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Embedded Parallel Practice: A Result of Divergence Between Exam Requirements and Clerkship Content

Cecilie Marie Fog-Pedersen [1], Charlotte Soejnaes [2], Karen Borgnakke [3] and Sidse Marie Arnfred [4,*]

[1] Psychiatry Vest, Department of Clinical Medicine, University of Copenhagen, Region Zealand, 4200 Slagelse, Denmark; cemf@regionsjaelland.dk
[2] Copenhagen Academy for Medical Education and Simulation, Capital Region of Denmark, 2100 Copenhagen, Denmark; charlotte.soejnaes@regionh.dk
[3] Department of Media, Cognition and Communication, University of Copenhagen, 2300 Copenhagen, Denmark; karenb@hum.ku.dk
[4] Psychiatric Research Unit, Mental Health Service, Department of Clinical Medicine, University of Copenhagen, Region Zealand, 4200 Slagelse, Denmark
* Correspondence: sidar@regionsjaelland.dk

Abstract: Transitioning from being a student to becoming a professional is challenging even though medical education provides periods of clinical practice and clerkships to support the transfer between university and the future work as a doctor. Using an ethnographic approach, we investigated how medical students navigated their clerkship in psychiatry. We applied the concepts from situated learning in the analysis of students' navigation of discrepancies between course requirements and clerkship routines. The analysis shows different ways of navigating the clerkship, which all beget a *parallel practice embedded in the clinical setting*, where students choose to engage in tasks that directly prepare them for the university exam. The *parallel practice* is counterproductive for the student's development of a professional identity, which is an important element of transitioning from being a student to becoming a medical doctor. Therefore, it is imperative to consider, if this undermines the university's ambition of delivering doctors prepared for clinical practice.

Keywords: work-based learning; medical education; psychiatry; pre-graduate

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1. Introduction

It has previously been shown that the transition into practice for newly educated practitioners is rather complex. Though most health educations do provide periods of clinical practice, the transition from student to professional is still challenging [1]. One reason might be that practice-based learning and the university-based scholastic ideals are not aligned. Discrepancies between faculty and students' expectations of attainment and what is achievabl during the clinical education periods are frequently reported [2–5].

Like other types of health education, medical schools include periods of clinical education in the form of clerkships. These clerkships traditionally comprise a range of specialties. The clerkships are characterized by students carrying out tasks in the clinical field, along with guidance and instruction from more experienced doctors who function as role models [6,7]. This supports practice-based learning processes intended to equip the students for their future careers in medical practice [3,8,9] and to build a professional medical identity [2,6,7,10]. Yet, not much is known about what kind of practice-based learning actually happens during clerkships [11–14] or how students navigate the discrepancies they encounter.

The purpose of the study is to investigate how medical students participate in the clinical work and learn psychiatry during their three-week clerkship. We use the theory of practice-based learning to examine the students' approach, given that the daily tasks on the wards seem somewhat misaligned with the learning outcomes stated in the course description and with the end-of-term exam. Further, we discuss what implications the findings have in relation to the students' preparedness for transition to practice.

1.1. Clinical Clerkship in Psychiatry as the Case

Though psychiatric patients are seen in all medical specialties [15], psychiatry is a low-prestige specialty with a shortage of doctors [16,17]. This affects the opportunities to watch specialists carry out work tasks [18] and challenges the students' apprentice role and therefore their learning processes during the clerkship [19]. In the case analyzed in this article, the clerkship is part of a mandatory course in clinical psychiatry at the University of Copenhagen Medical School (taught in the fifth year of six). The course consists of 16 lectures followed by a three-week clerkship at a psychiatric hospital, subsequently followed by three days of lectures leading up to an exam in clinical psychiatry and neurology. It also includes one week of child and adolescent psychiatry. Together, the learning outcomes in the course description, the attestation log (LOG) and the end-of-term exam (exam) govern the students' aspirations for competency achievement in the clerkship. In Table 1, the content is briefly outlined, focusing on clinical skills and competencies rather than the much more detailed scholastic knowledge.

