

Navigating Iran's National Nursing Internship Program: A Qualitative Study of Structural, Psychosocial, and Managerial Barriers from Students' Perspectives

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Abstract

Background

Despite the nationwide implementation of a clinical internship program for final-year nursing students in Iran since 2016, no systematic qualitative evaluation of the challenges experienced by these students has been conducted. This gap is important because unresolved barriers during this critical transitional phase can jeopardize professional socialization, development of clinical competence, and ultimately patient safety.

Objective

To explore and describe in their own words the lived experiences of difficulties faced by final-year nursing students during the implementation of the clinical internship program.

Methods

This qualitative study was conducted at Jahrom University of Medical Sciences from January to April 2026 using the conventional content analysis method proposed by Graneheim and Lundman. The participants were 11 final-year nursing students who were purposefully selected and interviewed using semi-structured interviews lasting between 45 and 65 minutes. Data were analyzed using six inductive steps, yielding 309 primary codes. The trustworthiness of the study was assessed using the four criteria of Guba and Lincoln (credibility, transferability, dependability, and confirmability). Data were managed using MAXQDA version 10.

Findings

Three broad themes were identified: (1) Unpreparedness, including poor student preparedness (limited understanding of program objectives, low self-efficacy, and knowledge and skills gaps) and unprepared clinical settings (poor welfare facilities and inadequate staffing); (2) Psychosocial issues, including lack of institutional support from both faculty and clinical staff and professional misconduct, including exploitation, inappropriate behavior, and verbal harassment; and (3) Lack of program management, including poor coordination between academic and clinical institutions and structural planning issues.

Conclusion

This study presents a three-domain framework for identifying key structural, psychosocial, and managerial barriers in Iran's national nursing internship program. The results directly inform policymakers, nursing school administrators, and hospital managers in revamping pre-internship orientation protocols, establishing formal faculty-hospital coordination structures, and creating structured anti-harassment policies to protect students' learning environments.

1. Background

The transition from nursing student to professional nurse is one of the most difficult stages of professional development worldwide. Studies indicate that inadequate preparation during this transition period results in reality shock, high attrition rates, and compromised patient safety (1, 2). Clinical learning environments are key for students to develop professional competence, participate in the nursing profession, and make informed decisions about whether to pursue or reject nursing as a career (2). These environments offer opportunities for nursing students to transform their theoretical knowledge into the mental, psychological, and psychomotor skills needed for patient care through experience (3). Simultaneously, the unpredictable nature of the clinical training environment can present challenges to nursing students (4). Despite the well-known significance of clinical education, recent evidence consistently shows that nursing students still fail to meet core expectations. Studies indicate that students' expectations about learning opportunities, clinical skill development (5, 6), and sense of belonging and adequate respect within clinical settings (7) remain unmet. As a result, a considerable number of nursing graduates experience reality shock upon entering the clinical environment, resulting in high psychological stress that limits their problem-solving ability and the development of their professional identity (8). Final-year undergraduate nursing students are moving from their student phase to the world of professional nursing (9). This transition is particularly important: these students must at the same time incorporate theoretical knowledge, develop clinical judgment, and manage complex professional relationships, often without adequate supervision or institutional support. Various studies in Iran show that nursing students, in their final year of study, experience issues such as fear of providing care (10), anxiety (4), concern about the clinical environment (11), and difficulty accepting professional identity (12). Various programs worldwide have been designed to assist students during this transition, including preceptorships and mentorship programs (13, 14). In Iran, a clerkship program was introduced in 1992, revised in 2012, and ultimately replaced by a national internship program implemented in 2016. Under this program, students work full shifts in hospitals similarly to nursing staff, under the supervision of the head nurse, while receiving training and benefiting from hospital facilities such as meals and transportation. However, despite nearly 10 years of implementation, the national internship program in Iran has not undergone systematic evaluation. The challenges faced by the students, particularly in the unique cultural, professional, and organizational context of Iranian healthcare, remain largely undocumented. This evidence gap impedes evidence-based program improvement and denies policymakers the contextual data needed to address structural deficiencies. Qualitative approaches are well suited to the study of such phenomena, providing rich, context-specific insights into the lived experiences of people navigating complex and underexplored situations (15, 16). Therefore, the present study was conducted with the aim of systematically exploring and describing challenges experienced by nursing students in the final year of study in the national internship program in Iran using qualitative conventional content analysis.

