

Bullying culture: Valuing the teacher-student relationship

Elizabeth Berryman

The New Zealand Medical Students' Association (NZMSA) is calling on all clinical teachers and students to take a new approach to teacher-student relationships in the light of medical students reporting high levels of bullying when on clinical placements. The NZMSA 2015 survey found that 54% of students reported being bullied. Other New Zealand and international studies have shown similar results.¹⁻³ Such high levels have been received with disbelief by some of the medical profession, and some have doubted whether what was being captured was indeed bullying.⁴ This indicates the need to clearly define what is appropriate behaviour, and what is not.⁵ NZMSA believes that if both parties place a higher value on the teacher-student relationship, a bullying culture could not exist.

The NZMSA survey

In August this year, the NZMSA conducted a nationwide survey of fourth, fifth and sixth year medical students studying in New Zealand. The survey found that 54% of students had experienced what they perceived as bullying when on clinical placements and 76% had witnessed another student being bullied. The 772 responses were from a pool of 1,536 NZMSA clinical students. The survey allowed students to anecdotally share their experiences of bullying if they wished. Many of these experiences were significant, with teachers blatantly crossing professional boundaries and breaching codes of ethics and workplace health and safety policies.^{4,6,7} However, students commonly reported more subtle forms of bullying, such as isolation, rudeness, inappropriate humour, humiliation and intimidation, which holds the same negative outcomes.^{1,8}

Students' experiences

The results show that a large proportion of students are encountering what they perceive as bullying, and we know that this behaviour has negative impacts on students learning and wellbeing.^{3,7} It tells us that we are not creating a safe environment for students, we are not fostering positive teacher-student relationships, and we are not placing a high value on the teacher-student relationship, even though it is one of the main factors known to contribute to 'good learning'.^{9,10}

The statistics capture the extent of the problem, but the stories shared by the students illustrate it better. Here are a few of them.

Racism

A staff member refuses to learn the names of his Asian students, despite the students wearing name badges and having names that are easy to pronounce. Instead, he refers to them as "Bob" or "Bill", regardless of whether they are male or female. Three students from different years told this story:

"He would refer to me in third person in theatre...such as saying, 'It's Bill's fault—she keeps making mistakes.'"

"It made me feel annoyed and that I was in some way inferior to the other student I was paired with (a European male) whom the consultant addressed by his proper name and didn't make jokes about. I knew I had to take it because that was the price of passing."

"If you don't pull hard enough [assisting in theatre], I'll send you back to Hong Kong."

Sexual harassment

“The registrar said a few of the team were going for drinks after work on Friday and he asked if I would like to join them. I agreed, but when I got to the bar it was just him. I asked where the others were and he said they had all pulled out last minute. He then proceeded to buy me an alcoholic drink and pressured me to have more. I kept making excuses to leave but was told, ‘I will tell the consultant you haven’t been good on this clinical run if you don’t have another drink with me.’ I made an escape, but the rest of the run he would make inappropriate sexual jokes out of earshot of others and say things like, ‘You won’t get very far in a career in medicine if you don’t know how to have a bit of fun.’”

Intimidation

“I was grilled by consultants constantly from day one; on ward rounds, in clinic, in front of patients and other staff. I was questioned intensely and embarrassed by not being able to verbalise the answer adequately. The style of questioning was not friendly and sounded like an interrogation. I can remember one ward round vividly: one of my discharged patients from a few weeks ago came in overnight and I was told to present him to everyone on the team at the patient’s bedside during ward round. I did not have his notes on me and I couldn’t remember much about him. I tried presenting but I fumbled and couldn’t quite get it right. The consultant then started interrogating me about the condition that the patient had come in with, firing question after question; eventually I just had a blank. I stood there for what seemed like several minutes not doing anything. The worst thing was when the consultant said, ‘this patient must not have made a big impression on you then?’ My heart sank. I felt as though whatever shred of confidence I had left was destroyed and I felt like I let down the patient. The embarrassment

in front of the entire team and the patient made me want to leave and cry. I went to the patient after and apologised. He said not to worry, but he seemed quite concerned about the events that occurred.”