Table 1. Major educational components of clinical psychiatry at the University of Copenhagen.

Learning objectives psychiatry	**Skills** Be able to show proficiency in psychiatric terminology. Be able to conduct a comprehensive psychiatric examination, including assessing whether the patient is psychotic or suicidal. **Competencies** Be able to write up a medical record, with suggested diagnoses and provisional examination and treatment plan.Be able to write up involuntary admission forms according to the Mental Health Act.
Clerkship attestation log (LOG)	**Overall aim** To acquire skills that are required to work as a resident in a psychiatric department as well as in a general hospital. **Requirements** Complete four, full medical records including mental status examination and treatment plan; receive feedback on these from faculty or clinical doctors. Fill out two involuntary admissions forms. Follow the doctor on call for two days shifts and one evening/night shift. Observe patient receiving electro-convulsive treatment
Clerkship Content (three weeks)	**At the inpatient ward** Participate in rounds and standard psychiatric ward routines. Participate in the department's morning and midday conferences. **Afternoon clinical tutorials** A student presents a patient record while the patient is present, followed by supplementary patient interview and clinical discussion. **Additionally** Duties at the Psychiatric Emergency Unit

Table 1. *Cont.*

Psychiatry exam	**Traditional oral long case** **Preparation** 75 min for conducting a patient interview and writing up the medical record. **Examination** 30 min for reading the medical record aloud with the patient attending for the first five minutes; cross-examination on the case, diagnosis and treatment plan.

On certain points, the requirements of the LOG, the course exam and the clinical tasks on the wards are misaligned. For example, the students' final exam comprises an oral long case, i.e., medical history taking and writing of the medical record with a real patient, equivalent to an intake record. This task is also required in the LOG. However, intake interviews are only carried out in the emergency unit, it is unpredictable when it happens, and they often take place at odd hours (during late afternoon or nighttime). Each student can only spend a few days in the psychiatric emergency unit (PEU) to avoid congestion.

1.2. Practice-Based Learning

Clinical training is frequently conceptualized within the framework of participant-orientated and practice-based learning [9,20] inspired by Lave and Wenger (1991, 2003). Hence, we apply the concepts of situated learning, legitimate peripheral participation and community of practice in the current analyses. The concepts help us to sharpen both analysis of practice-based learning as a social practice [19,21] and our focus on participation in practice as a crucial factor in medical students' learning processes and identity formation.

We identify the communities of practice in a psychiatric department as several intertwined circles of professional collaboration. In the analysis below, we only distinguish between the doctors' community, the students' community and the ward's community of practice.

Lave and Wenger's concept of *legitimate peripheral participation*, used in analyses of profession-oriented education [8], frames the students as legitimate members on the wards in a double sense. The clerkship is a mandatory part of the students' education in which they participate—both as students *and* trainees—in peripheral positions. This means that the students participate on unequal terms with staff in the ward's community of practice; the students cannot independently solve tasks, they need to ask permission to talk to patients and so forth. As the students move towards full participation in the community of practice, they can take on small assignments. The students' movement towards full participation is facilitated by the relation between the *newcomer* (students) and *old-timer* (doctor). As newcomers, the students must learn from the old-timers—mainly the experienced doctors—who are fully fledged members and provide access to the wards' communities of practice [22].

2. Material and Methods

We used an ethnographic approach to enhance in-depth insight into the students' actions and interactions during the clerkships [23]. Participatory observation [24] was carried out with three consecutive rotations of medical students during their psychiatry clerkships; in total 12 students. In each term the department received three rounds of students, i.e., there are three 3-week clerkship periods. In the beginning of each clerkship period, researcher C met with the students and asked if any would volunteer as the key informant. This volunteer student was subsequently shadowed for the entire clerkship, during ward tasks, tutorials, lunch etc. At the end of the 3-week clerkship period all the students participated in group interviews about their experience of the clerkship and their

learning strategies. This data collection format was repeated three times. The first key informant opted out of the role after a week and a new student stepped in, resulting in three key informants in all, as we rejected the observations related to the key informant who opted out. The other key informants volunteered on their first day in the clerkship after being introduced to the study. See Table 2 for details.