2. Methods

2.1 Study Design

This study employed a qualitative design using conventional content analysis, as described by Graneheim and Lundman (17). This inductive approach is appropriate where little theory or literature exists concerning a phenomenon, in that it allows the categories and themes to be derived from the data itself rather than imposing existing frameworks (17). Conventional content analysis was selected—rather than directed or summative approaches—because the primary aim was to generate a descriptive understanding of students' experiences from their own perspectives without prior theoretical mapping.

2.2 Participants and Sampling

The study population included final-year nursing students from Jahrom University of Medical Sciences who were actively participating in the national internship program. The participants were selected purposefully from January to April 2026. Maximum variation purposive sampling was utilized to ensure diversity with respect to gender, clinical rotation site, and reported internship experience. Eligible students were identified based on the recommendation of nursing school officials. The inclusion criteria were (1) active enrollment in the final year of the nursing program, (2) current participation in the internship program, (3) willingness to cooperate, and (4) ability to articulate and reflect on their experiences. Eleven students (five male, six female) aged 22 to 25 years (mean age: 23.64 ± 0.7) participated. Sampling continued until data saturation was reached, defined as the point at which no new codes or conceptual categories emerged from successive interviews—operationally confirmed when the final two interviews produced no new information (17). Demographic characteristics of participants presented in Table 1.

Table 1
Demographic Characteristics of Participants

Participant	Gender	Age	Primary Rotation Site
P1	Female	23	Internal Medicine
P2	Male	22	Emergency
P3	Female	24	Surgery
P4	Male	25	ICU
P5	Female	23	Pediatrics
P6	Male	22	Internal Medicine
P7	Female	24	Orthopedics
P8	Male	23	Emergency
P9	Male	23	Surgery
P10	Female	25	Gynecology
P11	Female	24	ICU

2.3 Data Collection

The interviews were conducted in a semi-structured manner and lasted 45 to 65 minutes, held at the School of Nursing or affiliated hospitals of Jahrom University of Medical Sciences. Before each interview, participants were informed of the study's purpose, their right to withdraw at any time, and the principle of data confidentiality. Written informed consent was obtained before audio recording. Each interview commenced with the open-ended question: "Describe a day in your internship program." Follow-up probing questions like "Can you tell me more?" or "What do you mean by that?" were used to elicit richer detail. Data collection and analysis proceeded simultaneously, in keeping with qualitative iterative methodology.

2.4 Data Analysis

Data were analyzed using the six-step conventional content analysis method proposed by Graneheim and Lundman (17): (1) Familiarization: Interview transcripts were read repeatedly to achieve immersion in the data and grasp overall meaning units. (2) Generation of meaning units: Sentences and paragraphs relevant to the study aim were identified and condensed. (3) Initial coding: Meaning units were condensed and coded using labels that represented latent and manifest content. (4) Categorization: Codes with similar content were grouped into subcategories and these into categories. (5) Identify Themes: Underlying meanings abstracted across categories into higher order themes. (6) Validation and Refinement: Categories and themes were repeatedly reviewed for internal consistency and distinctiveness throughout all stages of the analysis process. This process generated 309 initial codes, which were progressively abstracted into 6 subcategories and 3 main categories (themes). MAXQDA version 10 was used for data organization and code management. Illustrative coding pathway (sample) presented in Table 2.