Differing expectations

We all agree that we should not tolerate blatant bullying of the kind exemplified in the racism and sexual harassment examples above.¹¹ However, what about the more commonly reported perceived bullying of isolation, rudeness, inappropriate humour, humiliation and the kind of intimidation described by the last student? Do we all agree that these kinds of behaviours are no longer acceptable in the clinical learning environment? We believe that the survey results indicate that students and teachers have differing expectations of what is acceptable.¹² This produces an uneasy tension between teachers and students, and erodes the teacher-student relationship.¹⁰ If this difference is not dealt with, it will continue.

Valuing the teacher-student relationship

Of course, many factors affect the teacher-student relationship, including wider system pressures, and we cannot possibly cover them all in this article, but we acknowledge the impact these.^{13,14} The apprenticeship model of clinical medical education means that the relationship between the teacher and the student is pivotal, so we will focus on this.¹⁰ It is personal interaction that determines the quality of a relationship, and like all good relationships we need to dedicate time and effort into developing it and value its importance to see improvement.¹⁰ We will focus on three key things we can do right now to place value on the teacher-student relationship.

Firstly, we should acknowledge that each relationship is unique. Every teacher and every student is different, and each relationship requires a different set of skills.¹² Educating both students and teachers in how to deal with these differences is important. Currently, there is very little

training provided for clinical teaching staff, and students are not taught how to be an effective clinical student.⁸ We have workshops for ‘dealing with difficult patients’, but we have nothing for dealing with ‘difficult team dynamics’.

Secondly, as with the doctor-patient relationship, there is a clear power difference between teacher and student. The hierarchical structure of the system increases the power disparities.¹³ Compounding the issue is what the literature describes as the ‘hidden curriculum’, in which teachers unconsciously try to teach students about ‘real-life medical culture’.⁹ An article by Haidet & Stein states that sometimes this hidden curriculum includes premises such as a:

“demand for ‘right’ answers (avoidance of uncertainty); intimidation, public shaming, and humiliation (doctors must be perfect); the treatment of students as objects to be ‘filled up’ with knowledge and facts (outcome is more important than process); unhealthy competition (medicine takes priority over everything else), and deference to experts, regardless of their teaching abilities (hierarchy is necessary) p. S17.”¹⁰

Teachers must acknowledge this power difference and this unconscious hidden curriculum, and try to reduce its impact so that accurate and constructive feedback, both teacher-to-student and student-to-teacher, can be given.¹³ Simple things, like learning students’ names, giving student’s opportunities to ask questions, saying ‘Good Morning’ directly to students or acknowledging them with a smile around the hospital, are a start.

Some teachers are already adapting these kinds of practices:

Allowing feedback from students:

“I had some trepidations going into my final attachment for the year in light of the recent NZMSA showcase on bullying, however two days into the attachment our surgeon said the following to me and my classmate: ‘I know that my style of teaching can be quite abrupt and blunt and

I will push you both hard. I’ve found this to be an effective way for students to learn. However if this is too much, or if you think that it crosses a line, then I want you both to feel comfortable in letting me know that and I will adjust my approach accordingly.’ The doctor then went on to ask if we were happy to continue with this style of teaching and we both agreed that we were, but that we would like another opportunity to give feedback midway through the attachment.”

Developing the relationship

“She [doctor] greeted us with a warm welcome and big smile on our first day. She took us on a tour of the ward and introduced us to all the staff and made sure they knew who we were. We then went to a small room and she asked us questions about what schools we went to, what we did before medicine, and what we wanted to learn from this placement. She told us a bit about herself, her hobbies and her children. It felt like a safe place to discuss what we needed to do on the placement and to ask questions. This took 30 minutes. During the attachment she was quite strict and sometimes asked us difficult questions on the spot, but it was okay ‘cos we knew her and that she wasn’t going to think we were idiots for getting it wrong.”

