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# More than just teaching procedural skills: How RN clinical tutors contribute to medical students' professional identity development

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## More than just teaching procedural skills: How RN clinical tutors perceive they contribute to medical students' professional identity development

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### RESEARCH

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### ABSTRACT

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#### Background

On their journey to “becoming” doctors, medical students encounter a range of health professionals who contribute to their socialisation into clinical practice. Amongst these individuals are registered nurses (RNs) in clinical practice who are often employed by medical schools as clinical tutors. These RNs will encounter medical students on campus and later in the clinical setting.

#### Aims

This qualitative study explored RNs' perceptions of their contribution to medical students' developing professional identities in order to provide a greater understanding of this process and ultimately inform future curriculum.

#### Methods

This qualitative study took place in 2012 at one Australian medical school as part of a broader study exploring medical students' professional identity development from the perspectives of their teachers and trainers. Eight of the nine RNs involved in teaching procedural skills were interviewed.

Recorded interviews were transcribed verbatim. Data were analysed inductively by the research team.

#### Results

Two major themes emerged: RNs as *change agents* and RNs as *facilitators of medical students' transition to the clinical environment*. RNs as change agents related to their role modelling good practice, being patient-centred, and by emphasising factors contributing to good teamwork such as recognising and respecting individual professional roles. They facilitated students' transition to the clinical environment often through personal narratives, by offering advice on how to behave and work with members of the healthcare team, and by being a point of contact in the hospital.

#### Conclusion

Based on their descriptions of how they role modelled good practice and how they facilitated students' transition to clinical practice, we believe that RN clinical tutors do have the experience and expertise in clinical practice and a professional approach to patients to contribute to medical students' developing professional identities as future doctors.

#### Key Words

Medical students, registered nurses, professional identity development

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#### What this study adds:

##### 1. What is known about this subject?

Medical professional identity development has largely been described from students' perspectives. Little is known, however, about how others perceive this happens or the contributions of the various teachers and trainers with whom medical students interact.

##### 2. What new information is offered in this study?

This qualitative study adds to our current understanding of medical students' professional identity formation by bringing to light the ways in which a group of RNs employed

as clinical tutors at one Australian medical school believe they contribute to students' developing identities as future doctors.

### 3. What are the implications for research, policy, or practice?

This study suggests that RNs can potentially contribute to medical students' developing professional identities as doctors—e.g., by changing attitudes and practice through role modelling professionalism and patient-centredness, and assisting students transitioning to the clinical workplace. Accordingly, medical educators should capitalise on RNs' expertise, experience, and willingness.

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## Background

The process of “becoming” a professional involves developing an appropriate identity. Professional identity development has been defined as a socialisation process in which an individual internalises the “culture” of the profession as he/she transitions from learning about the profession to doing what is expected in the role.<sup>1–3</sup> As an individual's professional identity is a set of attributes, beliefs, values, motives, and experiences by which he/she will define him/herself within the profession,<sup>4</sup> the formation of this identity is complex (influenced by a number of factors) and dynamic (changes over time). The development of a professional identity is thus socially constructed through interactions with individuals or groups within (e.g., clinical role models) and outside (e.g., having a parent who is a health professional) the learning context.<sup>1,5,6</sup>

Of particular importance in this regard are the broader constituent factors relating to perceived strengths of group membership and in-group-defining elements that have been explained by theories relating to social identity (i.e., a person's sense of who they are, based on their group membership) and self-categorisation (i.e., circumstances under which a person will perceive collections of people, including themselves, as a group).<sup>7,8</sup> More specifically, these theories assert that there are sets of practices (e.g., discourses, gestures, and implicit associations) that are assigned to individuals and groups of people. When considering these theoretical perspectives, it becomes apparent that individuals develop two principal identities: a personal self and a collective self. This collective self, or social identity, reflects the extent to which individuals feel committed to a specific group as well as the status and characteristics of this group relative to other social categories. Such a position is particularly relevant in health care given the increasing networks of clinical specialities and professional groups where different factors may impact

professional identity formation in various health professions such as nursing<sup>9</sup> and medicine.<sup>10</sup>

