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Exploring Attitudes of Resident Doctors Towards Teaching Undergraduate Medical Students: A Concurrent Mixed-Methods Study

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Abstract

Background

As medical students begin clinical attachments, healthcare staff, particularly resident doctors, become directly involved in their education, often alongside their clinical duties. Existing literature mainly focuses on consultants. To identify modifiable barriers to effective teaching provision, the researchers explored resident doctors' attitudes towards teaching medical students during clinical duties.

Methods

A questionnaire was distributed to resident doctors at one hospital in 2024 (41.7% response rate), with statements rated on a five-point Likert scale and space for supporting comments. Qualitative data were analysed using Braun and Clarke's thematic analysis process. The quantitative and qualitative data were triangulated and augmented by reflexivity.

Results

Three themes were identified and related to previous literature. First, conflicting identities as clinicians and teachers were often a source of frustration, particularly as doctors enjoyed providing high-quality teaching. Doctors reported that material support was needed (and often lacking) to foster a teaching culture. They offered suggestions for overcoming these tensions, particularly training in teaching and curricula, and expressed a strong desire for change. Third, respondents recognised a collective responsibility for education within the learning environment and did not place blame on learners.

Conclusion

This study has demonstrated a rich narrative describing resident doctors as enthusiastic teachers who experience multifactorial challenges to effective teaching practice, alongside a desire for change. As they are not a homogeneous group, further work is needed to compare attitudes across different settings and stages of training.

Categories: Medical Education
Keywords: medical education, medical student, mixed methods, resident doctor, undergraduate

Introduction

The structure of UK medical school education involves a shift from didactic teaching to clinical apprenticeship, thus directly involving clinical healthcare staff in students' education. Resident (non-attending/consultant) doctors are expected to provide this informal teaching during their busy clinical duties.

The value of situating learning within the clinical context has been highlighted by Lave and Wenger through the theory of legitimate peripheral participation [1]. Historically, medical students have highlighted challenges in professional socialisation during attachments [2,3]. Consultants have previously commented on the difficult balance of competing roles of research, service provision, and teaching [4].

The General Medical Council's professional standards in Good Medical Practice highlight skills in teaching and mentoring [5]. While there are training courses, they are expensive and time-consuming, and attendance can therefore be prevented by reductions in study leave budgets and rota shortages.

Existing literature has mainly explored consultant attitudes towards undergraduate medical education in a

secondary care setting, with some research in general practice [6-11]. Harris et al. summarised findings into two main themes: Doctors vs Teachers and Teaching Practicalities [12]. Whilst consultants contribute greatly to undergraduate teaching during their Supporting Professional Activities (SPAs), their day-to-day duties are arguably less relevant [6-13].

Amid the paucity of research surrounding resident doctors and teaching, Hayden et al. also highlighted the tensions of carrying both clinical and educator roles, alongside various material barriers to teaching on the acute take [14].

This paper explores resident doctors' attitudes towards and perceptions of teaching medical students to identify modifiable barriers to effective teaching provision in this informal setting.

Materials And Methods

Institutional setting

The Rotherham main hospital site is a 370+ bed acute and community hospital with over 200 resident doctors on the establishment, not including locum doctors. Each year, the institution hosts approximately 300 medical students from the local university for clinical placements.

Questionnaire design and data collection

A paper questionnaire was distributed to resident doctors in all departments within the hospital over six weeks from May 2024. Convenience sampling methods were used, with the primary researcher visiting teaching sessions, departmental meetings, and clinical areas to distribute the questionnaires.

The rationale for using paper questionnaires rather than online/email questionnaires was the high number of locum doctors in the trust who were not formally on the establishment and the traditionally low response rate for electronic questionnaires.

The questionnaire consisted of six sections and is included in the Appendices. Sections 2-4 comprised a total of 23 statements rated on a five-point Likert scale (1 = strongly disagree, 5 = strongly agree), followed by space for supporting comments.

The questionnaire statements were based on validated content by Hendry and Darragh [6,7] and modified based on feedback from a supervisory consultant body. Informed consent was implied by completion and return of the questionnaire, which was accompanied by a Participant Information Leaflet. Questionnaires were printed using recycled paper in A5 booklet format to reduce paper waste and promote sustainability.