Table 2
Illustrative Coding Pathway (Sample)

Raw Code	Condensed Meaning Unit	Subcategory	Main Category
"I didn't really know what they expected from us"	Unclear program objectives	Insufficient student readiness	Lack of preparedness
"They gave all 13 patients to me"	Workload exploitation	Professional abuse	Psychosocial challenges
"The internship came before we had done our training"	Illogical sequencing of rotations	Deficiency in program planning	Deficiency in program management

2.5 Scientific Rigour

To evaluate trustworthiness, the four criteria proposed by Guba and Lincoln (18) were applied. Credibility was ensured through prolonged engagement with the data, peer debriefing (conducted with two faculty members external to the research team who independently reviewed a sample of coded transcripts), and member checking (findings were returned to five participants for verification of interpretive accuracy; no significant disagreements arose). Thick descriptions of the research context, participant characteristics,

and analytical process supported Transferability. Dependability was addressed through the immediate transcription of interviews and an audit trail maintained throughout the analysis. All decisions regarding the analysis were carefully documented to ensure confirmability. Reflexivity statement: The lead researcher is a nursing faculty member with experience in clinical education. To minimize interpretive bias, assumptions were bracketed before analysis, and analytical memos were maintained throughout the process to make the researcher's positionality explicit and transparent (19).

2.6 Ethical Considerations

This study was approved by the Ethics Committee of Jahrom University of Medical Sciences (Ethics Code: IR.JUMS.REC.1405.027). Complete information about the study was provided to all participants before enrollment (20) and written informed consent was obtained voluntarily. Participants were assured that their identity would remain confidential and known only to the research team. They retained the right to withdraw at any time without consequence.

3. Findings

The participants were 11 final-year nursing students (5 male, 6 female) aged between 22 and 25 years (mean: 23.64 ± 0.7). Analysis of the 309 initial codes produced 3 main categories (themes) and 6 subcategories, as summarized in Table 3.

Table 3
Classification of Main Categories and Subcategories

Main Category	Subcategory
Lack of Preparedness	Insufficient student readiness
	Low preparedness of clinical environments
Psychosocial Challenges	Lack of support
	Professional abuse
Deficiency in Program Management	Incomplete coordination of education and clinical practice
	Deficiency in program planning and implementation

3.1 Lack of Preparedness

The experience of inadequate preparation for independent clinical participation was the first major challenge reported across all eleven participants. This theme comprised two subcategories: insufficient student readiness and low preparedness of clinical environments.

3.1.1 Insufficient Student Readiness

All eleven participants described entering the internship without a clear understanding of their expected roles, responsibilities, or the program's objectives. Three related types of unreadiness were identified: lack of full understanding of program goals, low self-efficacy, and deficits in knowledge and skills. Regarding program goals, participants consistently reported confusion about what was expected of them, attributing this to inadequate pre-internship communication:

"We gradually and over time understood what they wanted from us and what we needed to do." (Female, 23 years)

Low self-efficacy was the most emotionally prominent manifestation of unreadiness, reported by nine of eleven participants. Students reported increased anxiety, diminished self-esteem, and a pervasive doubt of their clinical competence when placed in unsupervised settings:

"The internship started with shifts, and we were independent, and the anxiety was very intense. I didn't really know whether I could handle the tasks or not. I thought it would be the same as the internship, but we were calm with a supervisor." (Female, 23 years)

"We doubted ourselves—our capabilities. This position is precisely the opportunity to test our capabilities. Can I handle it? That's why we were very stressed." (Male, 22 years)

Knowledge and skill deficits were described by eight participants and manifested most acutely in procedural competencies and communication skills:

"Many of us still didn't know how to work with the emergency trolley. It was obvious that we were students. We made many mistakes due to a lack of knowledge." (Female, 23 years)

"Many of our peers face many problems with their communication skills. They don't understand how to deal with a patient properly." (Female, 24 years)

3.1.2 Low Preparedness of Clinical Environments

From the participants' perspective, clinical environments were also structurally unprepared to receive intern students. Two major deficiencies were identified: limited access to welfare amenities and chronic staffing for amenities, participants reported uneven provision of basic facilities in wards:

"They don't provide facilities for students in the wards. There was no food either. Using the facilities of the ward depends on the head nurse—in one department, yes; in another, no." (Female, age not specified)

Students' marginalization was exacerbated by staffing shortages; overwhelmed nurses did not have the time or capacity to guide students:

"The number of staff was usually low, considering the patients and their tasks. That's why they didn't pay much attention to us. They neither had the time nor the patience." (Female, 24 years)

3.2 Psychosocial Challenges

Psychosocial adversity was the most emotionally distressing dimension of the internship experience, reported in varying degrees by all participants. This theme encompassed two subcategories: lack of support and professional abuse.

