An auto-ethnographical argosy of the experiences of nursing educators who implemented Mask-Ed™ (KRS Simulation).

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ABSTRACT

Mask-Ed™ (KRS Simulation) hereafter referred to as Mask-Ed is a vivid, realistic, high fidelity simulation modality (McAllister, Reid-Searl, & Davis, 2013; Reid-Searl, 2011; Rhodes & Reid-Searl, 2015) developed out of Reid-Searl’s, desire to better prepare nursing students for the reality of their discipline, in an authentic and meaningful manner (Reid-Searl, 2011). Mask-Ed is when a nurse educator dons silicone props and transforms into a character (Reid-Searl, 2011; Reid-Searl, Happell, Vieth, & Eaton, 2011, 2012; Rhodes et al. 2015). The Mask-Ed character has a socio-medical history that serves as the platform for learning and teaching. The Southern Institute of Technology hosted a Mask-Ed workshop to broaden their repertoire of simulation modalities, and implemented this into the institutes nursing and inter-professional education programmes.

The primary aim of this inquiry was to capture our experiences of implementing the simulation modality of Mask-Ed, and secondly to gain critical insights into these experiences. An auto-ethnographic narrative inquiry enabled us to convey our experiences by using narrative reflexive vignettes. Our thematic analysis resulted in four themes, (1) vulnerability, (2) the art of masking, (3) healthy scepticism, and (4) breaking down silos. This study offers an insight into the implementation of Mask-Ed as an authentic member of the Southern Institute of Technology simulation modalities. The experience by the nursing educators has added to Mask-Ed research, and provided a genesis for further studies.

KEY WORDS

Mask-Ed™ (KRS Simulation); education; simulation; auto-ethnography; vulnerability; nursing education; inter-professional education

FUNDING SOURCES

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

ETHICAL APPROVAL

The Southern Institute of Technology Human Research Ethics Committee (HREC) granted ethical approval November 2014.
BACKGROUND

The foundations for Mask-Ed include three fundamental elements. The Mask-Ed character’s socio-medical history serving as the teaching platform. The hidden educator, through their character directs the learning process through spontaneous engagement with students, and thirdly the educator un-masking and debriefing with the students (Reid-Searl, 2011). The hidden educator (behind silicone props), Reid-Searl (2011) explains, enables a disassociation between the educator and the student, and the reverence of engagement between the character and the student, hence a reduction of power disparity. The masked educator can direct the simulation learning experience and know when to redirect the learning, pause or even cease the simulation. The Southern Institute of Technology hosted the first Mask-Ed workshop in 2014, and became the first New Zealand institute to implement this simulation modality. We received funding to purchase four silicone masks. These did not arrive in New Zealand until later in the year. Therefore, we began our Mask-Ed implementation with latex masks. Our first two Mask-Ed characters were Maddie and Muriel. When our silicone masks arrived, Wallace, Polly, Jools, and Tarquin joined our Mask-Ed characters.

LITERATURE REVIEW

Simulation according to Othman, Rukban, Salah, Abdulmohsen, and Zalabani, (2010) is a generic term that refers to an artificial representation of real-world processes to achieve educational goals through experiential learning. McGaghie, Issenberg, Cohen, Barsuk, and Wayne, (2011) conducted a “comparison of the effectiveness of traditional clinical education towards skill acquisitions goals versus simulation-based medical education (SBME) with deliberate practice (DP)” (p. 706). Their results suggested that a simulation-based medical education with deliberate practice was superior to traditional clinical medical education particularly in clinical skills acquisition goals. The simulated learning environment has provided the architecture to “amplify key learning’s necessary for developing competency in health care contexts” (Brown et al., 2012, p. 179). Simulation mimics, amplifies, and replicates real clinical settings and situations where students assess, use critical and clinical reasoning, make decisions, implement and evaluate care without harm to vulnerable patients (Bond & Spillane, 2002). These reconstructed clinical situations are characterised by the opportunity for the learner to practice health care within a safe environment.
Reid-Searl and Mask-Ed achieved something special beyond simulation via artificial manikins and standardised or simulated patients (Frost & Reid-Searl, 2015). Standardised or simulated patients (trained actors), more often than not, have no medical expertise, and have a prepared script. The scripted nature of the scenario may not allow them to capture teachable moments within the simulation that an educator could. An experienced educator has the capacity and flexibility to recognise and respond to teachable moments (Cleland, Abe, & Rethans, 2009; Reid-Searl, 2011).