Data analysis

Percentage frequencies, means, and standard deviations of quantitative data were calculated to determine trends in agreement with the questionnaire statements. Qualitative data (free-text responses) were collated and coded by the primary researcher using Microsoft Word. Codes were grouped into themes and subthemes using Microsoft Excel, following the six-phase reflexive thematic analysis by Braun and Clarke [15]. Figure *1* shows the final concept map.

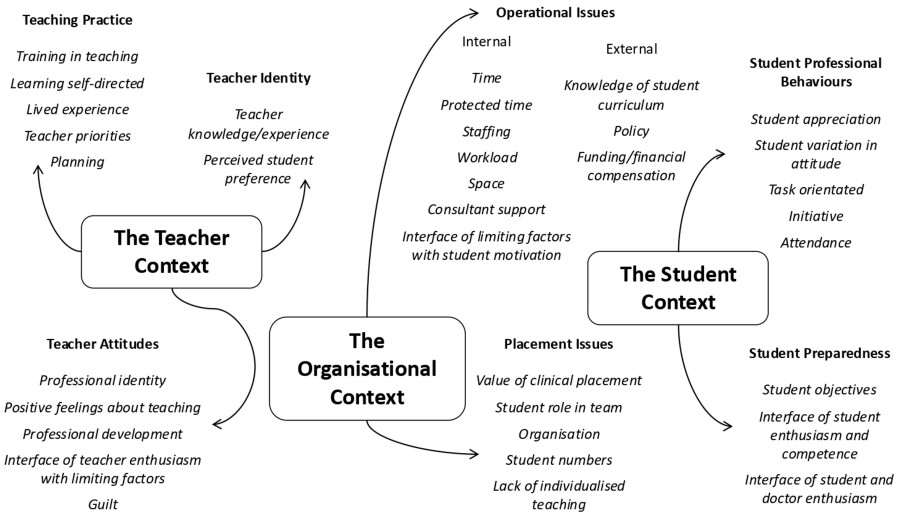


FIGURE 1: Concept Map of Analytical Themes and Codes

As a concurrent mixed-methods study, data were triangulated to extend the range of explanations drawn from them. Qualitative data therefore clarified and elaborated on the quantitative data and were further augmented by reflexivity [16]. This was important given the concurrent roles of the main researcher as a resident doctor and a teaching fellow, and of the other study authors as members of the undergraduate and postgraduate education teams. These strong interests in and passion for education have affected the interpretation of opinions and the identification of themes within the data.

Results

Demographics

A total of 192 questionnaires were distributed, and 80 (41.7%) were returned completed. The breakdown of respondents' training grades is shown in Table *1*. Figures *2*-*4* show the full quantitative responses, with salient points expanded on below.

Variables	n	%
FY1	14	17.5
FY2	6	7.5
GPST	4	5
IMT/CT/ST1-2	13	16.25
IMT/ST3+	12	15
JCF	13	16.25
SAS	16	20
Other - Locum SHO	2	2.5

TABLE 1: Training Demographics of Participants (n = 80)

n: number of participants; FY1: Foundation Year 1; FY2: Foundation Year 2; GPST: General Practice Specialty Trainee; IMT: Internal Medicine Trainee; CT: Core Trainee; ST: Specialty Trainee; JCF: Junior Clinical Fellow; SAS: Specialty and Associate Specialist; SHO: Senior House Officer.