Table 2. Overview of informants, interviews and field observations.

	First Group	Second Group	Third Group	Total
Group members *	3 females 3 males	3 females 1 male	1 male 1 female	7 females 5 males
Key-informants	Male (second and third week) 44 h	Female 64 h	Male 61 h	1 female 2 males **169 h**
Group interviews **	2 interviews with 3 students in each	2 interviews with 2 students in each	1 interview with 2 students	5 (total: 12 students)

(*) Students were randomly assigned by the faculty office to the different departments. (**) Groups were formed by convenience/availability.

The theoretical framework focused the observation and field notes on the students' *social interactions*, *relations between old-timers and newcomers*, *tasks performed* and the students' *possibilities for participation* during the clerkship. The field notes were handwritten and usually amplified the same day [25]; they registered actions, locations, the people involved and time, and the conversations were captured through original statements [26]. At the end of their clerkship, all students in the rotation were interviewed in group interviews by researcher C, following a semi-structured interview guide [27]. See Table 2 for an overview.

The interviews were audio-recorded and subsequently transcribed in full. In the following analysis, the empirical examples are drawn from the practice of the key informants as they are preserved in the field notes, yet, according to the discussion in the group interviews, the approaches were often replicated by other students.

One researcher carried out the observations and interviews continuously.

2.1. The Empirical Setting

The observations and the clerkships took place in a psychiatric hospital encompassing inpatient wards, PEU and outpatient units. As newcomers, each student was assigned to one of three patient wards as a 'home ward' where they spent most of their clerkship. The first day in the clerkship was a joint introduction day and the last day was a joint afternoon of mock-up exams; in the period between, students were required to be in daily attendance, scheduled according to the doctors' ordinary working hours.

In this specific hospital, a video library containing videoed vignettes of patient interviews was provided as an additional tool to enable the students to practice the Mental Status Examination (MSE) [28]. The students were introduced to the video library on the introduction day and encouraged to use it when they felt the need.

2.2. Ethics

Our study was fully described orally and in writing to all the students at the start of their clerkship, and they then gave signed consent to their participation in interviews and additionally, separately, as key informants. To ensure their anonymity, we have changed their names and the location in the article [29]. This type of study is exempt from the requirement to obtain ethical approval as it is regarded as a teaching/educational project and not a health research project.

2.3. Analytic and Theoretical Approach

At first, the field notes were read though by researcher C for an overview as a classic first step in thematic analysis [30]. During the second reading, done by researcher C and researcher CS, a pattern of dissimilarities between the key informants emerged. Some approaches were affirmed in the texts from the group interviews while others seemed to be idiosyncratic. This led to the third step in the analytic approach: using the theoretical framework to analyze the observations of each key informant as illustrative cases of three different ways of navigating the clerkship. The analysis was discussed by researchers C, CS, KB and SA and a few rearrangements were applied. In the fourth step, researcher C, CS, KB and SA chose to offer a comparison across the analysis of the key informants' approach to the clerkship opportunities. The impact points are related to the course requirements and the LOG as well as the course of the clerkship.

3. Results

The students navigated the clerkships in quite varied ways. For one of the key informants, a personal learning need was explicitly identified before the clerkship began, while the two key informants had no specific needs or goals for the clerkship in this regard. For a summary of the three different approaches to navigating the clerkship; see Table 3. In the following detailed analyses of the key informants' strategies, quotes from interview transcript are identified as IT, and from field notes as FN.

Table 3. Summary of the Different Approaches to Navigating the Clerkship.

Rehearsing the Interview	***Peers and Exam***	***Focus on the Doctor***
The student seeks to practice patient interviews, but writing up the medical record gets less attention. The doctors and other students are more or less unnoticed.	The student seeks to have a dialogue with, and participate in, student communities. The LOG is the guideline for activities and the doctor is exclusively seen as a role model when doing tasks related to the LOG.	The student lets clinical procedures, and the random opportunities they bring, structure the clerkship. The students seeks to observe the doctor. The LOG is not used.

