaning intentions; (2) helping learners understand that mistakes in simulation are normal, not a crime; and (3) moving the “heat” of pointed individual critiques to the team level and helping people develop a shared view of how to function as a team.

Simulation programs can develop faculty’s debriefing skills by supporting instructors to analyze their debriefing challenges as this instructor and her peer group colleagues did. The article provides a glimpse into the process and results of a faculty peer group helping a colleague enhance her skills. The instructor (and author) whose case we analyzed says of the process,

“Rather than seeing debriefing ‘train wrecks’ as unfixable and inevitable, I am becoming aware of the patterns I fall into and how my own frames put me there. This actually gives me confidence.”

“I think it is crucial that debriefers know where they get stuck, what conversations they struggle with, where their triggers are. I feel much more prepared when I know I have a couple key moves to get out of trouble.”

This analysis suggests one such set of debriefing “moves.” Based on a case study we think may generalize to other instructors,4⁹,9⁷ we show specific frames and behaviors that can
transform a debriefing strategy with the veneer of non-judgmental kindness into one that genuinely respects the learner’s strengths and weaknesses. This recipe can unlock simulation instructors’ ability to share their expertise directly and humanely.

ACKNOWLEDGMENTS

The authors would like to thank William R. Torbert and Diana MacLean Smith, who introduced them to the methods and spirit of inquiry used in this paper.

REFERENCES