In medicine, the need to better understand how professional identities develop is related, in part, to identifying ways of reducing adverse patient events, which Weller et al. believe are linked to power imbalances in the healthcare team, poor interprofessional communication, and inadequate teamwork skills.<sup>11</sup> As health care today invariably involves a multidisciplinary approach, it makes sense that during training, medical students engage with a range of healthcare professionals so that they understand and respect different scopes of practice. In line with this, a number of medical schools now include interprofessional experiences with, for example, nurses, physiotherapists, and social workers.<sup>12,13</sup> At Bond University, registered nurses (RNs) are employed as clinical tutors, helping pre-clinical medical students develop the procedural skills they require for hospitals and the wider healthcare setting. As many of these RN tutors work in the hospitals where students undertake their clinical rotations, interactions between students and these RNs are often longitudinal. These RNs are thus in an ideal position to not only comment on the evolving professional identities of our medical students, but can contribute to their socialisation into a world of patients and health care.

With the extant literature describing the formation of professional identities from medical students' perspectives,<sup>10,14</sup> we designed a broad, exploratory qualitative study to canvas the perspectives of different groups of teachers and trainers at one Australian medical school. The research being reported is in response to the following research question: How do RNs, as clinical skills tutors, perceive they contribute to medical students' professional identity formation?

## Method

### Study setting

Bond University is a not-for-profit, private institution in Australia that offers a compressed, tri-semester (four years eight months) undergraduate medical programme. Years 1–3 (eight semesters) comprise the pre-clinical phase (on campus), while in Years 4 and 5 students undertake clinical rotations. The annual intake is ± 92, the majority being Australian residents or citizens. Students range in age from 17 to more than 45 years, with approximately one-quarter of each intake comprising individuals with prior learning (e.g., 1–2 years of tertiary education; a degree), often in a health profession (e.g., pharmacy, nursing, physiotherapy), or in the biomedical sciences.

## Participants

RN clinical tutors in Bond University's medical programme are responsible for teaching a range of procedural skills (semesters 1–8) outlined in the Australian Junior Doctor Framework.<sup>15</sup> These skills include: medication administration, urethral catheterisation, and performing and interpreting an ECG. In addition, these RNs also serve as Objective Structured Clinical Examination (OSCE) examiners across the medical programme.

After obtaining ethical approval for the study, the principal investigator (PI: MM) contacted the nine RNs employed as clinical tutors in the Bond University medical programme. All potential RN participants were provided with an information sheet and consent form before being contacted by email to schedule interviews. They were informed that the interviews would be audio-recorded, conducted in a private and suitable location, and were also assured that transcripts would be de-identified before being read by members of the research team.

Eight of the nine RNs (89 per cent: seven females, one male) agreed to participate. Two RNs chose to be interviewed together. RNs ranged in age from 35 to their early 50s and had worked at the University for 3–5 years. All had post-graduate qualifications in specialist nursing (e.g., intensive care) and most had undertaken additional research and/or education training. All RNs were currently employed in clinical practice in local hospitals, with a number also teaching at other medical or nursing schools. They were not paid for participating in the research.

## Interviews

Seven audio-recorded, semi-structured interviews ( $\pm 1$  hour) with the eight RN participants (one pair interviewed) were conducted by the PI in late 2012. The main research question, "What role do you play in medical students' professional identity development as doctors?", also allowed the interviewer to identify RNs' views on positive and negative influences of professional identity formation. This was explored through open-ended questions to provide a rich, contextual account of and explanation for their responses to the main research question. Interviews were transcribed verbatim by a professional transcribing service and de-identified prior to analysis by the research team.

## Transcript analysis

The four members of the research team analysed the data inductively using template analysis.<sup>16</sup> In this approach, each member individually read two transcripts, generating a list of ideas and concepts, which they then grouped into

preliminary descriptive codes and categories. Codes were defined as initial notes made by each reader, which were then grouped into headings to provide provisional themes. The team then met to review and cross check this preliminary analysis and to consolidate the findings into final themes and subthemes. After considerable discussion, agreement was reached in terms of the representation of participants' views within the themes and subthemes. The team was also confident that sufficient data had been collected based on the level of saturation yielded by the analysis process; i.e., no new themes or descriptive categories emerged after the transcripts were read for the final time.