3.1. Rehearsing the Interview (Eric as Key Informant)

Eric explained that his main focus in this clerkship was to talk to patients, as he had previous been timid about patient contact and he had so far just talked to very few patients.

In his second week on the ward, Eric began actively seeking out doctors on the ward. Then, after twice passively observing while a doctor conducted the patient interviews, Eric decided he would rather conduct interviews himself.

Eric used the ward round to identify patients he would like to interview before approaching ward staff and doctors to get permission.

> *Eric walks over to the conference table, where the staff is having lunch. He says he realizes the designated nurse isn't there, but adds, 'I don't know if I can just go down and talk to patient X?'*
>
> *A nurse asks whom he wants to talk to. Eric repeats himself.*
>
> *Nurse: 'I doubt you'll get very much out of it (the interview).'*
>
> *Eric: 'Is there someone else you're thinking of who could be relevant?'*
>
> *Nurse: 'What do you need to talk to them about?'*

Eric explains. The nurse makes several different suggestions. Eric has already spoken to some of them. He finds a suitable patient among those mentioned. (FN)

The assessments by the staff emphasized that they see Eric as a student who is only there to get some practice and, therefore, needs to get something 'out of it'. This illustrates how Eric, supported by the staff, constructed a learning opportunity related to the exam that was otherwise not available on the ward.

He showed interest in the patients, but his main objective was to write an intake record without knowing the patient, i.e., equivalent to the condition in the oral exam; hence, it was senseless for him to speak to the patients a second time. Consequently, he 'ran out of' patients to talk to. This portrays the patients as instruments for Eric's learning process, something confirmed when the staff and doctors assessed whether the patient was 'interesting', 'uninteresting' or 'good' for the student training.

Eventually, Eric ended up taking charge of the intake interview in the emergency ward accompanied by a junior doctor with whom he later wrote up the intake record. In this instance, exam requirements and practice were congruent, and Eric solved a practice task as a newcomer accompanied by a more experienced community member.

Midway through the clerkship, Eric had not looked at his LOG. Case conferences, the daily routines on the ward and institutional tools appeared irrelevant to Eric. Eric felt he had no clinical function during the clerkship. Even if he knew a patient, he kept quiet when patients were discussed. Asked why, he explained that he saw his interviews and patient records as training on his own behalf. In this manner, his approach maintained him in the role as student and not a team member.

Navigation in Light of Situated Learning

Eric was accepted as a legitimate peripheral participant, but his learning approach reduced his contact with the ward and doctors' communities. By treating the patient interviews as training, while opting out of the doctors' community, his behavior stressed the contrasts between exam requirements and clinical routine; indeed, his self-training initiative formed a *parallel training practice* within the ward. Paradoxically, he wanted to be given 'proper' tasks but at the same time did not engage with the staff at the ward or with the doctors. Eric missed out on clinical elements of the clerkship and gained only a slight insight into what it means to be a doctor in a psychiatric hospital. However, from the perspective of exam preparation Eric did well, gaining experience in patient interviewing and writing medical records.

3.2. Peers and Exam (Sue as Key Informant)

A feature of Sue's clerkship was that three of the students knew each other from a previous clerkship. On their shared journey to the hospital, they occasionally made plans to write intake records or watch videos in collaboration.

Sue explained that she commenced her clerkship by finding doctors she could shadow. The LOG randomly got her attention on the second day, when Frida, another student in the clerkship, talked about its content.

On the first day on the ward, the registrar took Sue along after the morning case conference. During the ward round, the ward specialist spontaneously explained about the patients and both doctors thereby marked Sue's legitimate peripheral participation as a future colleague. However, the specialist refused to let Sue accompany her to see an agitated patient, who needed to be coercively medicated. Sue approached the registrar, who explained about involuntary treatment.

Registrar: 'We'll go along as well, then you can see it, too.'

