Conflict between clinician teachers and their students

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Conflict between clinician teachers and their students: the clinician perspective

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Abstract
The relationship between clinician teachers and their students is of major importance in medical education. However, there is little known about the effects on clinicians when conflict occurs with their students. What do clinicians perceive to be major causes of these conflicts? How do they react when and after conflict occurs? A phenomenological inquiry exploring the lived experience of 12 clinician teachers in medical schools was performed. The clinicians were selected using purposeful sampling and snowballing techniques. The interviews revolved around discussions based on episodes of conflict with medical students that the clinicians considered significant. The analysis and emergent themes were partially constructed around and informed by theories of conflict, and conflict management. A number of themes emerged from this study. Clinicians experienced that significant psychological and behavioural problems of students had a dominant impact on the likelihood and severity of conflict; these conflicts had a significant emotional impact on clinicians; though the responses to conflict varied, "avoidance" was a mechanism commonly used by clinicians and thus the assessment of attitudinal and behavioural professional issues in the workplace was problematic. This study shows how the clinician perspective to challenging student/clinician encounters impacts on the quality of education they are able to provide. We recommend medical schools consider these issues when designing their programs in order to develop and maintain clinician–teacher engagement and participation.

Keywords Phenomenology · Conflict · Medical education · Professionalism · Problem behaviour

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Introduction

Successful clinical teaching involves developing an effective working relationship between students and their clinical-teachers. This relationship evolves through a series of encounters that are mostly positive and rewarding for both students and teachers alike. In some cases however, there are moments of significant conflict between students and their teachers. The consequence for students following these conflicts are mostly understood. However, what is not known is the impact these encounters have on the teachers themselves. If these impacts are deep and enduring, what might be the implications for that teacher and by extension their dealings with future students and for their medical programs? This study aims to shed light on this important and unexplored issue.

By understanding the *perceptions of the teachers* in this complex environment and their behaviour within it, we will be in a stronger position to design educational solutions that reconcile some of these inherent tensions and avoid significant adverse outcomes. We therefore undertook this study of clinician–teachers who had previously had at least one episode of serious conflict with a student in order to gain insights into their emotional and cognitive response to the conflict and their behaviour during and after the event.

Good clinical teachers are regarded as essential for clinical learning (Prideaux et al. 2000); being a good clinical role model may be "the most powerful teaching strategy available to clinical educators" (McAllister et al. 1997). According to Giles et al. (2012) relationships are at the heart of educational encounters. Good clinical supervision involves a partnership between learners and their supervisors with a relationship built on mutual respect and openness to student learning needs (Pront et al. 2016).

Unfortunately, there are situations where the relationship does not progress smoothly (Broukhim et al. 2018). These situations may revolve around assessment. Alternatively, there may be concerns relating to a student's professional behaviours or their personal qualities (Mak-van der Vossen et al. 2017). There may also be times where the relationship breaks down through issues relating to clinicians' judgements or lack of commitment to the teaching role (Schomair et al. 1992). Finally, there may be factors in the learning environment which conspire against the development of a satisfactory clinician/student relationship (Seabrook 2003). For example, the conflicting roles that clinician–teachers are forced to take on may contribute to tension in the relationship between student and the clinician–teacher.

What drives potential conflict within the medical education environment has been well described. According to Sawa et al. (2006) *from a student perspective*, unrealistically high expectations, stress, competition, the need to be evaluated (and the high stakes nature of those evaluations), a culture of fear and the intensity of the learning experience in medicine all contribute to the likelihood of conflict. Additionally, they argue that the culture of medical education can promote isolation and that it can be rigid and communication is sometimes indirect or masked. These elements can grind down the spirit, result in "squelched feelings" or result in open conflict.

