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Review Article

Exploring Suspension of Disbelief During Simulation-Based Learning

Virginia C. Muckler, DNP, CRNA, CHSE*

Duke University School of Nursing, Nurse Anesthesia Program, Durham, NC 27710, USA

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suspension of disbelief;
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fiction contract

Abstract: Rooted in aviation and used consistently in the training and preparation of health care professionals for decades, simulation is an innovative teaching strategy that facilitates experiential learning in a safe learning environment. Effective simulation hinges on the ability of the learner to suspend disbelief. Participants must accept the otherwise unrealistic aspects of clinical simulation, and yet the concept of suspension of disbelief has not been fully explored in the field of nursing. What allows some simulation participants to fully believe or immerse themselves in simulation while others struggle to “pretend”? What are the determinants of a participants’ ability to suspend disbelief during simulation-based learning activities? Factors that contribute to the learner’s ability to suspend disbelief include fidelity, psychological safety, emotional buy-in, the fiction contract, and how learners assign meaning. Various other factors that enable or impede one’s ability to immerse in simulation are considered yet need further exploration.

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Rooted in aviation and used consistently to train health care professionals for decades, simulation has been shown to enhance clinical performance in health care settings (Meyer, Connors, & Gajewski, 2011; Singh et al., 2015; Zhang, Cheng, Xu, Luo, & Yang, 2015). Participants and facilitators believe that simulation is an innovative teaching strategy that facilitates hands-on learning and leads to the development of clinical competence and increased confidence levels before the initiation of direct patient care (Brydges, Nair, Ma, Shanks, & Hatala, 2012; Hayden, Smiley, Alexander, Kardong-Edgren, & Jeffries, 2014; La-teef, 2010; McCaughey & Traynor, 2010). One contributing

factor toward effective simulation is the suspension of disbelief (SOD) or the ability of participants to believe the unbelievable and resist judgment of the simulation’s authenticity—the cognitive act of accepting an imposter (simulation) as genuine (clinical). The concept of suspending disbelief applies to many genres such as literature, movies, simulation, psychology, technology, video games, animation, magic, and fairy tales (Duffy & Zawieska, 2012; Ferri, 2007; Holland, 2009; Rudolph, Simon, & Raemer, 2007; Serby, 2011), yet the SOD as it applies to health care simulation, is not well understood (Table 1).

The concept of SOD originated in 1817. From Samuel Taylor Coleridge, a poet and philosopher who during the romantic period, believed that readers would suspend their doubt and accept the unimaginable if the writer’s work

* Corresponding author: chris.muckler@duke.edu (V. C. Muckler).

resembled truth or reality (Chandler & Munday, 2014; Coleridge, 1817). While Coleridge identified that SOD allowed readers to enjoy a work of fiction, clinical simulation methods ask participants to suspend disbelief to become so engrossed that they are convinced the simulation is real.

Clinical simulation participants are encouraged to accept the unrealistic aspects of simulation as the means to an end. Despite recent evidence illuminating the benefits of simulation and the positive impact it has on participants' ability to achieve learning outcomes, SOD is not well studied in the clinical context. What allow some simulation participants to fully believe or immerse themselves while others struggle to "pretend"? If the potential barrier to learner engagement and immersion in simulation is the learner's ability to suspend disbelief (Adamson, 2015; McCaughey &

should be made available during the simulation such as multimedia displays for vital signs, documentation, and medical history to increase the realism of the simulation experience (Cheng, Duff, Grant, Kisson, & Grant, 2007).

The ambiguous concept of fidelity has been discussed for >50 years (Hays, 1980; Rehmann, 1995) as an expansive number of categories have emerged. Functional fidelity refers to the realistic responsiveness of the simulator. This type of fidelity is demonstrated by improvement of the manikin's lung sounds following chest physical therapy, administration of albuterol, and endotracheal tube suctioning. Psychological fidelity is "the degree to which the trainee perceives the simulation to be a believable surrogate for the trained task" (Beaubien & Baker, 2004, p. i52) and differs from SOD. The degree of psychological fidelity created by the facilitator affects the participant's ability to suspend disbelief, yet the onus of psychological fidelity lies with the facilitator who aims to create a believable environment. The onus of SOD lies with the participant and his ability and willingness to believe. According to Gillman, Widder, Blaivas, & Karakitsos (2016), psychological fidelity ignites emotion in participants and is perhaps the most important type of fidelity. The participant acting as the recorder in a simulated code situation, for example, experiences tachycardia, anxiety, and a sense of dread or doom. The stress of the situation is real for the recorder, who is visibly perspiring.

Traynor, 2010; Mills, Wu, Williams, King, & Dobson, 2013; Smith, 2014), what determines a participant's ability to suspend disbelief during simulation-based learning activities?

Suspension of Disbelief Determinants

Fidelity

Aspects of SOD overlap with aspects of fidelity. This altered reality or degree of realism is optimized by the physical, functional, and psychological fidelity of the simulation. Physical fidelity encompasses the equipment, supplies, sounds, staff, and setting in which the scenario might actually occur (i.e., suction is available and on following nasogastric tube placement or when a Certified Registered Nurse Anesthetist responds to a call for an emergency intubation; a noninvasive blood pressure cuff is available in the triage area of the simulated emergency department; an audible alarm sounds when the patient's pulse oximetry decreases to 80%). Participants need to be well oriented to the capabilities and limitations of the simulated environment if they are to fully engage in the learning experience. The room design should be similar to the work environment of the hospital. The equipment should be familiar to the participant, and any deficiencies from reality should be introduced during the prebrief (Page-Cuttrara, 2014; Rudolph, Raemer, & Simon, 2014). Appropriate resources

With references dating to 1962, the U.S. Army Research Institute for the Behavioral and Social Sciences reviewed various types of fidelity including equipment, environmental, psychological, and behavioral fidelity with obscure definitions (Hays, 1980). This report also suggests that the degree of fidelity influences the way the simulation is accepted and recognizes that some participants sense and perceive the simulation differently. What are these sensory and perceptual differences and what influences these differences? Do these differences affect the participant's ability to suspend disbelief?

Wilson and Wittmann-Price (2015) believe that SOD during simulation is vital in order for the participant to maximize learning and knowledge retention. They also believe that it is the simulation facilitator's responsibility to determine and implement the most effective techniques to ensure physical and functional fidelity for participant immersion in simulation. However, SOD, as part of psychological fidelity,

Key Points

- The ability to suspend disbelief leads the participant to further immerse and engage in simulation activities.
- Suspension of disbelief is affected by aspects of fidelity, emotional buy-in, and how learners assign meaning.
- Participants formulate opinions and assign meaning to simulation activities based on individual factors.

Table 1 Determinants of a Learner's Ability to Suspend Disbelief During Simulation-Based Education

Determinants	
Fidelity	Attitudes
Fiction contract	Previous learning experiences
Psychological safety	Feelings of presence
Emotional buy-in	Personality differences
Assigned meaning	Imagination

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