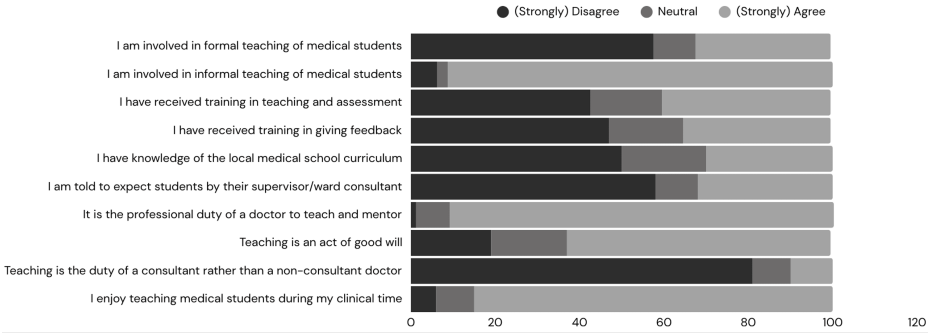


FIGURE 2: Bar Chart of Responses to Section 1 of Questionnaire

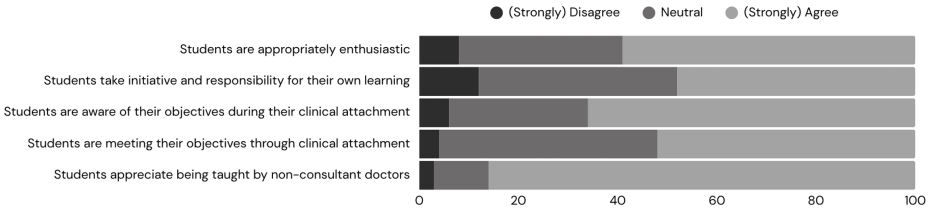


FIGURE 3: Bar Chart of Responses to Section 2 of Questionnaire

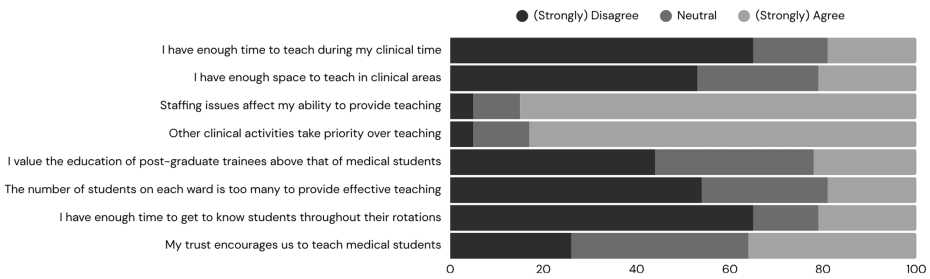


FIGURE 4: Bar Chart of Responses to Section 3 of Questionnaire

Doctor training/attitudes to teaching

Most respondents (73/80, 91.3%) stated that they were involved in informal teaching. Only 34/80 (43%) agreed that they had received training in teaching/assessment, with half (40/80, 50%) having knowledge of the local medical school curriculum. Most (73/80, 91.3%) agreed that it is the professional duty of a doctor to teach, and only 8/80 (10%) agreed that teaching is the duty of a consultant rather than a non-consultant doctor. The majority (68/80, 85%) stated that they enjoyed teaching during their clinical time.

Student attitudes to teaching

Responses were mainly positive towards student attitudes. Of the respondents, 47/80 (58.8%) felt that students were appropriately enthusiastic, but only 38/80 (47.5%) agreed that students took initiative and responsibility for their own learning. Whilst 52/80 (65%) agreed that students were aware of their objectives, only half (42/80, 52.5%) perceived that they were meeting them through their clinical placement. The vast majority (69/80, 86.3%) felt that students appreciated being taught by non-consultant doctors.

Practical considerations

Only 15/80 (18.8%) of respondents felt that there was enough time and 17/80 (21.3%) felt that there was enough physical space to teach medical students. Staffing issues affected the ability of 68/80 (85%) of doctors to provide teaching, with a majority (66/80, 82.5%) feeling that other clinical activities took higher priority than teaching undergraduates. Only 15/80 (18.8%) felt that there were too many medical students in clinical areas to provide effective teaching, but 52/80 (65%) felt that they did not have enough time to get to know them during their attachments.

Qualitative data

Of the 80 respondents, 73 (91.25%) made at least one free-text comment in the questionnaire. We generated three main contextual themes from the data. The data are presented below in subthemes, supplemented by illustrative quotes with the questionnaire section (S), participant number (P), and respondent's grade.

The teacher context

Teacher Identity

One constructed concept was that of the "ideal teacher". Respondents acknowledged that doctors at different stages of training possess varying yet equally valuable skills, which should be tailored to the learner and subject.

"Clinical teaching is best delivered by post-MRCP/S doctors. Ward skills, understanding day to day work of FY1/SHO is best delivered by that grade. Teaching clinical skills of FY1/SHO is best done when observed by someone who has sat their post grad exams." (S6. P13. IMT/CT/ST1-2)

Nonetheless, respondents felt that students were generally happy to be taught by anyone. However, they acknowledged that whilst resident doctors were more relatable role models, consultants held valuable specialist knowledge.