Quality in terms of data collection was ensured by the PI claiming no authority over the RNs as University employees. In fact, until the interviews, the PI had not met any of the participants. To enhance the quality of the research process throughout the data collection, analysis, and interpretation, members of the research team adopted a reflexive stance. Reflexivity is defined as a means "to explore the ways in which a researcher's involvement with a particular study influences, acts upon and informs such research."<sup>17</sup> With backgrounds in nursing, education, and psychology, members of the research team acknowledged that they may have been drawn to or paid less attention to certain aspects of the data depending on their prior knowledge and experience. This meant that each acknowledged and reflected upon the potential influences of her personal and academic experiences with terms of how she might personally have interpreted the data. For example, one of the team members was potentially drawn to emotional and behavioural aspects described in the data extracts on the basis of academic work as a psychologist. Two researchers were academic RNs and therefore discussed their own work experiences in terms of the data. These open discussions ensured that focus was not drawn to areas of personal interest at the expense of overlooking other aspects of relevance in the data.

## Results

Two broad themes emerged from the data analysis: RNs as *change agents* and RNs as *facilitators of medical students' transition to the clinical environment*. Verbatim quotes reflecting these two main themes and subthemes are provided in Tables 1 and 2, respectively.

During data analysis and discussions, it became apparent that RNs viewed themselves as part of the larger nursing community of practice ("We" rather than "I"), identifying strongly with their own profession and with well-defined

professional identities. As they collectively had many years of leadership in their clinical roles, they espoused high standards in terms of teamwork, patient-centredness, and ethical and caring practice, and consciously strove to instil these attributes and practices in students during their teaching. The RNs also drew on their personal experiences in clinical practice to offer medical students advice on dealing with the reality of contemporary healthcare practice.

### **Theme 1: RNs as change agents**

Our perceptions of RNs as change agents stemmed largely from their collective expertise and extensive experience in an ever-changing clinical environment and their aim to imbue students with the requisite knowledge, skills, and attitudes that they considered paramount as safe, competent, and caring practitioners (Table 1). Behaviours, approaches, and attitudes that were identified as reflecting RNs as change agents included their perception of themselves as professionals who role modelled good practice by keeping up to date (e.g., through continuing professional development) and by being patient-centred. Being in clinical practice with considerable responsibility (e.g., overseeing busy intensive care and surgical units), these RNs expressed high moral standards in terms of patient care and how it should be delivered. As they had witnessed the impact of substandard healthcare practices while working, they were fastidious about procedures such as hand washing and the riskiness of shortcuts, deliberately emphasising this in their teaching.

RNs' descriptions of their patient-centredness, in which safety and holistic care were priorities, reflected their desire to influence students' views, attitudes, and behaviour. They described themselves as empathetic and compassionate with good interpersonal skills, which, in their opinion, were not unique to the nursing community. These were qualities and skills required of all health professionals.

RNs also placed considerable emphasis on what they imparted to medical students in terms of the value of teamwork in which doctors and nurses (and other health professionals) have complementary roles. They also saw their role to challenge preconceptions about nurses and doctors in the team, highlighting again their status as change agents.

### **Theme 2: RNs as facilitators of medical students' transition to the clinical environment**

The second theme related to how RNs perceived they facilitated medical students' transition to the complex and

challenging world of clinical practice (Table 2). As they were all currently working in clinical practice at the hospitals where students train, they also saw themselves as ports-of-call and familiar faces for students new to the clinical setting. On occasion, they also acted as student advocates.

RNs facilitated students' transition from a conceptual world to a more realistic one through their narratives about their experiences, often with the use of humour. They drew heavily on their personal (which many described as tough) socialisation into the clinical environment, as well as that of relatives or colleagues who were currently studying or had studied medicine or from having witnessed first-hand what can happen to some medical students on the wards for the first time. RNs thus offered medical students advice on how to "get by" in the clinical environment. Mostly, this was about professional behaviour, which included respecting members of the clinical team, dressing appropriately, being punctual, and making a good first impression with members of the clinical team and with patients.