From the *perspective of the clinician–teacher*, there are many examples of where tensions exist which may result in conflict. For example, issues related to the *structure* of the job of clinician teacher may increase the likelihood of student–teacher conflict. "Role conflict" within the work of the clinician teacher may negatively affect the relationship between teachers and students. Clinical teachers take on many and varied tasks within the teaching role and sometimes need to switch between tasks from moment to moment. The inherent tension between these tasks may be difficult to reconcile. This is particularly the

case in the role conflict embodied in the mentor/coach versus assessor roles. It is known that this may have effects on trainee learning, the quality of the assessment and the emotional health of trainee and trainer (Cavalcanti and Detsky 2011). Sometimes this intra-role conflict can create a "disquieting paradox" for the clinician if their role as a gatekeeper conflicts with their own personal values (Bogo et al. 2007). For example, Cavalcanti and Detsky (2011) point out two major problems with the dual supervisor/assessor role; firstly, the problem of trainees concealing weaknesses to evaluators and secondly the conflict of interest for the evaluator, because as a coach s/he also has a vested interest in the trainee's success. Others (Taherian and Shekarchian 2008; Sambunjak et al. 2006) point out the potential conflict of interest in mentors multiple roles. They argue that "mentors should not be the mentee's educational supervisor or line manager or otherwise be involved in their assessment or appraisal to avoid blurring these distinct roles". Furthermore, these multiple roles (and accompanying workloads) and the subsequent need to prioritise one over another may also effect the student–teacher relationship. For example, if a clinician continually prioritises patient care over student needs, this might result in the relationship becoming damaged (Hoffman and Donaldson 2004).

Assessment is often central to the tensions around the student/clinician–teacher relationship and may be a source of conflict (Watling et al. 2010; Cleland et al. 2008; Dudek et al. 2005). The tensions inherent in the assessment process are known to sometimes result in the so called "failure to fail" phenomenon. Yepes-Rios et al. (2016) undertook a systematic review on the failure to fail phenomenon. The factors they identified as barriers to failing trainees included evaluators' personal and professional considerations, trainee-related considerations, unsatisfactory evaluator development and evaluation tools, institutional culture and lack of available remediation for trainees. From this research it is clear that a number of elements potentially "feed in" to assessment decisions and by extension, into any conflict episode which may arise from a failing grade.

This powerful mix of high-stakes assessments (with significant consequences for students and their supervisors), competition, role ambiguity and role conflict, personality and behavioural issues, and a sometimes secretive culture combined with poor communication creates an environment where interpersonal conflict is likely (Broukhim et al. 2018).

What is the effect on clinician–teachers when this conflict occurs? There are reports of supervisors feeling stressed and drained when giving negative feedback but very little information on the effect on the teacher and their subsequent response when manging a serious conflict with a student. What happens to a clinical teacher (psychologically and practically) when faced with a potential episode of conflict with a student? What strategies do teacher/clinicians employ who are able to successfully manage these events?

Frequently cited theories of conflict and conflict management are those of Kilmann and Thomas (Thomas 1976, 1992; Thomas and Kilmann 1978; Kilmann and Thomas 1975) They argue that there are five basic styles of *conflict handling behaviour* and have developed a model based on different mixes of assertive/unassertive and cooperative/uncooperative behaviour (Fig. 1).

In this model, the party's "strategic intent" is classified and plotted along two basic dimensions of intent, namely assertiveness and cooperativeness. "Assertive intent" describes the individuals' attempts to satisfy their own concerns and "cooperativeness" the extent to which the party attempts to satisfy the other's concerns. Five approaches to managing conflict are classified in terms of these dimensions. This scheme of conflict-handling provides a useful framework for understanding how individuals approach conflict situations. There is some evidence that physicians and other medical educators tend to use avoiding, compromising and accommodating strategies (Ogunyemi et al. 2013), but most