3.2.1 Lack of Support

Participants identified a dual absence of support: from the faculty (academic institution) and from clinical staff and managers. This bidirectional inadequacy left students feeling institutionally abandoned during their most vulnerable professional phase. Regarding faculty support, students described the faculty's role as administrative rather than clinical:

"Whenever an issue arose, whether in planning or in discussions with the staff, you cannot rely on the faculty's support. The faculty only provided a list of names of students being sent to the hospital." (Male, 23 years)

Clinical staff support was also perceived as absent or actively hostile. Participants described discrimination between nursing and medical students, distrust, and a pervasive sense of being viewed as a burden rather than a learner:

"The nurse and the head nurse didn't support us. They themselves would say, 'Whatever problem arises, we have nothing to do with it.'" (Female, 23 years)

"One time over a case, I argued with a medical student, even though I was the one handling the department's tasks. The head nurse took the file from me and gave it to him. I was very upset." (Female, 23 years)

3.2.2 Professional Abuse

Ten out of eleven participants reported professional misconduct toward intern students, making it one of the most alarming findings of this study. Three forms were identified: exploitation, inappropriate behavior, and verbal harassment. Exploitation was described as being assigned workloads equivalent to or exceeding those of full nursing staff, performing non-nursing tasks, and being used as staff replacements:

"The nurse and head nurse viewed us as full staff members to exploit. Instead of giving 2, 3, or 4 patients, he gave all 13 of his patients to me and went off to do paperwork himself." (Male, 24 years)

"Because it wasn't clear what you should do, they would put every task on your shoulders—get medication from the pharmacy, take a patient to the ward, and organize station papers." (Female, 23 years)

Inappropriate behavior from clinical staff manifested as indifference, humiliation, aggression, and rejection:

"After all, we went there to learn. We didn't know everything. I don't know why they would get angry over the smallest mistake or with such a tone." (Female, 22 years)

"One time during the evening shift, in front of everyone, the supervisor spoke to me in such a way that I really didn't know how to respond. It was so offensive." (Male, 22 years)

Verbal harassment was the most overtly damaging form of misconduct reported, including public humiliation and intentional discouragement:

"For example, today I heard 10 times that 'you won't make a competent nurse. You are not cut out for nursing.' He said it in front of the patient's companion, in front of the patient, and in front of the staff." (Male, 23 years)

3.3 Deficiency in Program Management

The third major theme reflected systemic failures at the organizational and institutional levels of the internship program. Students identified a pervasive disconnect between the program as designed and as implemented across both coordination and planning dimensions.

3.3.1 Incomplete Coordination Between Education and Clinical Practice

All participants described a fundamental misalignment between what the faculty expected of students, what hospital staff expected of them, and what the program guidelines stipulated. This coordination gap manifested in inconsistent evaluation practices and a lack of shared understanding of student roles:

"Not being aware of the principles of evaluation—evaluating a student is different from evaluating staff. Even the supervisors didn't know." (Male, 25 years)

3.3.2 Deficiency in Program Planning and Implementation

Structural planning failures were described by nine participants and included placement of students in unfamiliar wards before completing prerequisite rotations, assignment of students to wards without any designated tasks, absence of payment, and failure to utilize all available clinical facilities:

"In some departments, we hadn't even done our internship yet and were completely unfamiliar. That means the internship was before the actual training." (Female, 25 years)

4. Discussion

The current study systematically explored the challenges facing the Iranian national nursing internship program from the viewpoint of the students and proposed a three-domain framework: preparedness, psychosocial, and managerial barriers. While each domain contributes to the difficulties students face, they are closely interrelated. Problems in structural management result in greater unreadiness among

students, which in turn exacerbates their psychosocial vulnerability in an unsupportive clinical setting. The discussion below places these findings within the wider international literature and highlights the specific cultural and organizational aspects of the Iranian context.