### **Discussion**

From the time medical students begin their studies and throughout their training, various stakeholders (i.e., teachers, trainers, patients, broader society) have expectations of what they should know, be able to do, and how they should behave. In all probability, however, many of the young, school-leaving students entering medicine, particularly in undergraduate programmes, will generally have limited experiences of life, responsibility, and illness, and so their world of medicine is largely conceptual. As they journey through their studies, learning about the scientific basis of medicine and doing the things expected of doctors, they will hopefully develop a sense of what it means to be a doctor.<sup>1,2,3,6,10</sup>

During training, medical students will encounter individuals from a range of health professions, all of whom will in some way contribute to developing their identities as future doctors. In this study, the RNs responsible for procedural skills training articulated how, by role modelling good practice, and through their experiences, their up-to-date knowledge and expert skills, their caring and compassionate natures and their patient-centred focus, they can facilitate students' transition to clinical practice. They believed that they are able to enrich medical students' conceptual understanding of clinical practice through their narratives of the real world of patients, medicine, and the wider healthcare arena. Their stories, which are often based on their personal and often difficult journeys into clinical practice, thus not only offered students a realistic window

of what lay ahead as practitioners, but also sought to imbue in students those qualities RNs considered essential to be a safe, competent, and caring practitioner.

According to Goldie,<sup>1</sup> identity formation is largely social and relational in nature, influenced more by the informal or hidden curriculum<sup>18</sup> than through formal teaching experiences. In our study, the RNs who themselves exhibited a strong sense of social identity<sup>7,8</sup> often using “we” rather than “I”, exemplified this social and relational nature of identity development through their reinforcement of the positive aspects of the informal curriculum through narratives, role modelling, and nurture. With the limited life experiences of many younger students, RNs, through their accounts of what awaits students in clinical practice and through the advice they offered, followed by being available on the wards, can facilitate students’ often stressful and anxious transition to clinical practice.<sup>19</sup> Factors that have been cited as easing students’ transition, e.g., understanding their future role, developing the requisite technical skills,<sup>20</sup> feeling like part of the tribe or team,<sup>21</sup> and professional inclusivity,<sup>21</sup> have all been articulated by the RNs in the present study.

Historically, the relationship between doctors and nurses has been tumultuous, due, in part, to different and evolving professional roles, which has led to negative stereotypes and poor interprofessional communication practices.<sup>11,22</sup> Based on their narratives, the RNs in this study can be viewed as change agents through their positive role modelling, patient-centredness, and by facilitating a culture of teamwork in which the contribution of all healthcare professionals is recognised and appreciated. Incorporating interprofessional experiences into the formal curriculum, such as “a patient’s journey” described by Johnson et al.<sup>23</sup> serves to increase students’ awareness of the complementary and collaborative roles in multiprofessional teams.<sup>22</sup>

## Conclusion

As the RNs in this study had a strong sense of professional identity themselves, this could arguably be seen as contingent upon their perceived influence of shaping professional identities in related but different professions. Despite the aforementioned negative stereotypes and assumptions often cited in research about interprofessional relationships within healthcare systems, that RNs positioned themselves as playing a pivotal contributory role in the professional identity development of medical students, is a positive outcome of this study. We do acknowledge, however, that the views presented in this paper reflect

eight RNs at one Australian medical school and may thus be influenced by context. Moreover, student responses as reported by the RNs may also be influenced by a real or perceived power differential, where the student sees the RN as the teacher who examines and provides feedback on student performance. Notwithstanding this, in the light of the study being one of the first to explore professional identity development from teachers’ and trainers’ perceptions, we believe that viewing students’ journeys through a different lens offers a new perspective.

Through their narratives, storytelling, and through their explicit concern for patient-centredness, these RNs have contributed to the “hidden” curriculum,<sup>18</sup> not in the traditional, negative way in which it has often been described, but in terms of good practice (e.g., patient safety) and in terms easing medical students’ transition to clinical practice. As medical educators, we should capitalise on RNs’ willingness to be part of medical students’ development to becoming safe and caring doctors.

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### PEER REVIEW

Not commissioned. Externally peer reviewed.

### CONFLICTS OF INTEREST

The authors declare that they have no competing interests.

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### ETHICS COMMITTEE APPROVAL

Ethics approval was obtained from Bond University's Human Research Ethics Committee. Approval number RO1537.

