

## Questions from March 24 Journal Club with Responses

1. Are adjunct faculty also classified as clinical preceptors? Would you consider a similar study with clinical preceptors?

**Response:** Great question! It may depend on the profession, and the individual state in terms of how the regulations read. For this study, adjuncts were defined, in nursing, as part-time, paid faculty, who were clinical experts, normally involved in their own practice, but who taught part time for the school/college of nursing. As for medicine, the same, although I'm less certain of the pay structure. In nursing, preceptors are defined differently and separately from adjuncts: prelicensure preceptors are not generally paid, and are not a part of the teaching staff/faculty of the school/college of nursing. Preceptors remain a part of the hospital/clinical facility staff, but are permitted to work directly with students under specific circumstances. At least, that's how Ohio regulations read. So no – adjunct faculty, and clinical preceptors, were not the same thing for the purposes of this study.

2. Did you explore with the faculty members how they helped students really process or deal with the incivility, particularly across professions? Wonder how/if it could be a teaching moment somehow.

**Response:** Yes! That is a great question. I found that fascinating as well, and every faculty who mentioned incivility spoke about the experiences at some length, including how they; 1) helped students become more skilled in ways to handle future interactions; and 2) debrief and make meaning. Ways faculty dealt with moments of incivility depended on whether the student had been victimized, or students had been witness to an uncivil “moment” between two professionals in the clinical setting. If the former, faculty intervened where they could, then further processed with the student, and sometimes an entire clinical group, following resolution of the incident. Sometimes the incidents were reported to faculty after the fact, without information about who had victimized the student, so using the situation as a learning moment took on a different look. Some faculty even used role play in clinical groups to help students “practice” for future situations. In most facilities, there was zero tolerance for uncivil behavior, but when it did happen, it was dramatic enough that faculty spent some time talking about it with me.

3. How did faculty match up year in program across medical and nursing students -- are M2s well matched with N2s, for example?

**Response:** That's a great question! The match was very difficult – and that is spoken to (briefly) in the article re: the differences between maturity and mastery. Faculty found that, while med students may be more mature as students (& re: life experiences – generally an older group), nursing students begin integrating clinical experiences with theory much earlier. Where this was most apparent was in high-def simulation. So, for example, junior nursing students would know

exactly what to do with the IVs, the meds, but the med students who were, for example, at the beginning of their 3<sup>rd</sup> year and new to clinical rotations, may not “be there” yet. So faculty were careful to either fully brief both groups prior to the simulations, or work with the simulation scripts beforehand to level the playing fields. Faculty found table-top experiences were easier to match up. They were less authentic, but material could be new to both groups, e.g. QI/root cause analysis, etc.

4. Were any of the programs evaluating students' overall pre and post skills or attitudes and were your faculty aware of this?

**Response:** Yes. Most were gathering data, in one way or another. I noted that one research site published a study not long after I visited. Their identity is protected, or I'd share – it was a very nice article!

5. Thank you for this very interesting topic and presentation. Can you tell us how did your start the focus group analysis, what would be the best strategy

Response: Sure! And thank you. Actually, there was no focus group. These were 32 individual semi-structured interviews. So, I had 32 separate transcripts to analyze. NVivo (the qualitative software) was invaluable to the process. I just began reading – I had the transcripts organized by institution, then by profession, so I began with all nursing from program #1 first, then went to all medicine from the same program, and so on. I looked for conversations that responded to the research purpose and questions, named each one (e.g., if the conversation looked like “mentoring,” that's what I named that theme, or in NVivo language, “node”). I would create the new node, then highlight, drag, and drop that conversation into the node. NVivo recalls the source – so I could identify the transcript from which that particular conversation originated. I created new nodes for every new theme I identified in each transcript, then went on to the next transcript. After I'd done that for all 32 transcripts, I went back and did it again – 2 more times. As I did that, I saw that some themes were too finely defined, and merged well into one theme – so NVivo allows you to merge nodes into one. All the data is retained, but it all then goes into one node. If I hadn't done that, I would have had almost double the number of sub-themes.

I was also fortunate to have a wonderful advisor and co-author, Dr. Ada Demb, with whom I was able to have conversations about this process, and also a peer-reviewer (same thing – conversations about the sense of combining nodes, for example).

6. Where is your research going next?

**Response:** Thanks for asking that question! First, the data I already have is begging for a secondary analysis with regards to organizational change, so that's the next step. Also, we are

doing quite a bit at Ohio State, both in my own College of Nursing (we cooperate in interprofessional simulation with a variety of the health professions), and across the entire academic medical center (we have had two large events, drawing 850 – 900 students and enough faculty facilitators to handle groups of 10 – 20 students in the small groups). I'm working now with the leadership group that designed these orientation/follow-up IPE events to plan next steps.

7. Have you thought about extending targeting other health professions?

**Response:** Yes! I had thought about it right from the outset, and had hoped to include pharmacy along with medicine and nursing – and extending this to other health professions as well would only make the findings richer. However, the study would have been enormous, particularly for an unfunded doctoral dissertation. A sample size of 32 is essentially a double sample for this kind of qualitative study. So, as much as I would like to do that, I would need to seek funding that would allow the time to make that happen. Thanks for asking that question!