4.1 Lack of Preparedness

The finding that students entered the internship without a clear understanding of program objectives is consistent with evidence demonstrating that orientation to clinical placements is frequently inadequate or absent (5, 21). Preparing the mental, psychosocial, and psychomotor aspects of nursing students is one of the main factors in the successful implementation of the program and achieving its goals (22). This study reveals an institutional failure that is remediable: the lack of structured pre-internship orientation. It should be prioritized by program administrators.(23, 24). The absence of structured pre-internship orientation in this study represents a remediable institutional failure that deserves priority attention from program administrators.

The most psychologically salient manifestation of unreadiness was low self-efficacy, reported by nine of eleven participants. This finding is consistent with a large body of evidence documenting low clinical self-efficacy among nursing students placed in unsupervised or under-supervised settings (4, 25). Since final-year nursing students experience the realities of the clinical environment without an instructor present, factors such as encountering complex equipment and inappropriate reactions from staff may further reduce their self-efficacy (26). Importantly, Momeni et al. (2025) in Iran found that clinical education status was an important predictor of self-efficacy, indicating a bidirectional association between the quality of the environment and students' confidence (25). Knowledge and skill deficits, well-documented in the literature (27, 28), are particularly relevant in this study: students were placed in independent clinical roles before completion of prerequisite training rotations (as reported in the program management theme), resulting in a systemic rather than individual failure. This distinction is crucial for policymakers: addressing skill deficits requires not only pre-internship skills assessment but also ensuring that the sequencing and structure of clinical rotations are logically ordered and monitored.

The low preparedness of clinical environments, particularly insufficient staffing and inadequate welfare amenities, has been identified as a significant barrier to student learning in multiple international contexts (2, 29). In the current study, staffing shortages directly affected staff's ability to engage and guide students, thus effectively eliminating the informal mentorship that somewhat compensates for the lack of formal supervision. This finding is reflective of a structural challenge specific to the Iranian healthcare context where nurse-to-patient ratios are often below recommended levels, limiting the ability of bedside nurses to play a meaningful educational role alongside their clinical duties (30).

4.2 Psychosocial Challenges

A salient psychosocial stressor in this study was the lack of meaningful institutional support from faculty as well as the clinical staff. This bidirectional support deficit is consistent with findings from international literature (31, 32) and highlights a systemic disconnect between the support students

anticipate and the support they receive. The appropriate relationship between the student and the ward nurse is considered a supportive resource for nursing students (33). However, in the present study, this relationship was frequently characterized by indifference, discrimination, or active hostility.

Professional misconduct, reported by ten of eleven participants, constitutes the most disturbing finding of this study. The described behaviours – exploitation, inappropriate conduct and verbal harassment – are not specific to Iran but appear to be particularly common and serious in this case. Recent systematic reviews have shown that approximately 65.6% of nursing students globally experience bullying during their clinical placements, with verbal abuse being the most common behaviour and registered nurses among the most common perpetrators (34, 35). Importantly, it is estimated that 74% of such incidents go unreported (34), which suggests that our findings may underrepresent the true scope of the problem.

A particular vulnerability of Iran's internship model is the exploitation of intern students, who are given full nursing workloads and are required to do non-nursing tasks. The ambiguity of the legal and professional status of the student creates a structural loophole, which allows the staff to treat students as unpaid labor. This finding is contrary to the international literature, which more frequently describes emotional and verbal forms of misconduct and not systematic workload exploitation (36). This difference may be due to the specific structural design of Iran's internship program, where students work full shifts without clear role boundaries, which makes exploitation structurally possible in a way that supervised clinical placements in other countries do not allow.