**Table 1: Theme 1: RNs as change agents**

Subtheme	Associated Quotations
<p><b>Role-modelling in terms of</b></p> <ul style="list-style-type: none"> <li>• Continuing professional development</li> <li>• Being professional in the role</li> </ul>	<p><i>We make an effort to be well qualified and stay qualified. Even for myself, I go on advanced life support refresher courses. We keep continuously learning as well. We feel that we can teach this with confidence because we have that certificate that we've done in our own time, to come and be ready to teach these students....My aim is to teach them a really high standard of good practice. [RN5]</i></p> <p><i>We keep up-to-date with all the latest research on what we're teaching that's out there. Like ALS, our guidelines have changed so we have to keep up to date. We're reading all the time, doing courses, going to conferences. There are a lot of things I did extra for the teaching. [RN4]</i></p> <p><i>I think we help them overcome that uncomfortableness [e.g. with touching SPs (Standardised Patients)] by keeping it professional and reminding them that they're in a professional setting. Even the new ones, when they have to take a respiratory rate on a female SP, they are very uncomfortable with having to watch and count for chest rise and fall. And, so being able to help them take that from ... it's not something that is personal and creepy watching a woman's chest. This is a professional assessment of somebody's physiology. Just helping them make that shift in their mind helps them overcome some of those cultural things that make them so uncomfortable. [RN2]</i></p>
<p><b>Being patient-centred: A holistic, empathic and compassionate approach to care</b></p>	<p><i>It's very different being able to put an IDC [Indwelling Urinary Catheter] into a dummy than it is to a very unsure, 80 year old frail lady who doesn't really want to have it done at all. So there's that element of it and I always try to impress that on the students. It's not easy to do it on a dummy but it's even harder to put a cannula into a squirming five-year-old who is in pain and feels sick. I think they do appreciate that, "Yeah, there is a difference", so "Yes, I've got the technical skill but I need to learn to do the technical skill under the pressure of communicating, placating, calming, reassuring a patient at the same time". [RN7]</i></p> <p><i>The reason I still do it is still the reason I started when I was 17 realistically, and that's to look after people and to do it to the best of my ability. I just feel I can bring that to them... Compassion. I certainly hope that that is an underlying fact of why they [students] want to be there because in some cases that's all we can offer. We can have the best technology we've got but if we haven't got the compassion to even care for the dying people then there's nothing left for either of our professions really or the whole team. So I try to bring, not just the human trait, the human element, the human part of 'I'm a human, you're a human'. We all flounder. I try to throw in little stories. [RN6]</i></p> <p><i>I give them a lot in terms of helping them understand that they have an effect on a person, an SP or a mannequin or whatever. .... Yesterday, we did a scenario where we were only using a mannequin but the mannequin was a patient who was in their 50s who had pancreatic cancer. So, they're focussing on the task of 'I just have to do this to the dummy'. But, it's not that, you know. This is somebody who's still fairly young and they've got a potentially terminal illness. They've got to have this procedure done that means they're not going to be able to ... they can't eat, they can't enjoy the taste of food, they can't enjoy the satisfaction of having a meal. So, I think as a nurse in those times, we're giving them that well rounded picture of what it means ... this procedure itself is five steps. You can tick the boxes and, sure, you can do the procedure. But, it's far more than that when you're doing it to a person... it impacts on them, their life, their family, how they feel about themselves, how they feel about their future. [RN2]</i></p> <p><i>And safety, I think we teach them a lot to do with patient safety as well as that communication, which in the real world is actually a huge topic and a huge push. So, it's relevant, it's not just our own personal ideals. Patient safety is extremely important. [RN2]</i></p>