Thirdly, students must take responsibility for their own learning.¹² If we don’t understand something, or we don’t like something a teacher is doing, we have to raise it with the teacher. We must show our teachers that we recognise it is an enormous privilege to be involved in clinical practice, and that we appreciate the generosity of the many teachers who go above and beyond to help us to learn, despite many other pressures, but that we must take initiative ourselves to make the most of learning opportunities.¹⁵ We must also learn to ask what is expected of us in each new relationship and how to give constructive feedback to our teachers about how we individually learn.

Conclusion

The blatant bullying needs to stop, that we all agree on. But the survey results show that less obvious behaviour is having just as much negative impact on students, and it is because of differing expectations. Teachers and students need to agree on what is acceptable behaviour in the teacher-student relationship, then work on developing it. A medical taskforce workgroup has been set up to form recommendations for change, but it starts now with each and every

interaction we have. We need all parties to discuss openly and honestly with each other how we can do things better.

A new approach is needed to the teacher-student relationship. We call on all teachers and students to value and respect the relationship as much as we do the patient-doctor relationship.¹⁰ We cannot change the culture overnight, but with this renewed approach the teacher-student relationship in time can develop into a relationship of trust, communication, improved learning and positive outcomes.

Competing interests: Nil

Author information:

Elizabeth Berryman (4th year Medical Student), President 2015, New Zealand Medical Students' Association

Corresponding author:

Elizabeth Berryman (4th year Medical Student), President 2015, New Zealand Medical Students' Association
 president@nzmsa.org.nz

URL:

www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2015/vol-128-no-1424-30-october-2015/6705

REFERENCES:

1. Wilkinson TJ, Gill DJ, Fitzjohn J, Palmer CL, Mulder RT. The impact on students of adverse experiences during medical school. *Medical teacher*. 2006;28(2):129-35.
2. Jamieson J, Mitchell R, Le Fevre J, Perry A. Bullying and harassment of trainees: An unspoken emergency? *Emergency Medicine Australasia*. 2015;27(5):464-7.
3. Scott J, Blanshard C, Child S. Workplace bullying of junior doctors: cross-sectional questionnaire survey. *The New Zealand Medical Journal* (Online). 2008;121(1282).
4. Tran V. Dealing with bullying and harassment: a practical guide for Australasian emergency medicine trainees. *Emergency Medicine Australasia*. 2015;27(5):473-7.
5. Wearn A, Wilson H, Hawken SJ, Child S, Mitchell CJ. In search of professionalism: implications for medical education. *NZ Med J*. 2010;123(1314):123-32.
6. New Zealand Medical Association: Code of Ethics. Wellington: New Zealand Medical Association; 2002 [cited 2002]; Available from: <http://www.nzma.org.nz/about/ethics/codeofethics.pdf>
7. Ministry of Business, Innovation and Employment: Health and Safety in Employment Act 1992, (1992).
8. Du J, Sathanathan J, Naden G, Child S. A surgical career for New Zealand junior doctors? Factors influencing this choice. *Clinical Correspondence*. 2009.
9. Gofton W, Regehr G. What we don't know we are teaching: unveiling the hidden curriculum. *Clinical orthopaedics and related research*. 2006;449:20-7.
10. Haidet P, Stein HF. The Role of the Student-Teacher Relationship in the Formation of Physicians. *Journal of General Internal Medicine*. 2006;21(S1):S16-S20.

11. MCNZ. Good Medical Practice - A Guide for Doctors. Wellington: Medical Council New Zealand 2004.
12. Cottingham AH, Suchman AL, Litzelman DK, Frankel RM, Mossbarger DL, Williamson PR, et al. Enhancing the informal curriculum of a medical school: a case study in organizational culture change. *Journal of General Internal Medicine*. 2008;23(6):715-22.
13. Wood DF. Bullying and harassment in medical schools: Still rife and must be tackled. *BMJ: British Medical Journal*. 2006;333(7570):664.
14. Jaye C, Egan T, Smith-Han K, Thompson-Fawcett M. Teaching and learning in the hospital ward. *NZ Med J*. 2009;122(1304):13-22.
15. Haidet P, Dains JE, Paterniti DA, Hechtel L, Chang T, Tseng E, et al. Medical student attitudes toward the doctor-patient relationship. *Medical education*. 2002;36(6):568-74.