The culture of silence surrounding professional misconduct in clinical nursing environments—rooted in hierarchical power structures, fear of academic repercussions, and absence of formal reporting mechanisms—requires urgent institutional attention. Formal anti-harassment policies and safer reporting channels are necessary first steps (37).

4.3 Program Management Shortage

The finding that the coordination between academic institutions and clinical settings is essentially lacking is consistent with a significant body of evidence from Iran and globally (27, 28). Studies in Iran indicate that the main reason for the theory-practice gap is the lack of effective interaction and collaboration between clinical settings and faculties (38). Singh et al. (2024), in a systematic review, found poor faculty-hospital coordination among the six major structural barriers to effective clinical nursing education globally (27).

The structural planning failures identified in this study, such as illogical rotation sequencing, unclear role definition and underutilization of available clinical facilities, contribute to the preparedness deficits discussed above. When students are placed in wards where they have not yet completed prerequisite rotations, they are effectively set up for failure: lacking the knowledge base to function safely, the experience to manage complexity, and the professional confidence to seek help. Shoghi et al. (2019) highlighted that bridging the theory-practice gap in Iranian nursing requires structural organizational changes—not merely attitude shifts—at both the faculty and hospital levels (39).

A unique finding of this study was the absence of an effective supervision infrastructure: there was no formal mechanism for students to raise concerns, report misconduct, or receive structured feedback. This structural vacuum adds to all other challenges. International evidence supports the important role structured clinical supervision plays in safeguarding student well-being and improving learning outcomes (6).

4.4 Limitations

Several limitations need to be acknowledged. The study was conducted only on the participants of one university in southern Iran (Jahrom University of Medical Sciences). So, the findings cannot be generalized to other geographical and institutional contexts. Furthermore, the opinions of the clinical nursing staff, head nurses, faculty supervisors, and hospital administrators were not studied. This would have provided a more holistic understanding of the program's challenges. Thirdly, as with all qualitative research, the findings represent the subjective interpretations of the participants' experiences and are not objective measures of the quality of the program. Future research should use multi-site designs and incorporate multiple stakeholder perspectives.

5. Conclusion

This study offers a three-domain framework (lack of preparedness, psychosocial adversity, and managerial deficiency) for systematically mapping the challenges facing nursing students in Iran's national internship program. These challenges are not isolated phenomena: structural management failures create the conditions for psychosocial harm to occur, and insufficient preparation increases the vulnerability of students to both.

Based on the findings, the following evidence-based recommendations are suggested:

For policymakers and program administrators: A structured pre-internship orientation workshop on program objectives, legal status, role boundaries, and support channels should be mandatory. To avoid workload exploitation, program guidelines need revision to delineate the roles of intern students and nursing staff.

For nursing schools: Create official faculty-hospital liaison committees that meet periodically to review student placements, verify the logical sequencing of rotations, and follow up on student welfare. Include scheduled hours of clinical presence for faculty supervisors during internship periods.

For hospital administrators and clinical managers: Implement anti-harassment policies with formalized procedures for students to report harassment. Create orientation sessions for ward staff about their roles as they relate to intern students and the educational goals of the program.

Future research directions: Longitudinal studies are required to explore the impact of internship challenges on retention of professionals, competence development, and patient safety outcomes. Multi-

site qualitative studies involving perspectives of clinical staff, faculty, and hospital managers will develop a more robust evidence base for national program reform.

Declarations

Ethics approval and consent to participate:

This study was approved by the Ethics Committee of Jahrom University of Medical Sciences (IR.JUMS.REC.1405.027).

Consent for publication

Not applicable.

Competing interests

The authors declare that they have no conflict of interest.

Authors'contributions

MK, MT, MH and NT were involved in the manuscript's conception, design, drafting, data collection, and revising.

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Data Availability

Datasets are available through the corresponding author upon reasonable request.

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