**Table 1: Theme 1: RNs as change agents (cont'd)**

Subtheme	Associated Quotations
	<p><i>With the simulation like what we've done today, we're giving scenarios of what's actually happened in the hospital environment. I think simulation is a really good method for students to gain their confidence. One student said today "I'm glad we made that mistake here today, giving a milligram of adrenaline to a baby and not in the hospital environment in ED". I said "Go make all the mistakes you can here and learn by it, rather than going into the hospital environment and doing something wrong there". [RN4]</i></p> <p><i>To be safe, knowledgeable and experienced doctors when they go out of here. You can never know everything but at least if the basics are there and you know that they are going to do this skill when they come to emergency, they'll do it correctly without endangering the patient. If I can achieve that, then I feel that we've achieved a lot. [RN5]</i></p>
<p><b>Emphasising team work through:</b></p> <ul style="list-style-type: none"> <li>• Articulating different roles and scope of practice of doctors and nurses</li> <li>• Respect for individual roles</li> <li>• Improving the relationship between doctors (including medical students) and nurses</li> </ul>	<p><i>Where there's a more advanced skill, we never claim. Like a lumbar puncture, we never claim that we do it. We tell them "Nurses never do this". They [students] would maybe even not do it. It would be the consultant or under the guidance of the consultant. With the lumbar puncture, we teach them the basics. We don't claim to do the skill because in practice we don't. In suturing, we work with [a doctor] and it's always nurses with him so he teaches suturing and we support. I feel like we're very careful not to overstep the boundary. [RN5]</i></p> <p><i>I like the idea of bringing together it's a team. The teamwork. And even though we are a team, we are different. I mean I'm a registered nurse and there will be registrars and interns. So there's a difference in the profession. But I think if we have a mutual respect. [RN6]</i></p> <p><i>From my experience being a nurse on the wards, it can be a rough ride. If you're [the medical student] clashing with the nursing staff, your socialisation could be a rough ride. Because you rely on them so much at the beginning. And it makes you then think what type of enculturation do those residents get when they become registrars and think about nurses. So you can get this adversarial relationship that runs through. And I have seen that, where you have residents who have an adversarial relationship with the nursing staff and become registrars, and they still have the same adversarial ... because that's the way in which it was enculturated at the beginning. So I think that weighs sometimes heavily on me, the need to give some form of advice to the students to say "Look, if you said or behaved in that way on the ward, this is how the people around you would see you, primarily the nursing staff, and you would find that you could end up word of mouth, giving you pre-warning about you on the next ward you go visit". And you don't want that to be a negative connotation. [RN8]</i></p>

**Table 2: Theme 2: RNs as facilitators of medical students' transition to the clinical environment**

Subtheme	Associated Quotations
<p><b>Offering advice on:</b></p> <ul style="list-style-type: none"> <li>• Professional behaviour and expectations</li> <li>• How to work with others including doctors, nurses and patients</li> <li>• Students' performance</li> </ul>	<p><i>So I will say to them [the quiet ones], "Make sure you're thorough and think about things as well". Just to give them the heads up. Because they will be asked to present it and they will be presenting it in front of that whole group in ward rounds ... and I sort of say unfortunately, but some of our consultants can be a little bit intimidating...I said "One, never be late and dress appropriately because that just ... the short skirts and the high heels have to go because you're a professional". [RN6]</i></p> <p><i>I said "Whether you're a doctor or not, they [patients] don't necessarily agree with you, and you have to figure your way around to get them to do something that they don't really want to do". I mean it is hard because it is a scenario but you'll get the set ones that will raise their eyes, and I said "As soon as you raise your eyes like that, that patient's going to not do it at all. You have to keep that all inside". [RN6]</i></p> <p><i>You're walking into an environment where people have so much more experience over you. Some will lord it over you. How do you get your foothold? And so when I teach, I sit there sometimes and think "How do I make that easier?" Whether I give them cues to say "How do I get involved with these other people so that the transition from here is easier. So how do I make this transaction with nurses? How do I make sure that the nurses appreciate me and I appreciate the nurses, so that I can get the things that I need done without the rudimentary 3:00 o'clock in the morning phone call for Panadol?" "So how do I get myself on the good side of these people who literally run the ward?". [RN8]</i></p> <p><i>Doing their A&amp;E training... the consultant might be in 'til 5 o'clock and leaves, but they start at 8 o'clock at night. ....Their first 12-hour shift, they're being realistically guided by the nurses at the bedside as to what is the routine, what happens and that sort of thing. So, not that we ... I mean I can never take on ... I don't ever take on too much of a role myself. I will turn around and say "This is the norm but the consultant is only a phone call away. You can ring him if you don't know what you want". So I think when you've got the med students as well, on the wards can be a similar thing. The nurses, it's not just the med students, it's when they've been out a year or when they've been out a two year and then when they come to the gen medical ward and they haven't been to that ward before, or haven't done ENT before. There is still a lot of guidance for what that consultant likes. [RN6]</i></p> <p><i>Bond University tries to give their students a lot of support in lots of different ways, but for us as tutors, we try to be honest with them. They need to work hard and make sure that they do what they need to do to be able to get the theory and the practice worked out. So if they think they can just come in and "Oh, it'll be right", we are honest... We try to be very professional with them so they realise that this is the way that we treat each other. [RN3]</i></p> <p><i>You either do this badly and if you do it for real on somebody, you'll hurt them, in which case, we give you a realistic appraisal. So, if we say you did a good job, it's actually a realistic appraisal. You did a good job. As opposed to "Gee, you really need to bone up on that because you'll hurt somebody the next time". [RN8]</i></p> <p><i>Especially if you've seen them over a long period of time, sometimes you can tell when they're having a difficult time. We don't necessarily need to know why. We just want to acknowledge and try and keep them on track... And pick up on things, if they're having a bit of a hiccup and we notice things, we do try and refer them on, refer them back, or ask them if they're okay. [RN3]</i></p>
<p><b>Contextualising learning and providing a sense of realism</b></p>	<p><i>We did really try to simulate what it was. At times, like giving drugs in ED, it can be really busy that you're going to have to do the drugs or you're going to have to do the vitals if everyone else has different jobs. So they're understanding that what we're teaching is just not nursing skills. They are going to be expected to do it. [RN4]</i></p> <p><i>I don't know if its innocence or not knowing or not realising what the real world out there is like. We try to teach them all ... [RN5]</i></p>