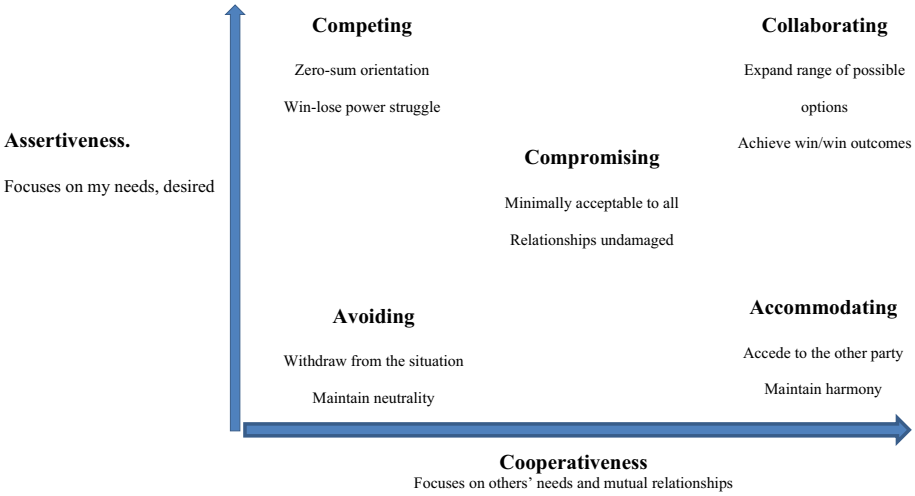

Fig. 1 Model of conflict handling behaviour

studies regarding conflict have been in nursing with few studies of medical students or doctors (Sportsman and Hamilton 2007). The theories of Thomas and Kilmann were used in part as a theoretical lens to inform the analysis of this study.

These issues come into sharper focus when one considers the direction that medical education is heading. Many medical schools around the world are now using or considering the use of programmatic assessment for learning, which relies heavily on the provision of direct feedback and the involvement of a mentor/coach (Van der Vleuten et al. 2012). Very few of these schools are resource rich, especially in relation to their clinician-academic resources. If the effect of conflict on clinicians is sufficiently bruising, the consequences are likely to impact on the medical school. For example they may decide to withdraw from the education role. Yet, in workplace-based assessment and even more so in programmatic assessment, faculty will sometimes have to combine the roles of teacher/mentor/coach and provider of feedback/assessor. Although this is plausible in theory, there is already evidence that students have difficulty distinguishing between the role of assessor or coach in programmatic assessment environments (Bok et al. 2013).

For all the reasons discussed, conflict is likely to occur at times during workplace-based learning. The way clinician–teachers respond to these conflicts may have significant consequences for medical programs. The current literature gives us limited insight into the effect of that conflict on the clinician teachers involved and how they manage those conflicts. The overarching questions of this research are therefore; how do clinician teachers perceive the factors which contribute to conflict between themselves and their students, what strategies do they employ to manage conflict, and what are the consequences of the conflict on the clinician and their subsequent actions?

Methods

A phenomenological inquiry was undertaken to explore the lived experience of clinicians who were involved in conflict with their students. Phenomenology was chosen as the most appropriate method to undertake this enquiry because the research was seeking to understand the conscious experience of the clinicians (their judgments, perceptions, and emotions) relating to their relationships with students during these moments of conflict (Colaizzi 1978; Creswell 2007). Purposeful sampling was used to select individuals for interview. Clinicians who were known to have experienced significant conflict with their students in the course of their work were invited to participate. Snowballing was used to expand the sample (Creswell 2014). Twelve experienced clinicians (four female and eight male) were interviewed using a semi-structured interview technique. The clinicians involved all had teaching and mentoring roles with medical students. Three surgeons, two general practitioners, and seven physicians participated, and their places of work included major urban hospitals, rural and remote environments and regional centres. The teachers were involved in the two medical programs in South Australia. One is predominantly a post-graduate medical program, the other predominantly an undergraduate program.

Ethics committee approval was received from the Southern Adelaide Local Health Network ethics committee.

Semi-structured, in-depth phenomenological interviews were undertaken. Following an introduction to orientate the interviewees to the topic, the interviewer asked the interviewees to describe one or more episodes from their experience where they identified a significant conflict with a student. The interviews explored the views of the interviewees as to the circumstances leading to the event, their experience of the conflict and the consequences of the episode. In other words, the questions were "directed to the participants' experiences, feelings, beliefs and convictions about the theme in question" (Welman and Kruger 1999). "Memoing" was used as the study progressed in order to facilitate reflection on what was happening during the interviews and as the analysis developed. Observational field notes were also made by hand as during the interviews to help make sense of the interviews. Additional data (personal notes provide by some of the interviewees as to the circumstances and outcomes of some of the episodes) were also involved in the analysis and provided the opportunity for some triangulation of the data.

The audio-recorded interviews were transcribed with the permission of the interviewees and then the data were de-identified. Two recording devices were used to minimise the risk of equipment failure (Easton et al. 2000). The transcripts were then given back to the interviewees for checking and an opportunity was given to all the interviewees to change or add any material they felt was relevant. The interviews were then read, and the transcription checked for accuracy and then coded. Initially coding was undertaken by two reviewers (EMS and LS). After initial codes were generated, further coding was undertaken by a single reviewer but further codes were generated as an iterative process with involvement of both authors (EMS and LS). All authors had input into the generation of the major themes. Further validation of the themes was provided by the interviewees themselves who received advanced drafts of the analysis for comment (Ely et al. 1991; Lincoln and Guba 1985).