"I can see how students may feel they are missing out on specialist knowledge if their allocated consultant is not involved in teaching." (S3. P46. FY1)

Teacher Attitudes

Many respondents expressed a belief that teaching is a core duty of a doctor, "fundamental" and "invaluable". However, some commented that teaching should be voluntary, depending on ability and enjoyment. Attitudes were positive towards teaching, notably recognising its value for respondents' professional development. Formal acknowledgement of teaching through certification or qualification was valued for career progression.

"I feel challenged and excited when there are medical students in the department... Even when one has the knowledge, teaching it to someone else is not always straightforward." (S6. P8. SAS)

"When students are on the ward the ward rounds tend to be more informative since the consultants tend to slow down and teach them. This in turn is very helpful for junior doctors as well." (S6. P22. IMT/CT/ST1-2)

Despite their wish to dedicate more time to teaching, respondents recognised some barriers to their efforts and intentions. Although these barriers were outside their control, they expressed feelings of significant guilt when struggling to teach.

"Understaffing and busy ward rounds make me feel so stressful as I do not have enough time to teach them and felt so sorry and guilty for not teaching them." (S4. P29. FY1)

Teaching Practice

Most respondents commented that they had "never" received training in teaching. However, many expressed a desire to teach, describing self-directed strategies at their own expense and in their own time. Notably, such opportunities are not accessible to all and may be of variable quality.

"I am tired even from the normal day job... I have done an e-learning teaching course, but don't feel we get any proper teaching as part of the curriculum." (S2. P70. IMT/CT/ST1-2)

Graduates of the local medical school commented that their own undergraduate experience influenced their teaching practice and knowledge of the curriculum. Another theme identified was that this identity was the sole reason they had curricular knowledge and that they were unable to identify where this information could otherwise be found. Further links were drawn between respondents' lived experiences during their student years and how and why they undertake teaching today.

The organisational context

Placement Issues

Respondents recognised the value of clinical placement as a tool to develop students' knowledge, with particular emphasis given to student participation and integration, notably a defined role in the clinical team. This, in effect, was linked to the respondents' ability to effectively deliver teaching tailored to individual students, alongside factors such as length of placement and student numbers.

"I find it easier once I have gotten to know the student as you develop trust and a working relationship- then medical students can be assets to the workplace." (S6. P70. IMT/CT/ST1-2)

There was, however, no consensus as to whether the number of students hindered teaching ability; this appeared to depend more on each clinical area, particularly as recognised by respondents themselves undergoing rotational training. Furthermore, respondents described poor communication regarding when to expect students, expressing that this information was vital for them to structure teaching alongside their clinical workload.

"Never know to expect medical students … Feels like a heart sink when several turn up on a busy day." (S6. P6. FY2)

Internal Operational Issues

Respondents strongly emphasised a lack of time in the working day to both prepare and deliver teaching while addressing wider clinical pressures. While respondents recognised factors such as "careful planning, time, and dedication" as important for effective teaching, they recognised that inadequate preparatory time could favour a less ideal "ad-hoc" approach.

"Quite often there is barely enough time in the day to complete the jobs, needed to provide good patient care and to keep patients safe- this does take priority" (S4. P70. IMT/CT/ST1-2)

As a result, many respondents voiced a desire for protected time in their work schedules for teaching. They reported that teaching was presently carried out during their rest time or by working beyond contracted hours to "catch up on jobs". Protected time was felt to contribute to higher-quality teaching and a more manageable workload.

"I feel more time should be included in junior doctors' work schedules for clinical teaching. Making it a part of an already strained work day often feels like too much to take on." (S6. P40. FY1)

Another expressed barrier was staffing shortages, contributing to a lack of teaching time due to increased workload. Respondents reported that they "struggled" and found this prospect "stressful". Regardless, clinical pressures alone were recognised as a barrier to teaching by many respondents, particularly having the "neural bandwidth" and "energy" to teach alongside competing patient-centred priorities.

Whilst respondents expressed appreciation for adequate physical space in the study setting's Medical Education Centre, they also highlighted a lack of appropriate space in the clinical environment except at the bedside, without which delivering high-quality teaching posed a significant challenge. There were no specific comments offered regarding space in the outpatient environment.

"If I have time put aside, then the next constraint is space. Wards are not supportive learning environments for formal sessions beside bedside examinations. Having bookable rooms… would be helpful." (S6. P44. JCF)

Respondents did not only comment on physical resources when considering effective teaching practices. Supportive consultants who were keen to teach were identified as influential in respondents' ability and enthusiasm. The ward round was highlighted as a valuable opportunity or limitation for both professional development and teaching.