All the staff walk down the corridor and into the patient's room. Sue, the registrar and I stay outside the door. The registrar suggests that Sue come in so she can watch it. Sue and the registrar stand in the doorway and look into the patient's room. The registrar explains to Sue. (FN)

The fact that Sue may not actively participate but could be permitted to 'see it' from outside underlined the fact that she was a student who was seen as a newly arrived legitimate participant.

On Sue's second day on the ward, the specialist mentioned that Sue needed to 'get some medical records written' and later added: 'It is for training, so you can read about them first' (FN). The specialist thereby accepted, that it was important for Sue to write medical records during the clerkship, although this is not a typical task on the ward. It underlined that Sue was a student and the task was for Sue's own sake. Sue herself summarized her experience after an interview with a patient.

Sue: 'I really need to work out what to do when they cry . . .'

She explained that, if it were a colleague, she would give them a hug, but as it's a patient, she doesn't quite know what she can do.

Sue: 'Now I want to see a whole interview with an (experienced) doctor so I can see how you ask.' (FN)

Sue wanted to learn both how to handle the emotional patient as a professional and to see the interview technique of an experienced doctor.

In the second week, Sue asked Frida to join her on the ward and they then started interviewing patients and writing records together. They approached all types of staff on the ward to get access to the patients. After their interviews, Sue asked Frida clarifying questions and orientated herself towards Frida as if she was an old-timer. Although both Sue and Frida sought feedback on their records, much of their dialogue about the patients ignored the clinical practice at the ward; it seemed not to concern Sue and Frida.

The fieldnotes show that the doctors tried to include Sue by explaining matters and bringing her along. They saw her as a future doctor and possible colleague.

Specialist: 'They (staff) aren't the ones who carry the responsibility. You must remember that. It's your responsibility (as a doctor).' (FN)

Here, the doctor marked their shared medical identity and the obligation that comes with that status and role. The relation was confirmed when, initially in the clerkship, Sue began the day by assessing if the doctors had any 'exciting tasks' she could observe. Nonetheless, as time passed, Sue got frustrated when the doctors encouraged her to perform tasks she thought were irrelevant for the future exam. By rejecting clinical tasks as irrelevant, Sue rejected to take on a clinical role on the ward, and the contrast between day-to-day clinical practice and the exam requirements became a barrier to Sue's participation in the clinical teamwork. The barrier was reinforced by the doctors' and Sue's own focus on exam requirements.

Sue's navigation was strongly oriented toward the other students; she coupled up with Frida, helped other students with practicalities and encouraged them to join their discussions.

Navigation in Light of Situated Learning

Sue was accepted as a legitimate peripheral participant on the ward, but she rejected the clinical tasks on the ward. She sought out training situations that offered the possibility of dialogue with other students, where the focus was on training for the exam. The psychiatric ward was portrayed as a place that provided access to patients and constructed

training opportunities; a portrayal supported by the doctors' talking about medical records 'for training'. It was thus primarily Sue's identity as a student that was supported during the clerkship. She wished to observe doctors performing tasks relevant to the exam, but the ward offered minimal opportunities for it.

3.3. Focusing on the Doctor (Allan as Key Informant)

Allan described how at the beginning he preferred to accompany the doctors to see how interviews were carried out (group interview, Allan). However, it was the psychologist who, on Allan's first day, remarked that Allan should come 'along to something'. Afterwards, as the specialist was reluctant, Allan accompanied the registrar to an interview. Allan contributed during the patient interview and later had a dialogue about the patient with the registrar; he was clearly acknowledged as a future colleague. On his second day on the ward, the specialist was accommodating and took him along to see some patients, but when she gave Allan an opportunity to conduct a patient interview on his own, he hesitated.

> *Specialist: 'You'd like . . . do you want to talk with the patient yourself, or aren't you . . .?'*
>
> *Allan: 'I'd like to, but I haven't done it before . . .'*
>
> *Specialist: 'You can read up on him and then we can go to the interview together, then you write the notes.' (FN)*

Allan then conducted the interview and the specialist supplemented; afterwards, Allan wrote the progress notes.