There is a relatively minor quantity of literature associated with Mask-Ed, and by far the most influential account is inhabited in the work of Reid-Searl. Almost all research on the topic uses qualitative research methods. Existing enquiry recognises the critical role played by the humanistic silicone props, the socio-medical history, and individualised personalities of the Mask-Ed characters to create an authentic vehicle for teaching, learning, and preparing students for clinical practice (Frost, Foster, & Ranse, 2017; Reid-Searl, Eaton, Vieth, & Happell, 2011; Reid-Searl, Levett-Jones, Cooper, & Happell, 2014). To examine the role of Mask-Ed, McAllister et al. (2013) hypothesised that Mask-Ed succeeds as a learning modality for various reasons, including providing a transformative learning experience for students.

McAllister et al. (2013) discussed the utilisation of drama and applied theatre. Their discussion focused on establishing why the technique of Mask-Ed is effective in students’ learning. McAllister, et al. (2013) suggested that through applied theatre the students hold two worlds in their mind at the same time, the fictional, and the real. In a previous investigation, Reid-Searl, et al. (2012) conducted a qualitative exploratory study that explained that even though students are aware that it is a nurse educator behind the silicone props; they soon forget their presence because of the virility of the props realism. The participants in Reid-Searl, et al. (2012) study verbalised that they interacted with the character, not the educator.

Predominately the studies and discussions pertaining to Mask-Ed focus on nursing students’ experiences. In their qualitative exploratory study Reid-Searl, et al. (2012) highlighted fear and anxiety as being a limiting factor for undergraduate nursing students’ clinical experiences, and emphasised the value of simulated learning experiences to increase confidence. They (Reid-Searl et al. 2012) suggested that most simulation techniques do not always reflect
clinical reality, and concluded from their focus group findings that their participants viewed Mask-Ed as a positive experience, particularly due to its realism. The research pertaining to Mask-Ed has tended to focus on students’ experiences. There remains a significant phase of Mask-Ed, about which relatively little is known. That is the experiences of Mask-Ed educators.

One previous study, Reid-Searl et al. (2014) discussed the implementation of Mask-Ed using reflections of educators using a qualitative descriptive approach. This methodology enabled the participants to share their experiences and is suited to an exploration of the characteristics of the phenomena in question (Denzin, 2014). The findings from their study concluded that Mask-Ed brings a level of realism into the simulation experience. However, they predominantly expressed that Mask-Ed requires mandatory supervised training, preparation, and replication. Our auto-ethnographical inquiry aimed to capture our experiences as educators in implementing Mask-Ed, and secondly to gain critical insights into these experiences. Our research question enquired how the lived experience of educators who implement Mask-Ed contribute to understanding the pedagogy of this simulation modality.

**METHOD**

The nurse educators explored research frameworks, and discovered auto ethnography. Our auto-ethnographic approach used chronological, reflexive narrative vignettes written by the nurse educators. Auto-ethnography is an analytic research methodology focusing on enhancing theoretical understandings of broader social phenomena, and their processes (Denscombe, 2014; Denzin, 2014).

The next part of this research was data collection, we had to decide how the self-reported data would be obtained and collected. The brief discussed was for each nurse educator to write reflexive journals reflecting their experiences to answer our research question; “how the lived experience of educators who implement Mask-Ed contribute to understanding the pedagogy of this simulation modality”.

The self-reporting technique, writing reflexive narratives was given a timeframe of one academic year. The narratives written by each nurse educator were intentional. On a monthly basis, there were collaborative meetings to discuss and analysis our narrative data. Coding
and theme development was directed by the content of the narrative data. Patterns were identified through a rigorous process of data familiarisation and theme development and revision. An inductive thematic analysis, a widely used qualitative data analysis method was used.