**Table 2: Theme 2: RNs as facilitators of medical students' transition to the clinical environment (cont'd)**

Subtheme	Associated Quotations
	<p><i>I said, "If you walk back in, it's actually telling me a lot more about you than if you walk away." And he went back in and did it. They all loved the fact that they got a crotchety patient. But I think they are the things that if we do bring those into a situational awareness, where you're given the narrative about the guy and then it makes sense that if I was him I'd be crotchety. So how am I going to respond to this guy and get the IV in? [RN8]</i></p> <p><i>I thought actually what this is, is about how do we change the focus of the learning from this rote learn ... and I think for doctors and for medical faculties, a quite comfortable way of doing it, to more of this "No, they can get this information anywhere so what is our worth now? How do we actually justify my wisdom? What wisdom do I have that I can actually impart now?" That has nothing to do or has very little to do with the knowledge, because they can find it themselves. So it's more, like you were saying, it's more about the learning I think needs to be more about contextualising it and preparing people for the context. And I think in those younger students, I think that's where the learning has to focus in a lot of ways. "This is ... you're going to be 24 and you're going to be looking after an 85-year-old who's just been told he's got six months to live. I mean what do you have to offer that person?" Honestly, what is a 24-year-old actually going to say? [RN8]</i></p>
<p><b>Being a point of contact in the hospital</b></p>	<p><i>The best thing is you come up and you say hello to me. . Then I can turn around and say "We're doing this at this bed today, can the gen med stay and watch this procedure? It might be of interest". And then they were all just thanking ... and it was quite funny because they were "Thank you so much for everything" and that. And then they were saying, a couple were saying "Oh" and I said "You'll be fine, it's fun, look at it as fun. This is what you spent all this time to actually go out there and be there on the floor and do something. [RN6]</i></p> <p><i>There's a whole wide world out there. So when they do see us, often it's a bit of comfort, I think, because "There's someone from the uni that knows what I was really like" as a student trying to remember how to do different things. [RN3]</i></p> <p><i>But I think when they're in the medical team as a student doctor, their questions and their involvement is all knowledge-based and the attempt to gain more insight into the medical side of things. But, I think, as a clinical tutor at Bond and as a nurse on the ward, I am more the friendly face that they've known from before, that they can be a bit more relaxed with, maybe. They don't have to have the front as much, because they know that we knew them when they were in the classroom, so I think it's more a friendly face type thing. [RN7]</i></p> <p><i>They'll [the students] come and seek us [Bond RNs] out. Plus, we go up and see them and see how they are going. We'll take them to something that's been done that they might be interested in and not seen before. [RN4]</i></p>