Interviewing was continued until no new ideas relating to the phenomenon were revealed, that is interviewees introduced no new perspectives. Saturation was achieved when no new themes emerged and no further coding was possible (Guest et al. 2006). This

occurred after twelve interviews. The principle researcher (EMS) is himself a practicing clinical teacher and has had some experience of this particular phenomenon. As such, the bracketing of his experience and reflexive writing in the research process was especially important in order to avoid prejudging the data and in order to gain the essence of the experience. However, hermeneutic researchers posit that these prior experiences might in fact become sources of knowledge and sensitise the researcher to meanings that might be presented in the narratives of the participants (Holloway and Wheeler 2010). The identified risk was the possibility of attempting to bring out the worst of the experiences and focusing too hard on these, to the possible detriment of seeing the positive experiences and opportunities arising from the conflict. By identifying this issue as recorded during the memoing process, the researcher made particular effort to enquire and pursue the more positive elements of the phenomenon. This issue was also discussed extensively by all three authors in the development of the discussion and this resulted in a paper which emphasises the learnings from the experiences of the clinician teachers.

Analysis of the interviews was undertaken using the philosophy of Heidegger and methods described by Colaizzi (Hyener 1999; Colaizzi 1978). Briefly, this analysis involved reading the whole interviews (repeatedly if necessary) in order to develop a holistic sense (the "gestalt") of the interview. The interviewer attempted to "bracket out" their own presuppositions and not allow their own meanings, interpretations or theoretical concepts to "enter the unique world of the informant/participant" (Groenewald 2004; Moustakas 1994). Units of meaning were delineated in order to illuminate the research phenomenon taking into account the literal content, the number of times the meaning was mentioned and how the meaning was delivered. Units of meaning were clustered to form themes to express the essence of the clusters. A composite summary was written to reflect the context from which the themes emerged. Multiple cycles of reflection and rewriting involving all authors produced the final manuscript.

According to Neubauer and Witkop (2019) in the hermeneutic approach to phenomenology, theories can help to focus inquiry and help understand the findings of the study. Thomas and Kilman's theories of conflict handling strategies were used in part to inform the analysis.

Results

The major themes which emerged from this inquiry concerned clinicians' reflections on student behaviours, reflections on their personal emotional experiences of the conflict and their responses to the conflicts. Assessment and clinicians' difficulties with the assessment process were a recurrent theme. Role conflict was considered to be an issue in clinicians' lives, but generally not a major management problem. Finally, the clinicians described powerful motives that underpin their continued involvement in teaching which go well beyond notions of personal gain. These themes are discussed below.

Clinicians' reflections on student behaviour

Clinicians highlighted the fact that significant conflicts with students were uncommon events and that the majority of the encounters were respectful and positive. However, when serious conflict did occur it was often in the context of students thought to have significant, deep seated personality or psychological problems. The students' responses to the conflict

often involved real or threatened violence either directed against the clinician or on occasions, themselves. These episodes left the clinicians feeling deeply uncomfortable. Sometimes they felt physically threatened.

> "He said "would I just go home and immediately leave town" and I said like "Why" and he said "oh because I've just had a phone call from a very distressed student and they've threatened your life to me on the phone and they've indicated that they're distressed and they've amputated their thumb" He had an army background and he had been a sniper in the army before he joined the medical program…." F02
> (Clinician F02 relating an urgent telephone conversation with a colleague.)

A number of these students were well known to have had previously identified personality or repeated behavioural problems prior to their clinical attachments.

> "On the first occasion I met her she had presented with an episode of self-harm and she disclosed to me at that time that she'd engaged in some sort of deceptive behaviour to be able to do that self-harm in terms of misrepresenting herself to a pharmacy to get medications to use for an overdose." F01

The fact that some of these issues had been previously identified in earlier years of the medical program, and the students had still been allowed to progress was a source of frustration for the clinicians. On occasions despite the school being aware of the issues, they had not been passed forward to the clinicians supervising the students.

The other element of student behaviour which was frequently commented on by the clinicians was the difficulty that these students had with accepting feedback. In one exchange, a (male) medical student physically stood over a (female) clinician in an exchange where she felt physically threatened.