During our collaborative meetings there appeared to be many different themes emerging, however what was also evident were the connections between these. An inductive process of looking for broad patterns, and generalisations enabled four themes, (1) Vulnerability, (2) The art of masking, (3) Healthy scepticism, and (4) Breaking down silos to became discernible. We viewed, reviewed, discussed, and checked the themes for the viability of each. The presentation of our results, supported by quotes in italics, in a first person plural voice, is consistent with auto-ethnographical narrative inquiry (Chang, 2008).

RESULTS

Vulnerability

The vulnerability of our Mask-Ed characters (both latex and silicone), and our own vulnerability emerged as a theme.

“I feel vulnerable behind the mask, I am hidden, yet exposing a character, I have to get this right, I am responsible for my character”.

“As I am standing clutching a bleeding tissue and looking lost, I feel defenceless”.

“Polly is vulnerable. I sensed this as I shuffled to the classroom. The students are vulnerable, is this a common feeling we (Polly & I) and the students have, maybe this will help with building our relationship”.

Maddie, created from two Halloween masks, cobbled together with staples and string.

“The mask is gradually deteriorating; I do not know how long this mask will last. I am torn between ending Maddie’s time, and waiting, or buying another mask. However, a new mask would be different; would I have to create another character? I tried superglue, but all that did was make my eyes water”.

While Maddie and Muriel became regular attendees in classes, in the background Jools, Wallace, Polly, and Tarquin were developing. A responsibility to these new characters featured in our vignettes.

“I have decided on the name ‘Tarquin’ for my young 35-year-old character. Tarquin is usually a male name, but Google assures me that females are called this also. I think I want a name that is a little controversial, which is perhaps my way of giving this character a unique personality, perhaps her name adds to her vulnerability, perhaps it protects mine”.

“I see Wallace’s face on the ‘interweb’ as he would call it. I see him, and know he is a gentle giant of an elderly man. He wears a suit jacket most of the time. He is clean but slightly dishevelled; there is a vulnerability about him”.

When we received notification that our silicone masks were on their way, new feelings emerged.

“My dilemma about what do about Maddie has been resolved. I have decided that she will have some complications after her hip surgery, and decide to move to Christchurch to be with her daughter”.

The day the masks arrived was breath taking.

“Jools has arrived; I feel like I need to make a video of Maddie to say goodbye, it is hard to find closure”.

“He (Wallace) is here. When I put the mask on, I am him, I find his voice”.

“Tarquin and Polly are here, they are real, and I am excited”.

Reid-Searl trusted us with her innovation, a responsibility and passion that collectively we respect alongside our own, and our characters’ vulnerability.

**The act of masking**
The act of wearing our masks (latex and silicone) threaded through our vignettes.
“It was incredibly hot being Maddie today, and I did not take a break – big mistake! I was exhausted at the end of the day! Must remember to take breaks, drink plenty of water, and breathe between simulations”.

When our silicone masks arrived, new challenges presented.

“Trying Jools on for the first time was awful! I could not get the mask on. I felt claustrophobic, and frustrated! It took three goes to get the mask on. I just wasn’t used to having to deal with the weight of it, given that she has two pendulous breasts at the front”!

“Tarquin has been here for a few days now, and I am struggling as I develop her character, and make sense of this younger vibrant female. I think I may have to take a few steps back in order to move forward”.

“On paper Polly’s personality, and socio-medical history is written, in reality she is different. I need to let her evolve. There are new pressures with the permanency of the silicone masks”.

These challenges faded as our characters developed. Tarquin introduced a pathophysiology and pharmacology session related to her type one diabetes.

“As I entered the classroom I felt a familiar confidence return. I had transformed, and was now the educator behind the mask as Tarquin shared her story”.

During our training to become authorised Mask-Ed users, we were taught to unmask in front of students to validate the three-way inter-play this teaching pedagogy propositions (Reid-Searl, 2011). However, our challenge was how to do this with the attached breasts on the female masks.

“It would be next too impossible to unmask in front of students as there is no way I would be able to remove the mask without pulling her breasts out of my garment. The masks we used to train did not have attached breasts”.