"I wish I could spend more time on [ward round] to provide education but I find that the rounds are often rushed/relies on having a consultant who also wants to teach." (S4. P44. JCF)

External Operational Issues

Many respondents volunteered a lack of knowledge of the undergraduate curriculum and acknowledged that this affected the quality of their teaching. Respondents were not clear about where to find this information; those who did know stated that the sole reason was that they were medical school alumni.

Respondents reported a lack of institutional formalisation, which was freely expressed without any explicit positive or negative stance. Additionally, two respondents offered suggestions for more funding for training and financial compensation for the efforts and time of educators.

"In my opinion the NHS and curriculum providers need to put more funding into training effective supervisors and educators." (S6. P7. SAS)

There was acknowledgement of the relationship between operational issues and student motivation. Respondents stated that in busy clinical areas, students tended to disengage when they felt that they were not prioritised or were not receiving teaching they perceived to be useful.

"I think it's very hard with clinical pressures to properly cater for students' learning needs which would lead to disengagement. I'm sure they would be more enthusiastic if we were able to provide more useful teaching time for them." (S3. P32. FY2)

The student context

Student Professional Behaviours

Overall, respondents felt that students were appreciative of any teaching they received, regardless of teacher identity. However, there was recognition of variability in student engagement. Some were described as enthusiastic and keen, whilst others appeared "less engaged". One respondent commented on a "more negative attitude shift" compared with their own student experience, describing some students as "ungrateful/rude".

"I feel some students are keen to learn and stay... while others want to leave as soon as the round is over. For this reason, some take responsibility and others don't for their own learning." (S3. P37. IMT/ST3+)

Furthermore, many respondents described evidence of enthusiasm as having a "defined objective" and an "interest in knowing more". Students were often described as driven by "sign-offs" for their mandated assessments, about which concern was expressed. Students were also described as lacking initiative to seek out learning opportunities, instead requiring explicit guidance from doctors.

"I am unclear of how much the curriculum has changed, but students are often 'tick box' driven to do a set skill and leave, and less keen to 'learn on the job'." (S3. P60. FY1)

Student Preparedness

Whilst respondents generally reported being unaware of learning objectives, there were mixed opinions on whether students themselves were aware of them. Respondents cited student requests to complete assessments and clinical skills as evidence of awareness. However, respondents also expressed a desire for explicit training on learning objectives to help them guide students. This was particularly emphasised by one respondent who expressed that they "do not think objectives [were] ever clear", even during their own student years.

Respondents recognised a positive relationship between a student's enthusiasm and their clinical competence. Greater enthusiasm precipitates increased team participation, in turn delineating a role for the student in the team, thus allowing access to greater educational opportunities. This process was described as self-fulfilling by one respondent.

"I think you do notice a difference with [enthusiastic] students- they seem more competent and knowledgeable." (S3. P70. IMT/CT/ST1-2)

Respondents also reflected on students they described as "proactive" and highlighted the impact of that enthusiasm on their own motivation and excitement to teach. Conversely, respondents described that they would be "unlikely to make effort" to teach unenthusiastic students.

"As a junior doctor who teaches students occasionally, I find that their motivation works as an incentive for me to keep teaching." (S3. P68. IMT/ST3+)

Discussion

As determined previously [12,14], discussion around the competing roles of Clinician versus Teacher was a dominant outcome in this study, with this duality often reconciled in context [17]. Doctors are trained as clinicians, rarely as teachers, yet are expected to fulfil both roles to a high standard. This presumption can contribute to feelings of frustration, guilt, and stress.

To combat this, dedicated training in both teaching methods and local medical school curricula would provide essential skills and confidence [18]. Given the proven efficacy of near-peer teaching [19], an exploration of the impact of the ever-expanding role of clinical teaching fellows would be of value.

Respondents reported that developing a framework for teaching medicine is affected by several contextual tensions, previously described by Hoffman [20]. Despite a lack of material support and protected time, doctors generally enjoy teaching [21]. Notably, attempts to manage these conflicting priorities are necessarily sacrificial, compromising teaching quality and clinician wellbeing [14]. Clinicians, however, are not despondent and offer suggestions for overcoming these conflicts, demonstrating a strong will for change. Of note are the purported benefits of integrating protected time for teaching into resident doctors' job plans [14]. Literature demonstrates the value of fostering communities of practice [1], and senior support is also conducive to this.