While Allan pro-actively accompanied the doctors, he was reluctant to conduct interviews himself. The doctors frequently offered Allan tasks, and chance events generally determined whether he engaged with patients. When the doctor was unavailable, Allan more actively sought out patients or tasks. Hence, the content of Allan's clerkship was organized by the doctor's (daily) tasks and understanding of Allan's needs.

In the last week of the clerkship, Allan decided that he would primarily write up training records, and two days later he was offered the opportunity to interview a patient being admitted to the emergency ward and to carry out an explicit task: doing precisely the type of interview which, according to the LOG, *must* be practiced and fits perfectly as preparation for exam.

> *Allan asks the junior doctor if it is she who will carry out the admission interview. She confirms and Allan asks if he can sit in. He can.*
>
> *Junior doctor: 'You are also welcome to do it (the admission interview) yourself.'*
>
> *Allan: 'I'll just sit in.' (FN)*

Although he first declined, he afterward wrote up the intake record from the junior doctor's notes, thus contributing to clinical practice.

The doctors were inclusive and found tasks for Allan, but Allan was reluctant, when it came to tasks related to psychiatry. In several cases, the staff asked Allan to look at physical problems such as wounds. Here, he assessed the patient's condition without reservation. Allan was thus accepted as a team member by the staff, but his degree of engagement depended on whether the tasks to be solved were somatic or psychiatric.

Allan's approach was ambivalent. On the one hand, he was concerned about whether what he was doing 'will be used for anything'; on the other, he described the notes he wrote in the EHR as '*just* a note', not acknowledging his own input. Moreover, he considered it beneficial to write 'training records', which he did only for his own purposes. He did not seek feedback on his records.

Navigation in Light of Situated Learning

Allen's approach gave him experience with the routine clinical tasks on the ward. The legitimate peripheral participation was underlined by doctors and staff, who included him in practice and supported him a by giving him real clinical tasks. He was especially welcome in the community as medical generalist resource while he kept his distance when it came to carrying out psychiatric tasks. However, Allan preserved his student identity by primarily accompanying the doctors, leaving the ward before them, and withdrawing when he believed there was nothing for him to do on the ward. Mostly by chance did his approach support preparation for exam. It was stressed by Allan at the end interview that he still felt he needed to acquire much clinical expertise.

3.4. The Strain Between the LOG and Exam Requirements and Participation in the Ward Practice

All the students created opportunities—to which they did not otherwise have access on the ward—to train for the exams, although to different degrees. They negotiated, manipulated, and constructed learning situations: Sue left the ward to join her fellow students to watch videos to see how an old-timer works; Eric asked staff members if he could speak to patients; Allan constructed his own opportunities, such as writing up 'practice records'. As such, these training situations seem to be forms of simulated practice placed in the real setting. We label this *'parallel training practice embedded in clinical practice'*. The students carried out real tasks that are routinely performed in clinical practice, but the work was not really used by staff or doctors.

This construction of training options is only possible when embedded in clinical practice, as the ward provides students with vital access to real patients. This is as close to training for the tasks in real life as the students can come. Moreover, there seems to be an unspoken agreement between the old-timers and the newcomers about their construction of parallel training practice to support preparation for the exam tasks, with the doctors referring to LOG-related tasks and practice records. Here the idea of the clerkship as an opening to be part of the ward team and part of the medical profession is lost.

