

A study of “toxic” phenomenon during bedside teaching: a medical student’s perspective

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Dear editor

We read with great interest the study by Olosoji¹ exploring the mistreatment of medical students by the bedside. As senior medical students at Imperial College London (ICL), we have had many teaching sessions and therefore have first-hand experience on this matter of “toxic teaching”.¹

We thank the author for undertaking this study as this is a contemporary issue that ought to be addressed. It was found that 85% of medical students “experienced toxic practice during bedside teaching”, yet only one student reported their experience to the faculty.¹ In addition, a study by Chung et al² found that over half the medical students at University of California Los Angeles did not report their mistreatment because of barriers such as “fear of reprisal” and “perception that mistreatment is part of medical culture”. This suggests that students are afraid to speak out.

We agree “it is the responsibility of the institution to take the lead”.¹ At ICL, we are fortunate to have several opportunities to voice our concerns – for example, via our Personal Tutor, Teaching Coordinator, or Student Online Evaluation (SOLE) surveys. SOLE surveys are emailed to us directly at the end of each rotation, where we can anonymously express our thoughts without fear of retribution. We disagree with the ideology that mistreatment is “only students” perceptions, not reality.¹ A study by Bursch et al³ provides evidence that refutes the notion that students who experience mistreatment are merely being oversensitive.

We agree with the author’s recommendation that courses are needed to master the skill of clinical teaching. As part of our curriculum, students at ICL are required to complete a “Teaching Skills” course. Senior students organize bedside teaching sessions for a younger medical student, having been taught the theory behind how to do so effectively, and are then encouraged to reflect on the experience. The lack of such training for our senior medical educators is what we consider to be the most significant reason for “toxic teaching”.

The specific form of mistreatment could have been explored further in this study. Previous studies have highlighted domains such as “verbal abuse, ethnic insensitivity and power abuse”.³ Furthermore, Olosoji’s¹ student sample comprised a diverse demographic, and perhaps there would be merit in exploring the differences in both the incidence and perceptions toward “toxic teaching” across different genders and years of study. This new information could aid decision-making and guide intervention strategies.

Additionally, we believe it would be invaluable to explore how the cohort is faring at the end of his or her medical school careers, as there are not only short-term implications

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of recurrent mistreatment, but also long-term consequences such as “medical student burnout.”⁴ The author does not put forward any alternative intervention strategies to prevent future students suffering a similar fate. In developing such strategies, we believe it is essential to interview clinical teachers and gage their perspective. Once such strategies are implemented, an evaluation with the cohort is crucial in order to assess the effectiveness.

Disclosure

The authors report no conflicts of interest in this communication.

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Author's reply

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Dear editor

Thank you for the opportunity to respond to those comments related to the article on broadening conceptions of medical trainees' mistreatment.¹ I appreciate the thoughtful comments and constructive suggestions as provided by the authors of the letter, from the Faculty of Medicine, Imperial College, London.

Indeed, mistreatment of medical students during clinical training is not a new phenomenon, and as highlighted by the authors of the letter, there is mounting evidence that mistreatment within the health care teams has potentially

long-term negative effects on individuals, learning environments, and patients.²

The point that specific forms of mistreatments and differences in incidence and perceptions toward “toxic teaching” across years of study could have been explored further in the study is well taken. The present study¹ is the result of the first part of a larger study, and I hope that the findings of the ongoing study, using instruments including surveys, interviews, and focus groups to collect data from clinical teachers, graduates, nurses, other ward staff, and administrators, will suggest alternative intervention strategies.

Again, I would like to thank the authors of the letter for their thought-provoking comments on the study.

Disclosure

The author reports no conflicts of interest in this communication.

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