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“After practising and experimenting I worked out that staying in the room and turning around enabled me to unmask. The students could see what I was doing, but could not see exposed breasts. I think this respects the students, the characters, and myself”.

The reality of being a ‘masked’ nurse educator is inimitable. It is a meticulous and unique metamorphosis. Alongside the vulnerability, the energy and onus to our characters is imperative as maintaining the authenticity of our characters requires substantial physical and mental energy.

**Healthy scepticism**

An underlying scepticism emerged from educational colleagues; we embraced this as it encouraged a deeper consideration of how we were using Mask-Ed. Through collective exposure to collegial nettle, robust and invigorating ponderings emerged.

> “Since the silicone masks have arrived I have noticed an increased polarisation across my colleagues”.

As our confidence incrementally lifted, we became equipped to have professional discussions with colleagues, not in an effort to change their opinions, but rather to develop mutual understandings and respect of different teaching philosophies.

**Breaking down Silos**

The value of using Mask-Ed in our inter-professional education programme was the final theme that stemmed from our vignettes. Traditional education of health professionals occurs in self-contained speciality silos with the assumption of these training paradigms being that collaborative team skills are acquired, during clinical practice (Rhodes, et al. 2016). However, this assumption does potentially leave the development of these critical skills to providence. Our inter-professional education programme developed by Southern Institute of Technology promotes shared learning, and active communication between health disciplines (Rhodes, et al. 2016). The use of Mask-Ed is the foundation of these sessions.

> “From behind Polly, I noticed the nursing, medical, and dietician students working together, learning from each other. They have a shared goal to help Polly”.
The simulated replication of the clinical environment for the purposes of learning from, and with each other enabled the participants to become authentically familiar with clinical situations, while instilling inter-professional values, respect and perspectives. Mask-Ed remains the cornerstone of these sessions due to its clinical realism, and its capacity to form effective learning platforms.

“The opportunity to have health disciplines working together crystallised my philosophy of ‘real not pretend’. Mask-Ed is real, the characters are real, and the assessments and interventions that the students perform are authentic”.

DISCUSSION

The four emergent themes as previously discussed are; (1) Vulnerability, (2) The art of masking, (3) Healthy scepticism, and (4) Breaking down silos. As described these themes were, by necessity, subject to multiple viewings/reviewing and checked against the individual narratives for confirmation of their discrete viability.

**Vulnerability**

To teach, in itself is recognised to be vulnerable (Bullough, 2005). The vulnerability of the educators and their Mask-Ed characters (both latex and silicone) emerged as a theme. Vulnerability has been identified as not at all uncommon and is closely associated with teaching pedagogy. A pedagogy of vulnerability does present a challenge to educators, namely; to be transparent, knowingly expose themselves to critical scrutiny, to make mistakes and to take risks (Brantmeier, 2013). Vulnerability is a means to import the humanistic and clinical grounded reality directly into a learning environment (Frost, et al. 2015; McAllister et al. 2013; Rhodes, et al. 2015). Outside the physicality and immediacy of the clinical environment, it is the closest some students will get to working with an actual health consumer and within the safety the simulation modality. It allows potential clinical mistakes to not be life threatening or career potential ending (Edgecombe, et al. 2013). There was a recognition of the risks to the educators when in Mask-Ed character. There are risks in any study, however the recognition of the human risk of vulnerability enabled the educators to, at least in part, attenuate this through collective collegial support (Gregory & Austin, 2016).
This is consistent with the view that humans perform at a higher level in the presence of collegial support (Capella, Smith, & Philp, 2010).

**The act of masking**

As commented on by Wainscott and Fletcher (2010), the mask is an artefact of power that is dynamic and dependent on circumstance, it is powerful and iconographic. There are minimal, if any, societies anywhere that do not contain evidence of employment of masks in some capacity (Roy, 2015). Simply stated, masks have a role, a place, a value, in all known cultures. Masking can capture moments of humanity, and is well suited to trained utilisation in education (Roy, 2016). The act of masking, and challenges associated with the wearing of our masks (latex and silicone) threaded through the vignettes. The educators commented on the challenges of masking and unmasking and noteworthy is the paucity of literature on the challenges associated with unmasking. The normative genre of de-masking occurs whilst facing away from the audience. Reid-Searl in a moment of inspirational, profound innovation and counterintuitive thought posited a substantially different thesis with the masked educator de-masking facing the audience at the time of debriefing (Frost et al. 2015). Consequently, the educators were early pioneers of the ethos that involves de-masking facing the audience, within an educational context, and hence have stepped into a sparsely occupied verdant territory.

