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Letter to Editor

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Process of Acquiring Competence and Gaining Acceptance: Journey of a Surgical Nursing Student through the Operating Room

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Dear Editor,

Clinical education in the operating room (OR) is widely recognized as one of the most demanding components of surgical nursing education. Unlike many clinical settings, the OR is characterized by time-sensitive decision-making, rigid hierarchies, and highly specialized teamwork. Consequently, learning in this environment extends far beyond the acquisition of technical skills; it requires students to become legitimate members of a complex professional community. This process of acquiring competence while gaining social acceptance represents an essential yet often overlooked dimension of surgical nursing education (1, 3).

From the perspective of Situated Learning Theory, learning is embedded within authentic clinical practice rather than isolated classroom instruction. Lave and Wenger's concept of *legitimate peripheral participation* provides a useful framework for understanding how novice learners gradually move from peripheral observers to active participants within a community of practice. In the OR, surgical nursing students initially occupy peripheral roles, observing communication patterns, sterile techniques, and inter professional collaboration before assuming greater clinical responsibilities. Their progression depends not only on technical competence but also on their ability to understand and adapt to the implicit social norms governing the surgical team (4, 5).

This process also reflects the broader concept of professional socialization, through which students internalize the values, behaviors, professional identity, and ethical standards of their discipline. The OR functions as a unique social learning environment where students acquire tacit knowledge through daily interactions with surgeons, scrub nurses, circulating nurses, anesthesiologists, and other team members. These informal learning experiences frequently shape professional identity more profoundly than formal curricula because they expose students to the realities of teamwork, accountability, and patient safety under high-pressure conditions (2, 5, 6).

Equally important is the role of experiential learning, whereby students construct knowledge through observation, participation, reflection, and feedback. Consistent with Kolb's experiential learning model, meaningful clinical learning occurs when students are allowed to participate in progressively challenging activities while receiving constructive guidance from experienced practitioners. Supportive mentors encourage questioning, normalize early mistakes as part of learning, and provide timely feedback, thereby strengthening students' confidence and clinical reasoning. Conversely, unsupportive behaviors, including dismissive attitudes, exclusion from procedures, or limited teaching engagement, can interrupt experiential learning and negatively influence motivation, self-efficacy, and professional identity formation (5, 6).

Within this learning ecosystem, surgeons frequently function as influential gatekeepers. Their willingness to involve students in surgical

procedures substantially determines the quality of educational experiences available to learners. Surgeons who explain clinical decision-making, encourage observation, and gradually enhance student participation facilitate both competence development and professional socialization. In contrast, when opportunities are restricted to permanent team members, educational inequities emerge, making student learning dependent on individual teaching preferences rather than educational objectives (4, 8). This inconsistency has been identified in contemporary literature as an important challenge to equitable clinical education.

The gradual transition from observer to trusted team member therefore represents more than technical proficiency; it signifies successful integration into a community of practice. Trust develops as students consistently demonstrate preparation, responsibility, effective communication, and commitment to patient-centered care. Informal teaching moments, brief guidance from experienced nurses, constructive corrections during procedures, or opportunities to anticipate surgical needs, often become transformative learning experiences. Such interactions exemplify the "hidden curriculum," through which professional values, teamwork behaviors, and clinical judgment are transmitted beyond formal educational plans.

These observations have several implications for improving OR-based clinical education. First, educational responsibilities should be explicitly recognized as shared professional obligations among surgeons, nurses, and other OR personnel. Faculty development initiatives focusing on clinical teaching, feedback strategies, and learner support could strengthen educators' teaching competencies. Second, healthcare organizations should establish formal recognition and incentive systems that reward excellence in clinical teaching, whether through promotion criteria, continuing professional development credits, or institutional recognition. Third, structured mentorship models integrating clinical instructors with experienced OR nurses may provide continuity of supervision despite the demanding workflow of surgical services. Finally, systematic evaluation of students' educational experiences should be incorporated into quality improvement initiatives to identify barriers to learning and promote psychologically safe educational environments.

The journey of a surgical nursing student in the OR extends beyond acquiring technical proficiency; it is fundamentally a process of professional socialization within a complex community of practice. Much of this learning occurs through the hidden curriculum, where teamwork, leadership, communication, professionalism, and the unwritten norms of the OR are transmitted through everyday interactions rather than formal instruction. Recent evidence suggests that making these implicit learning processes explicit through structured reflection, guided discussion, and mentorship enhances students' ability to interpret team dynamics, navigate hierarchical relationships, and develop professional identity and leadership skills (8). Accordingly, optimizing OR education requires moving beyond the traditional emphasis on technical competence alone. Educational programs should intentionally integrate opportunities for reflective practice, faculty development, structured mentorship, and feedback on non-technical competencies, including communication, teamwork, and professional behavior. Such an approach aligns the formal curriculum with the hidden curriculum, creating psychologically safe learning environments in which students can progressively transition from legitimate peripheral participants to trusted members of the surgical team. Ultimately, fostering both clinical competence and social acceptance is essential not only for successful professional identity formation but also for improving teamwork, patient safety, and the quality of perioperative care.

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Declaration of Generative Artificial Intelligence in Scientific Writing

During the preparation of this work, the author Zardosht R, used [Deep Seek] to Summarize the collected data according to the journal’s formatting requirements. These data were extracted from a large qualitative study (grounded theory) that formed the author's doctoral dissertation.

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