

# “Toxic” bedside teaching: patient impact

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## Dear editor

I have read with great interest the article by Olosoji,<sup>1</sup> demonstrating how “toxic” teaching methods are still very much prevalent, and damaging, within medical teaching. As a final-year medical student who has experienced “toxic” teaching throughout several of my clinical attachments, I felt that I should share my opinion, and how this may affect future clinical practices.

Despite Olosoji’s focus on Nigeria, America and Australia, I have seen several colleagues embarrassed and humiliated to the point of tears through “toxic” teaching practices and can confirm that the practice is also strongly present in the United Kingdom as demonstrated by Lempp and Seale.<sup>2</sup> As a result, I wholeheartedly agree with Olosoji that such teaching practices have no place in medical student education. However, I also believe that in order for “toxic” teaching to be removed from the hidden curriculum of students, it must also be removed from the hidden curriculum of junior doctors.

It is likely that many of the senior doctors “pimping” and displaying “toxic” teaching methods were themselves subject to such practices during their own development, hence conducting the same teaching style to their juniors. This has created a self-perpetuating cycle that must be broken, whether by education of faculty, persecution of negative teaching methods or improving the learning environment (safe, respected and supported) as recommended by Olosoji.<sup>1</sup> This perpetuating cycle continues to extend into doctorhood as well; however, I would argue that it is even more dangerous as patients are also put at risk. Crowe et al<sup>3</sup> showed that in specialist doctor training courses led by senior doctors, the effect of hierarchical power and negative teaching methods caused anger, fear and disillusion in the junior doctors. This amounted to worse patient care due to reduced communication, lack of confidence and anxiety in the junior doctors. Furthermore, the medical author, Suzanne Gordon, commented on how, in addition to doctor–doctor and doctor–student relationships, the doctor–patient relationship is also damaged to patients so often witnessing these “toxic” practices, with fear of displeasing their physician for the worry that they will receive worse care as a result.<sup>4</sup>

Olosoji stated that his study is part of a larger study; however, in addition to the prospective student-focused research, it would be of great interest to see how the cohort from Maiduguri medical schools progress. Would it be possible to garner their opinions

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on medical teaching once they are qualified as doctors and contrast this information with their previous opinions to see if they have improved or worsened?

To conclude, “Toxic” bedside teaching methods need to be abandoned in all hidden curriculums so as to benefit patients, students and doctors, and I look forward to reading the subsequent papers from this study.

## Disclosure

The author reports no conflicts of interest in this communication.

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## Author's reply

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## Dear editor

I thank Jack FT Cope for the knowledgeable comments on my study.<sup>1</sup> Indeed, mistreatment of medical students during clinical training is not a new phenomenon and as highlighted by the author of the letter, there is mounting evidence that mistreatment within the health care teams has potential long-term negative effects on individuals, learning environments and patients also.<sup>2</sup>

It is, however, of note that despite several documented programmatic and curricular attempts to decrease the incidence of mistreatments, medical trainees at all levels worldwide continue to describe a culture of prevalent and persistent mistreatment.<sup>1,2</sup> Learning in the clinical context takes place in a complex system,<sup>2</sup> and current traditional intervention strategies to address trainees' mistreatment focusing separately on individual, educational organization or structures may not be appropriate for this problem. The intent of this study<sup>1</sup> was to propose that attempts to fix the problem require a broad view

of our conceptions of mistreatment by linking both the root cause/s of trainees' mistreatment and proposed intervention to sociocultural theoretical framework.<sup>3</sup> Suggestions in more recent articles by Fleming and Smith<sup>2</sup> and Mazer et al<sup>4</sup> seem to be in line with this proposal.

The suggestion that the perspectives of qualified doctors (from Maiduguri medical schools) on "toxic" teaching be assessed and compared with previous opinions of medical students is appreciated and of great interest. This hopefully will be incorporated in the ongoing second part of the study.

Again, I would like to thank the author of the letter for the interesting comments on the study. I hope larger scale ongoing study on "toxic" phenomenon will provide further results.

## Disclosure

The author reports no conflicts of interest in this communication.

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