> "He got incredibly angry and disagreed with every point I made and seemed very, almost delusional, but really resistant or disagreeable with respect to every domain that I had sort of said he had underperformed at, and it was despite notes that I had carefully taken in front of him where it was clear that he hadn't really presented well" F03

The emotional impact on clinicians

Clinicians often work in emotionally charged environments, particularly when dealing with sick and dying patients. They are usually able therefore to manage the emotions resulting from negative exchanges with their students effectively. Without doubt however, many of these exchanges evoked strong emotions in the doctors which flowed through to other relationships.

> "I had one suicide that occurred as a consequence of the assessment which, was very disturbing, and I spent a lot of time thinking about, how I was going to deal with it and I sought some help…" M03

Managing the conflict

The clinician responses to conflict varied significantly, but avoidance was a common response. This often revolved around moderating the student assessment or a so called "failure to fail" approach.

> "But what I'm really trying to say is that 4's not a good mark. The 4/7 looks, you know, everyone can go around saying "oh I passed, I passed, I passed" **but** that's a shit mark, that's code, that's my code…a hidden code but…um, so this is, ah, so this is the controversial bit, I think, because it's, it's a scale of, um, 1-7 so basically now I think a 4 is sort of code for not very good…I don't think we've needed to give a 3, like to give a 3 is a harsh, we give it as a fail…"M06

Some reported a wish to avoid conflict or the consequences of conflict;

> "I might have shied away from being, challenging because, I liked to be seen as pleasant and, loving and caring and all those things". F02

Others described "retreatism" that they had observed in their colleagues;

> "At least one of the supervisors along the way was developing the attitude of "bugger it I don't want anything more to do with this…" M08

Disengagement with subsequent student education was reflected upon frequently, with some of the interviewees observing that they had previously been far more engaged with the teaching programs prior to their damaging student encounters.

If clinicians' behaviours fell more strongly in the "competing" domain of conflict management a lot of their energy was spent on making their responses more "defensible" with careful written records of the experiences with that student.

> "And then we needed to think about how we could frame the feedback in such a way that it was specific enough to be defensible… if we had to defend, you know, in court or in some situation the claim that the student said that she hadn't been supported" F02

This approach was reinforced by one story of a clinician having to face a student's lawyer in an appeal situation, without the support of legal representation from the University. This was clearly a psychologically traumatic event for the staff member involved who felt isolated and ambushed.

Clinicians' struggle with assessing students professional behaviours

Many clinicians felt it was difficult to fail students without clearly measurable domains to base this judgement on. They felt comfortable giving students poor grades in the knowledge domain, and comfortable if the behaviour of the student was *measurably* poor (for example repeatedly tardy attendance). However, the "space in-between", where many of the problems really lay, was very difficult to assess and hard for the clinicians to rate the students in these areas. Issues raised by the clinicians as difficult to assess included attitudes, motivation, professional behaviours, avoidance behaviours, and communication skills. Some of this hesitancy related to a view that the domain was inherently difficult to assess, whilst others lacked confidence in their own abilities to undertake this task.

> "I mean these things are all very subjective, I think these assessments of students, I don't know actually how you, based on my previous experience, I don't know how you actually fail a medical student. I don't know whether any of them ever fail". F01

Role conflict issues mostly related to work load

The majority of the "role conflict" issues identified by clinicians related to workloads and balancing various demands of their multiple jobs.

> "I mean there's, there's a great tension. I would describe it in terms of you having to work for multiple masters, so may be for instance in this case you can say you work for the state health department and they demand 100% of your time and you work for the university and they demand 100% of your time and sometimes you're involved in other things and they demand 100% of your time so, trying to make that 300% fit into 100%, is a very difficult tension"… M.01

Occasionally, the question of mentor versus assessor emerged, but others felt no conflict in this situation.

> "I think, I think a caring mentor can still be an objective or a fair assessor…I don't see, the, mentor versus providing difficult feedback to students as a conflict, as a inter role conflict. I think it's like being a mother and my responsibility is equally to have fun with my children…as to tell them off and make them go to bed…you know like, um, so I don't see it as a conflict". FO2

Clinician teachers are strongly motivated by altruism

The overwhelming sense of a responsibility to the community, the profession and the institution (university, health service) were the dominant reported motives of the clinicians. Personal satisfaction by way of helping students to develop was also discussed whilst financial incentives were barely mentioned.