Reid-Searl recognised the challenges of wearing silicone masks within an educational setting (Frost, et al. 2015; Reid-Searl, 2011). The masks authorize educators to become, and to inhabit, characters. As Landy (1985) noted, and as the masked educators found, the silicone and latex masks can be employed as a potent projective technique that does separate one part of self from another. Roy (2015) commented that masking has a largely untapped educational role as a pedagogical tool resident in sponsoring an effective curriculum.

**Healthy scepticism**

This quintet embraced Mask-Ed. It would be prudent to note that the Mask-Ed simulation modality within our institution has critics. All nursing educators have not universally endorsed Mask-Ed. Indeed, it would be quite fair to say a robust scepticism is, evident in several faculty colleagues. This is a healthy attribute and embraced as it encouraged deeper consideration.
**Breaking down Silos**

The fourth and final theme arising from the research was breaking down silos. Mask-Ed is used as a potent component to nurture and promote inter-professional communication within the tripartite inter-Professional education (IPE) programme developed by the Southern Institute of Technology, The University of Otago, and Southland Hospital (Rhodes et al. 2016). IPE pioneers the thesis that learning from, of and with each other within the health professions is a foundational tenet for advancing the narrative of trust and communication and hence reduces the tendency of health disciplines to train and function in relatively self-contained silos (Gregory et al. 2016; Rhodes et al. 2016). IPE advances the notion that the harvesting and subsequent distillation of collective inter-professional wisdom will lead to an innovative and optimal health outcome (Gregory et al. 2016; Rhodes et al. 2016). IPE is currently under relatively widespread international study (Rhodes et al. 2016). Mask-Ed was a foundational component for the development of the IPE programme as the educators’ had anecdotally noted that the quality of the engagement within simulation sessions is replicated in the quality of the intra and inter professional engagement (Awuah- Peasah et al. 2013). It was a sufficiently convincing reason for Mask-Ed being to the fore in the inter-professional education tripartite programme (Rhodes et al. 2016; Rhodes et al. 2015). As noted previously Mask-Ed is a simulation modality that enables students and educators to learn strategies for attending to everyday clinical health challenges (Reid- Searl, 2011), and is an ideal contributor to the breaking down of silos.

**CONCLUSIONS**

The encapsulation of our lived experiences and insights of implementing Mask-Ed, brings to the forefront the vulnerability, and challenges with masking experienced by the educators. These significant findings contribute to understanding the pedagogy of Mask-Ed whilst potentially provide a platform for further exploration to understand what happens to and for educators during the development, immersion, transformation, de-briefing, and de-roling processes. The value of using Mask-Ed in inter-professional education extends Mask-Ed beyond nursing education, and invites other health disciplines to consider this simulation modality in their education programmes. As with any teaching modality, healthy scepticism occurs, which we feel is to be embraced and allows for robust discussions.
Our auto-ethnographic study, made possible only with the help and goodwill of others, primarily the educators, and the students who participated in the Mask-Ed simulation modality experiences. As articulated by Chang (2008), “given that culture is a web of self and others, auto-ethnography is not a study of self alone” (p. 65). The educators concluded that their current position is by no means static, and their teaching progression with Mask-Ed will continue to evolve, and from our experiences, we share these with fellow educators who have, or may consider implementing, Mask-Ed into their teaching. We recommend that future studies should consider:

a. An exploration of the vulnerability that occurs for Mask-Ed educators.

b. An inquiry of the impact of Mask-Ed on students learning. Has this made a difference to their clinical practice, and patient outcomes?

c. An evaluation of the students’ perceptions of inter-professional education. Has this made a difference to their clinical practice, and patient outcomes?
REFERENCES


