

Commentary on: Diagnosing conflict in clerkship: insights from medical students' experiences

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Article Info

Article Notes

Received: November 17, 2025

Accepted: December 26, 2025

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Abstract

Our recent study examined medical students' perspectives on conflict during clinical clerkships, identifying common settings, types, and triggers of conflict, and the strategies students used to respond. These findings are particularly relevant to anesthesiology, where high-paced, team-based work creates both opportunities for productive disagreement and risks for mismanaged conflict. In this commentary, we highlight the implications of our findings for anesthesiology training and practice, outlining practical strategies to strengthen team communication, psychological safety, and conflict competence in perioperative care.

Introduction

Conflict in clinical training is inevitable, especially in dynamic, high-stakes specialties like anesthesiology. This commentary focuses on the implications of clerkship conflict within anesthesiology. Our study examined the often overlooked student voice, capturing how conflict emerges, is handled, and impacts learning from their perspective¹. While the findings apply across specialties, anesthesiology offers a unique context: rapid transitions, multidisciplinary interactions, and layered hierarchies in the OR, ICU, procedural suites, and acute pain services. Many of these teams are ad hoc and assemble quickly, vary in membership across shifts and cases, and may lack time to build shared mental models, trust, or psychological safety². As White and colleagues note³, ad hoc teams depend heavily on individual readiness and emotional intelligence to bridge these gaps, allowing members to read the situation, anticipate needs, and adapt fluidly under pressure. Understanding where and why conflict arises can help anesthesiology teams transform moments of friction into opportunities for safety, efficiency, and professional growth.

Key Conclusions with Anesthesiology Relevance

Three findings from our work have particular resonance for anesthesiology teams:

1. **Task conflict dominates—and is double-edged.** Students most often described disagreements about the *what*, *when*, and *how* of patient care: the sequence of procedures, the timing of induction or extubation, or priorities when urgent needs compete. In anesthesiology, these disagreements frequently arise during case turnover, managing unexpected surgical requests, or deciding when

to escalate care in the ICU. When addressed constructively, such task conflict can clarify assumptions, surface overlooked information, and improve decision-making. However, without clear expectations and respectful communication, it can quickly shift into relationship conflict - creating tension between colleagues, eroding trust, and discouraging team members from contributing in the future. For learners, a poorly handled disagreement can have lasting effects, shaping their willingness to speak up long after the immediate situation has resolved⁴.

2. **Mode mismatch can stifle important information.** Our data revealed a common mismatch: students gravitated toward *avoidance* as a conflict mode, while those in authority (often residents, attendings, or senior nurses) were perceived as using a *competing* style. In the hierarchy of the OR or ICU, this mismatch is magnified by power dynamics. For a medical student, speaking up to challenge a resident or attending, particularly in a public setting, can feel risky, even when patient safety is at stake. The competing style, while sometimes necessary in emergencies, can unintentionally reinforce silence, as students learn to “stay in their lane” rather than risk confrontation. In anesthesiology, these dynamics can delay the surfacing of critical information, such as an equipment malfunction, a dosing concern, or a change in patient status. Addressing this requires leaders to actively invite and normalize contributions from all team members, explicitly stating that dissent and clarifying questions are valued. One way to soften this hierarchy is to begin cases with genuine introductions; although often rushed, this simple step reduces anonymity and makes it easier for learners to speak up when something is wrong⁵.

3. **Five triggers are addressable at the team level.** Across all reported conflicts, five recurring triggers were raised, each of which is highly relevant in anesthesiology and can be mitigated through intentional, teachable strategies:

- **Unclear expectations:** Roles and responsibilities in the perioperative space can shift quickly, especially when cases run over or team members rotate in mid-case. Without explicit clarity, misunderstandings arise about who is monitoring vitals, managing the airway, or communicating with the surgical team⁶.
- **Poor or hostile communication:** Short, directive statements, which can be common in the OR space, can be perceived as dismissive or aggressive if not paired with context. Misinterpretations are amplified for learners unfamiliar with the pace and tone of the environment⁷.
- **Low psychological safety:** In settings where mistakes or questions are met with criticism, learners become reluctant to speak up. Over time,

this erodes open dialogue and diminishes team adaptability⁸.