4. Discussion

Students shape their approaches during the clerkship to manage the discrepancies between course requirements, the exam and the daily tasks at the hospital. A noteworthy feature is the pervasive construction of *parallel training practices* embedded in clinical practice. It underlines the fact that students are seen as legitimate participants although not yet really belonging to the doctors' community. A study by Liljedahl et al. shows that although the students are seen as legitimate, they are only considered to be present for learning purposes and are not expected to contribute to clinical practice (even in their graduate years) [31]. This perspective mirrors our findings of the staff and students' co-creation of a parallel training practice due to medical students' need to train for the exam and the staff's obligation to support the students' learning. Yet this is critical as it raises questions about the possibility of students arriving at professional medical identity-formation in a clerkship. From Lave and Wenger's perspective, clerkships are conceived of as an opportunity for the medical student to create an identity through acceptance into communities of practice and to experiment with tacitly framed learning opportunities [19]. Eric and Sue's navigational approaches focused on the exam and not psychiatry as a medical specialty, nor residency in general. Hence, their parallel practice did not support professional identity development. On the contrary, it maintained their 'still just a student' identities. Our analysis shows that this paradox operated both when they were fulfilling the course's requirements (and thereby moving away from becoming part of the community of practice) and when they were seeking to join the community of practice but could

not yet take on 'proper' patient-oriented tasks in the clinic. When the doctors helped the students with LOG-related tasks, they substantiated the paradox and the movement between low/high degrees of participation.

For the students, participation in day-to-day practice should provide an opportunity to master what is termed 'the informal curriculum'. This curriculum is about values, ethics, culture and professionalism. It can be understood as a crucial part of the transition from layperson to professional [32]. The current analysis shows how, as the students did not join the community of practice, learning from the informal curriculum was limited. While we agree with Cruess et al. 2014 and Hafferty, who point to the importance of making students' professional development a more explicit part of medical education [20,33], our findings raise questions about the importance of professional identity-making in a three-week clerkship in psychiatry. Speculatively, the transition from students to medical doctors might be much more difficult if the students do not develop a professional identity during their clerkships.

Some of the problems in the transition include lack of skills, and the students' lack of confidence and identity as a professional [1,34,35]. In an article from 2017, Monrouxe et al. relate the missing identification with the medical profession to burn-out among students in transition into clinical practice [36]. Patient safety is also an important issue in the transition process [37–39]. As such, the transition from student to professional is an important issue in the health institution, and our findings can be used to argue that the current clinical education might not be optimally designed to prepare the students for real practice. Butts 2019 points to the lack of novelty in curricular reform and tested an additional introductory course on clinical skills and decision-making prior to their clinical clerkship years. Their results were increased confidence in students in the clerkships, and that faculty members perceived students as better prepared [40]. Our study could support this approach, however. Butts et al. do not relate their findings to the formation of a professional identity. Aligned with the growing focus on simulation training [41,42], a more daring suggestion is posted by Cleland et al. (2016). They suggest simulation training to prepare the learners for the transition, as it can help students to 'learn parts of the puzzle in advance (so information is in storage to draw on as required)' [39] and thereby free up 'working memory to focus on what is new, novel, or unexpected' [39]. In comparisons between parallel practice and simulation training, we find that simulation training might not be enough to ease the transition to clinical practice. Drawing on our findings, another suggestion could be to make the skills training based on simulation (the embedded practice shows how that could be) in institutional format. Then, the time spent on the wards could be used to take part in, and contribute to, the treatment of patients, socializing and becoming more confident with the doctoral community. In the end, this might provide a much better preparation for professional identity formation.

A possible limitation of our study is that it is only based on students' perspectives. Insights from patients, doctors and staff would have made an interesting contribution to understanding the clerkship as the way into the community of practice. Another limitation is that the focus on strategies might have made the researchers ignore other important observations.

There is also a limitation related to the institutional and organizational structure of the education and the health-care system in our study, as they are both publicly funded. Furthermore, the department where the study was undertaken was in a deprived region and somewhat understaffed as to psychiatrists. This might lead to a low transferability of the findings to settings in which this is not the case. We do not claim that these strategies are the only strategies used by students or that they are representatives of universal patterns.

5. Conclusions

We have observed and named a previously undescribed feature of clinical education —*embedded parallel practice*. Such practice, demonstrated herein in the psychiatry clerkship, is a consequence of the discrepancy between course and exam requirements and clinical practice. The parallel practice does not support the students' engagement in the clinical work at the ward and therefore also undermines professional identity formation. This calls for serious reconsideration of the purpose of clerkships and the learning outcomes hoped for.

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