Learning is felt to be a collective responsibility, with doctors offering unifying characteristics of the "good" student [22]. However, doctors often fall victim to learner blame, neglecting the impact of the environment on student socialisation and preparedness for practice [7,17,20,23,24]. This theory of situated learning is represented here via the interplay of organisational, teacher, and student contexts [1]. If considered by teaching hospitals and medical schools, these suggestions could empower both medical students and resident doctors to develop superior learning environments.

Considering published discourse surrounding consultant attitudes towards teaching undergraduates [11], this study demonstrates shared sentiments despite the heterogeneity of these groups. That said, resident doctors provide less commentary regarding institutional policy, administrative divides (between medical school and placement provider), and recognition (financial or otherwise) beyond teaching qualifications. Generally, resident doctors were less critical and comparative of current medical students. Rather, reflection on recently lived experiences encouraged empathy in dealing with a challenging system.

Overall, this study reveals a rich narrative offered by a previously minimally explored population. Purposive convenience sampling allowed exploration of a variety of opinions, further contributed to by the participants' range of disciplines and experience. We recognise the limitations of a single-centre study of a limited cohort, although the identified themes are concordant with current literature, thus supporting transferability. Finally, notwithstanding reflexivity practices, the identity of the primary researcher as a UK graduate resident doctor, particularly a clinical teaching fellow at the time of the research, does lead to a limited perspective that should be explored further by others in varying settings.

Conclusions

In conclusion, resident doctors are valuable, committed, and enthusiastic teachers of undergraduate medical students during their clinical placements. However, they clearly articulate barriers and challenges to effective teaching practice. Though multifactorial, the identification of these problems and, significantly, a willingness to change highlight several key areas for improvement. Finally, as doctors and clinical teaching environments are not a homogeneous group, further work is required in different settings, alongside comparisons of attitudes across different stages of training.

Appendices

Section One: Demographics

Please tick the box which best represents your title

FY1 ☐ FY2 ☐ IMT/CT/ST1-2 ☐ GPST ☐

IMT/ST3+ ☐ JCF ☐ SCF ☐ Specialty Doctor ☐

SAS ☐ Other ☐ _____

FIGURE 5: Questionnaire Section 1 of 6

Section Two: Doctor Training/Attitudes to Teaching
Please tick the most appropriate single option

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I am involved in formal teaching of medical students					
I am involved in informal teaching of medical students					
I have received training in teaching and assessment					
I have received training in giving feedback					
I have knowledge of the local medical school curriculum					
I am told to expect medical students by their educational supervisor/ward consultant					
It is the professional duty of a doctor to teach and mentor					
Teaching is an act of good will					
Teaching/supervising medical students is the duty of a consultant rather than a non-consultant doctor					
I enjoy teaching medical students informally during my clinical time					

Please support your answers to this section with a comment

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FIGURE 6: Questionnaire Section 2 of 6

Section Three: Student Attitudes to Teaching Please tick the most appropriate single option					
	Strongly Disagree	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
Students are appropriately enthusiastic					
Students take initiative and responsibility for their own learning					
Students are aware of their objectives during their clinical attachment					
Students are meeting their objective through their clinical attachment					
Students appreciate being taught by non-consultant doctors					

