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"Sandwiched"

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"You're doing well with clinical cases—families enjoy meeting you, and seniors like working with you. That said, we've received feedback: your notes take too long, your handwriting is hard to read, and your English needs improvement. Overall, though, everyone enjoys working with you. Keep it up!"

This isn't a verbatim account, but it captures the essence of my first feedback session as a pediatric intern. I had just completed a demanding inpatient rotation and was proud to have made it through what felt like one of the hardest months of my training.

It was also my first encounter with **constructive criticism**—a widely accepted feedback model in medical education across the U.S., Europe, and likely other countries.[1] When used well, it fosters clinical and professional growth, reinforces positive behaviors, and promotes reflection and improvement, particularly when delivered nonjudgmentally.[2]

I use it regularly now when teaching students, mentoring residents, and collaborating with peers. But that wasn't always the case.

Growing up and training in Ecuador, feedback was often direct and disciplinary—action-reaction, usually accompanied by judgment. Constructive criticism was not part of the cultural norm.

As the only Latino resident in my class, I experienced and later became aware of how underrepresented trainees often face less supportive learning environments, discrimination, or biased evaluations.[3,4] Research shows disparities in how feedback is both given and received, particularly along lines of race, ethnicity, and gender. Latino trainees often receive disproportionately negative or biased feedback compared to their white peers—possibly driven by cultural misalignment, evaluator bias, and communication differences.[5,6] Many Latino trainees are also first-generation or international medical graduates (IMGs), adding further complexity.

Throughout my intern year, I repeatedly received the "sandwich method" of feedback—a positive comment, followed by criticism, and then another positive remark. While this approach is common in U.S. medical training,

it's not without flaws.[6,7] Late in the year, a senior resident told me I was perceived as "resistant to feedback" and "unwilling to improve"—labels that felt inaccurate and confusing.

Then one attending tried something different. He engaged me in reflective dialogue, aiming to understand how I processed feedback. He showed cultural humility—something I hadn't experienced until then. That interaction made all the difference.

Cultural humility enables clinicians and educators to better understand people's motivations, decisions, and lived experiences. It's widely endorsed in clinical care for delivering patient-centered outcomes, yet its role in medical education remains underutilized—even as medical trainees become more diverse.[8]

If we don't share the same background or lived experience as our learners, practicing cultural humility can help us support them more effectively—without assigning harmful labels.

Medical training is already intense—academically, emotionally, and physically. The added burden of being misinterpreted or "sandwiched" between cultural expectations and evaluator bias can wear down even the most resilient learners.

With new pathways expanding opportunities for non-citizen IMGs and residency programs becoming more diverse,[9,10] we must evolve how we deliver feedback. This includes rethinking how we interpret resistance, recognizing power dynamics, and actively seeking to see the strengths and potential in our students, residents, and early-career physicians.

This is part of my story—and it shapes how I now teach, mentor, and lead. Over time, I've come to value the feedback I received, even when it was imperfect. I hope my experience prompts you to reflect on your own approach, especially when working with learners who may need a different kind of support.

And maybe, like me, you'll come to prefer eating the sandwich—rather than being trapped inside it.

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