> "My incentives would be more a sense of the greater good if I can call it that, my responsibility towards the community… and I would like to see a just society where people get, just, care…ensuring, there's, I would say that that would be the strongest motivation for a lot of medical teachers would be some kind of a, a personal value that they place on, providing the community with good doctors or providing good teaching to medical students or having some kind of a feeling of personal responsibility in that regard"… M01

Discussion

This phenomenological inquiry has examined the lived experience of clinician teachers working in the health services and Universities. The inquiry focused on moments of significant conflict with their students and their views as to the causes of the conflicts and how those conflicts were managed.

One of the clearest concepts to emerge from the enquiry was how deeply these clinicians were emotionally affected when dealing with such conflict. On occasions they felt isolated and abandoned by the institutions in which they worked. On other occasions they reported that the conflict episode had impacted on their relationships with others and they sought psychological support from outside the institution. These emotions were deep seated and persistent. On occasions the stories related by the subjects had occurred several years prior to the interviews and yet remained as vivid memories. It was clear that the severity of many of the episodes was well beyond what an individual teacher could reasonably be expected to manage alone. These situations required an institutional and organisational response which was lacking.

The causes of the conflict as reported by the clinicians were often complex and multifactorial. Assessment was often a part of the mix of causes and sometimes a tipping point. Other causes which emerged were poor student professional or learning behaviours (in particular a perceived lack of ability to reflect on feedback), the high stakes nature of the assessment, and workload issues of clinicians combined with time constraints when managing students. Role conflict per se did not emerge as a strong theme amongst the participants, although it was occasionally eluded to. There were however plenty of examples of "failure to fail" either discussed directly or obliquely. This suggests that although clinicians did not consciously articulate the notion of role conflict within their jobs, one of the major consequences of this phenomenon was very much on show.

In terms of managing the conflicts, of the five potential responses to conflict in Thomas and Kilmann model most of the approaches adopted by the clinicians involved responses in the "avoiding" or "competing" domains. There appeared to be little in the way of "compromise", "collaboration" or "accommodating" domains. Presumably this was because those strategies had been used on occasions which had resulted in resolution of the conflict to the satisfaction of the parties concerned. Also, because we focused on major conflict, it is possible some of the more collaborative type approaches could not be effectively employed to manage the dispute. The reflections of the consultants relating to "avoiding" mainly related to their future activities following the major conflict episode. Offering emotional intelligence training to enable clinicians to be more aware of their emotions and those of their students might be a way to successful conflict resolution for some (Ogunyemi et al. 2013).

Many admitted that following the conflict they either modified future student assessments or reconsidered their involvement in student teaching (i.e. engaged in role retreatism) (Stryker 2001). This should be of considerable concern for those involved in student assessment. Motives for this type of (future) behaviour included not wanting the personal trouble, not wanting the emotional or legal impact, and wanting to minimize the impact on the future students. They also frequently alluded to this type of behaviour in their colleagues. These concerns echo strongly many of those themes reported in a recent systematic review of the literature on the subject of 'failure to fail" (Yepes-Rios et al. 2016). In particular the themes identified in the review that focused on the assessor's "professional and personal considerations" and "unsatisfactory evaluator development and evaluation tools" emerged strongly in our enquiry. In addition, the work by Ziring et al. (2018) regarding faculty's reluctance to report medical student's professionalism lapses resonated with our work. In particular the "uncertainty about the process" and the need to substantiate lapses in case of challenges or appeals were commonly expressed views in our interviews. Supporting teachers in teaching and assessing professional behaviour and involving them more directly in students' remediation may help reduce their reluctance to fail students demonstrating unprofessional behaviour (Mak-van der Vossen et al. 2014).