- **Mistrust:** Past negative interactions, inconsistent supervision, or perceived inequities in workload can reduce the willingness to collaborate or share information. One study shows that gossip in training environments can shape reputations, amplify hierarchy, and erode psychological safety making team members, especially learners, more hesitant to speak up⁹.
- **Stress overload:** High caseloads, unexpected emergencies, and staffing shortages can spill over into team interactions, with frustration directed at the most junior team members¹⁰.

Practical Strategies for Anesthesiology Teams

Drawing from our findings, we propose five ways to create conditions for effective teamwork and constructive conflict:

- **Clarify roles early:** Begin each case by defining responsibilities, introducing all members of the team, and explicitly inviting input from all team members, including students
- **Use precise, respectful communication:** Where possible, combine requests with rationale and confirm understanding to minimize misinterpretation
- **Embed psychological safety cues:** Establish shared language for escalating concerns (e.g., “yellow” for emerging risk, “red” for immediate stop)
- **Repair in the moment:** Acknowledge tense interactions, clarify intent, and recommit to collaboration
- **Manage stress spillover transparently:** When demands exceed capacity, explain delays or task reassignments and provide follow-up

Educational Implications

Conflict competence should be a core skill in anesthesiology education. Embedding brief, specialty-specific training before and during clerkships can give learners the tools to navigate disagreements constructively. Incorporating these skills into resident and faculty development reinforces modeling for students and helps normalize respectful challenges that will inevitably arise¹¹.

Conclusion

Anesthesiology's complexity and pace mean that conflict will always be part of the work. The challenge and opportunity is to ensure that disagreements contribute to better decisions, safer care, and stronger teams. If we can better address known triggers and build simple, repeatable habits into daily practice, anesthesiology educators and

clinicians can create learning environments where all voices are heard and conflict becomes a driver of excellence rather than a source of harm.

Disclaimer

The opinions and assertions contained herein are the sole ones of the authors and are not to be construed as reflecting the views of the Uniformed Services University or the Department of War.

References

1. Barry ES, L'Huillier JC, White BA. Diagnosing conflict in clerkship: insights from medical students' experiences. *BMJ leader*. 2025.
2. White BA, Eklund A, McNeal T, et al. Facilitators and barriers to ad hoc team performance. In *Baylor University medical center proceedings*. Taylor & Francis. 2018; 31(3): 380-384.
3. White BA, Healy MG, Orgill BD, et al. Enhancing ad hoc team performance with emotional intelligence. In *Baylor University Medical Center Proceedings*. Taylor & Francis. 2025; 38(3): 354-357.
4. Lin MW, Papaconstantinou HT, White BA. Moving beyond teamwork in the operating room to facilitating mutual professional respect. In *Baylor University Medical Center Proceedings*. Taylor & Francis. 2023; 36(1): 45-53.
5. Birnbach DJ, Rosen LF, Fitzpatrick M, et al. Introductions during time-outs: Do surgical team members know one another's names? *The Joint Commission Journal on Quality and Patient Safety*. 2017; 43(6): 284-8.
6. Barry ES, Bader-Larsen KS, Meyer HS, et al. Leadership and followership in military interprofessional health care teams. *Military Medicine*. 2021; 186(Supplement 3): 7-15.
7. Barry ES, Varpio L, Teunissen P, et al. Preparing Military Interprofessional Health Care Teams for Effective Collaboration. *Military Medicine*. 2025; 190(3-4): e804-10.
8. White BA, Walker J, Arroliga AC. Avoiding organizational silence and creating team dialogue. In *Baylor University Medical Center Proceedings*. Taylor & Francis. 2019; 32(3): 446-448.
9. L'Huillier JC, Silvestri C, Brian R, et al. The anatomy of gossip: dissecting dynamics and impacts in surgical residency. *Surgery*. 2025; 180: 109126.
10. Van Mol MM, Kompanje EJ, Benoit DD, et al. The prevalence of compassion fatigue and burnout among healthcare professionals in intensive care units: a systematic review. *PLoS one*. 2015; 10(8): e0136955.
11. Tung MG, Jerman CF, Healy MG, et al. Leveraging just-in-time simulation to train ad hoc teams. In *Baylor University Medical Center Proceedings*. Taylor & Francis. 2025.