Please support your answers to this section with a comment

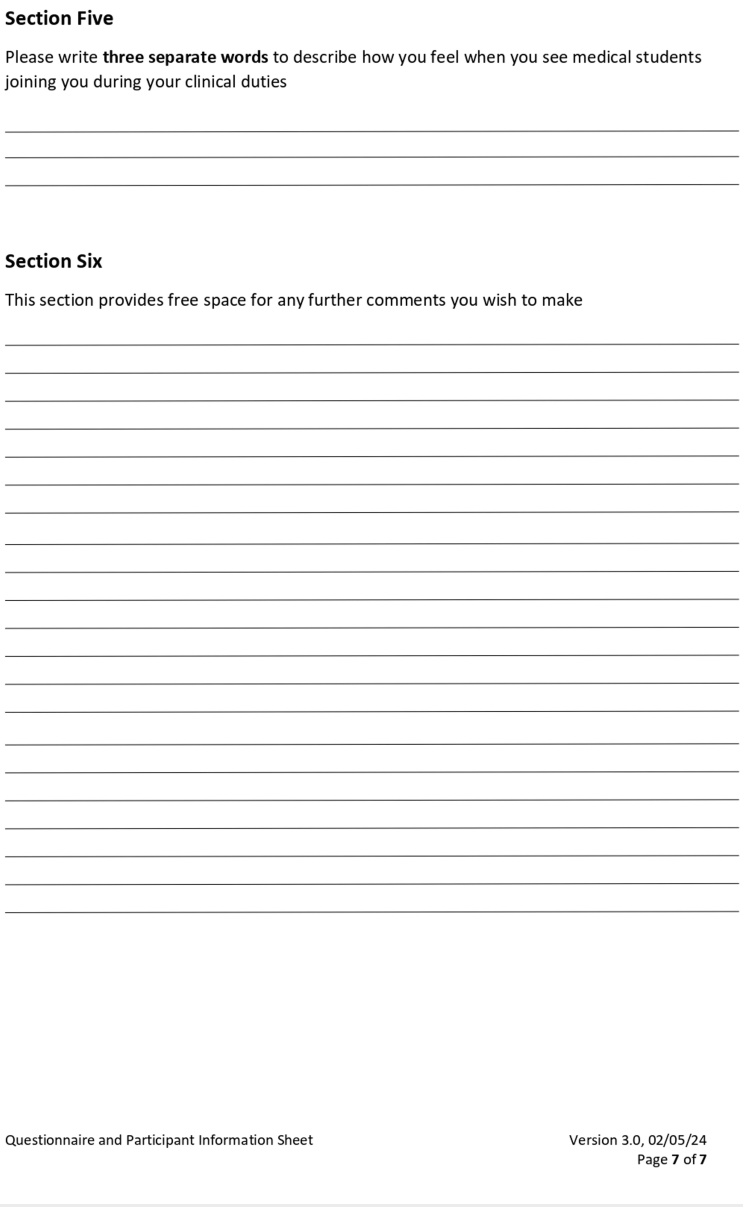
FIGURE 7: Questionnaire Section 3 of 6

Section Four: Practical Considerations Please tick the most appropriate single option					
	Strongly Disagree	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
I have enough time to teach medical students during my clinical time					
I have enough physical space to teach medical students in clinical areas					
Staffing issues affect my ability to provide teaching to medical students					
Other clinical activities take priority over medical student teaching					
I value the education of post-graduate trainees above that of medical students					
The number of medical students on each ward is too many to provide effective teaching					
I have enough time to get to know the medical students throughout their rotations					
My trust encourages us to teach medical students					

Please support your answers to this section with a comment

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FIGURE 8: Questionnaire Section 4 of 6



Section Five

Please write **three separate words** to describe how you feel when you see medical students joining you during your clinical duties

Section Six

This section provides free space for any further comments you wish to make

FIGURE 9: Questionnaire Sections 5 and 6 of 6

Additional Information

Author Contributions

All authors have reviewed the final version to be published and agreed to be accountable for all aspects of the work.

Concept and design: Kiana Mostaghimi, Stuart Richards, Alexis Kocheta, Omar Tawfiq

Acquisition, analysis, or interpretation of data: Kiana Mostaghimi

Drafting of the manuscript: Kiana Mostaghimi

Critical review of the manuscript for important intellectual content: Kiana Mostaghimi, Stuart Richards, Alexis Kocheta, Omar Tawfiq

Supervision: Stuart Richards, Alexis Kocheta, Omar Tawfiq

Disclosures

Human subjects: Informed consent for treatment and open access publication was obtained or waived by all participants in this study. Health Research Authority and Health Care Research Wales issued approval 342824 dated May 9, 2024. **Animal subjects:** All authors have confirmed that this study did not involve animal subjects or tissue. **Conflicts of interest:** In compliance with the ICMJE uniform disclosure form, all authors declare the following: **Payment/services info:** All authors have declared that no financial support was received from any organization for the submitted work. **Financial relationships:** All authors have declared that they have no financial relationships at present or within the previous three years with any organizations that might have an interest in the submitted work. **Other relationships:** All authors have declared that there are no other relationships or activities that could appear to have influenced the submitted work.

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