The notion that these events were isolated and rare, and therefore could be handled on an individual level, is not born out by the data. It became clear that frequently what was missing (from the viewpoint of the clinicians) was an adequate integrated response from their organisation. The early identification and management of students with significant behavioural issues, ongoing faculty development concerning assessment and better support during appeals processes were all identified by the clinicians themselves as approaches which might help manage some of these episodes. There is already sufficient evidence that prior behaviour in medical school (including a diminished capacity for self-improvement) is a predictor of disciplinary action taken by medical boards following graduation (Papadakis et al. 2005). One element of the student behaviour identified by the clinicians was their inability to accept and act upon negative feedback. Perhaps the missing link here is the students' lack of reflection (Sargent et al. 2009) and this is something that could be taught and learned early in medical training (Driessen et al. 2005). Improving remediation pathways and providing honourable exit strategies for medical students unable to complete training may help reduce the psychological distress for both students and educators (Ellaway et al. 2018). This approach however relies on a community of teachers with high levels of teaching presence (Winston et al. 2012) and may be beyond reach of many clinician teachers untutored in high level teaching skills. Perhaps the development of teams of remediators using appropriate coaching techniques and learning plans (Kalet et al. 2017), thereby separating clinicians from this task might be a pragmatic way to manage some of these situations. Finally introducing clear pathways for managing significant and repeated professionalism relapses might assist faculty to negotiate some of these situations (Mak-van der Vossen et al. 2019).

Addressing these issues at an organisational level requires clear communication between preclinical staff, clinical staff and educational designers. Creating and supporting a learning culture and acknowledging the role of the clinicians emerge from this inquiry as two practical and positive activities that medical schools and universities can undertake to support this group of teachers. From these actions could emerge a large number of strategies which would assist clinicians in this task which is central to the future of most medical schools' teaching programs. These strategies could include better managing time and teaching commitments (Seabrook 2003), focusing on assessment literacy development, identifying and managing conflicting roles and encouraging and supporting intrinsic motivation (Schomair et al. 1992). Assessor training in delivering difficult messages to students and trainees (Jervis and Tilki 2011) developing support systems to assist with managing mental stress when dealing with conflict (Pratt et al. 2013) and the training of clinician–teachers in ethical competence as an enabler for failing a trainee "as part of a deeply rooted sense of duty" (Black et al. 2014) are all approaches that have been considered and which might help manage these issues. One of the most challenging approaches to diffusing many of the conflict moments reported in this study could be to change the culture of assessment to a culture of improvement. Moving from a summative assessment culture a programmatic assessment process with multiple low-stakes assessments combined with rich feedback could reduce many of the high tension moments. However, such a change is immensely difficult to achieve especially in the face of deeply-rooted personal beliefs among clinicians and students (Harrison et al. 2017; Watling and Ginsburg 2019). Rethinking and addressing tensions within the medical education environment using novel tools such as the Polarity Thinking™ model outlined by Govaerts et al. (2019) might help reduce the potential conflicts within the assessment process.

One of the strengths of this study was the rigorous application of the phenomenological approach employed to delve into the experience of these clinician–teachers. However,

this study's generalisability is limited by the nature of the inquiry. According to Moustakas (1994) the empirical phenomenological approach involves a return to experience in order to obtain comprehensive descriptions that provide the basis for a reflective structural analysis that portrays the essence of the experience. That is the intent of this work, namely to portray the essence of the experience of the clinician teacher when facing a significant conflict with their students. It is not an attempt to systematically analyse the problem and design solutions, nor is it an attempt to generate testable hypothesis to examine the issue in any quantitative way. We did not attempt to obtain the student perspective in the conflicts described and from that perspective cannot claim to be balanced. Nonetheless the study gives us an insight into the lived experience of clinician teachers and some of the significant challenges they face. We attempted to validate the study with triangulation of written material and member checking. Although member checking is considered the most crucial technique to establish credibility (Lincoln and Guba 1985) it also has its drawbacks. Member checking relies on the assumption that there is a fixed truth of reality that can be accounted for by a researcher and confirmed by a respondent. Of course in this reseach there is no "fixed truth" with which the result of the study can be compared and therefore our work is open to alternative interpretations (Angen 2000, Sandelowski 1993).

This research has attempted to "shine a light" on an under-reported phenomenon, namely the impact serious conflict may have on medical clinician teachers. As a result of our research we would recommend medical schools consider these potential impacts on their faculty, and consider ways to better manage these episodes. Failure to do so may result in disaffected and disengaged teachers with significant consequences for students and medical programs. By acknowledging and understanding these issues it is possible to empower faculty and strengthen the relationship between Universities, clinical staff and their future students.

Compliance with ethical standards

Conflict of interest The authors report no declarations of interest.

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