Medical education

Beware the hidden curriculum

Sally C. Mahood MD

The "hidden curriculum"[1] refers to medical education as more than simple transmission of knowledge and skills; it is also a socialization process. Wittingly or unwittingly, norms and values transmitted to future physicians often undermine the formal messages of the declared curriculum.[2] The hidden curriculum consists of what is implicitly taught by example day to day, not the explicit teaching of lectures, grand rounds, and seminars.[3] I am increasingly aware of how those of us engaged in family medicine education are blind to it.

We teach that family medicine and whole-person care are critical, but the hidden curriculum continues to denigrate family medicine and glorify specialization, suggesting that the best and brightest become specialists. I recently asked incoming family medicine residents about their experience of this hidden curriculum. One resident recalled being told that family medicine was a "waste of her intelligence." Another was reassured family medicine residents need not know the answer to a psychiatry question because they were "just going to be [family doctors]." A third recalled questions about future career plans during clerkship. Instead of acknowledging her family medicine choice, she answered with "I'm leaving my options open" because of the negative responses received from attending physicians and colleagues. Despite widespread recognition of the importance of primary care, such messages continue to be conveyed in Canadian medical schools.

Competing priorities

The hidden curriculum is not limited to choice of specialty. It also undermines us as caring and ethical professionals. Collegiality, patient-centred care, and ethical practice are often subordinated for factual knowledge or are brushed aside by practical realities.

As students move from undergraduate to postgraduate medical training, not all transformations are positive. Students move from being open-minded to being closed-minded; from being intellectually curious to narrowly focusing on facts; from empathy to emotional detachment; from idealism to cynicism; and often from civility and caring to arrogance and irritability. This erosion of empathy and "vanquishing of virtue"[4] is repeatedly documented in studies of physicians in training.[4-8] Feudtner et al, in their survey of ethical erosion among clinical clerks, found 98% of students heard physicians refer to patients in a derogatory manner, 61% witnessed what they believed to be unethical behaviour by other medical team members, 67% felt bad or guilty about something they had done as clinical clerks, and 62% believed that some of their ethical principles had been eroded or lost.[5,9] These experiences included pretending to examine patients or making up vital signs, ignoring contamination, obtaining informed consent with little knowledge of a procedure, withholding results from patients, or doing unnecessary procedures for experience.[9] We all have our own examples.

The formal curriculum stresses interdisciplinary practice, collegiality, and patient-centred care. Interpersonal tensions and eye-rolling can subvert formal talk of collegiality, and praise of interdisciplinary teamwork contrasts with the hierarchy of our institutions. Academic hierarchy and convenience are at the centre of medical education, not the patient. Offhand ridicule of patients' weight, poverty, or ethnicity can juxtapose with talk of cultural sensitivity and competence. Verbal endorsement of "the importance of family dynamics" is undercut by physicians who want to "get to the important stuff," or who always leave the ward before families can ask questions. We all see physicians deride nurses or other health care workers, "dump" patients, violate confidentiality, ignore rules, use inappropriate language, or demonstrate inability to work effectively with others. The hierarchy of authority often protects such behaviour or accepts it in exchange for efficiency or productivity. Many of us ignore such events or just shake our heads and get on with the job. A recent survey of 1900 physicians confirmed that only 64% thought they should report a severely impaired or incompetent colleague.[10] One-third of physicians would not do so, citing impotence to effect change, lack of responsibility, or fear of retribution.[10] In studies students can *identify* the qualities of an outstanding physician, but they are actually more often impressed by responsibility or status than by "outstanding" characteristics.[11]

Influenced by informal lessons

For learners, professionalism can be confused with getting along with superiors, not rocking the boat, being subservient, or remaining "flexible." Showing up on time, finishing the workload, and covering up minor mistakes often get more recognition than adhering to avowed professional values or patient-centred care.[12]

La traduction en français de cet article se trouve à **www.cfp.ca** dans la table des matières du numéro de **septembre 2011** à la **page e313.**

Young doctors can become ethical chameleons, slowly redefining themselves as primarily technicians, narrowing professional identity, and discarding explicit professionalism for emotional detachment. Lempp and Seale document the hidden curriculum's effects including loss of idealism, adoption of ritualized professional identity, emotional neutralization, change of ethical integrity, and acceptance of hierarchy.[8] This powerful undercurrent can change even those who are the most confident and altruistic. Even when residents are conscious of it, a sense of futility or fear of confrontation maintains the silence.[13]

Much of this socialization occurs in corridors and call rooms, outside formal learning environments, but it is considered "sticky knowledge,"[14] more memorable than the explicit formal curriculum. Every word spoken, every action performed or omitted, every joke, every silence, and every irritation[3] imparts values we might never have intended to impart. Attending physicians model for residents, who model for medical students, and so on down the line.[9] This cascade might explain why changes to the formal curriculum do not always get intended results. Many reforms result in no real change, as day-to-day experiences are more influential than curriculum content. Thus we reproduce the presumption of professionalism on the basis of institutional status rather than individual behaviour.

Sadly, the manpower and resource stresses in the health care system exacerbate these tendencies, as does our own sense of entitlement about the rigours and demands of medical training and practice. Untenable work situations do foster diminished ethical standards, but professional entitlement and elitism are no solutions.

Professionalism is an essential competence. Most actions against physicians involve deficiencies in professionalism, not competence.[15] Troublesome behaviour in medical school carries over and is associated with subsequent disciplinary action by professional licensing bodies.[15] Yet, lack of professionalism in learners is usually met with silence, or "vanishing feedback"[16]—feedback so muted, bland, or vague that it has no effect. It is difficult to confront professional failures in our students. We often have trouble gathering such information, and we resist assessing students' attitudinal behaviour, fearing accusations of subjectivity, and even litigation. This fear contributes to the hidden curriculum's success.

Some characteristics help "immunize" students against the hidden curriculum: being older and more mature; having had a previous career or life project; being a woman; having nonmedical commitments; having strong patient-centred modeling; or having a family medicine, primary care, or generalist orientation.[7] However, we continue to privilege cognitive traits in the admissions process, and we consider clinical competence a central virtue in a physician at the expense of professional character formation and ethical reflection. Further, immunization is only partial, and immunity wanes with prolonged exposure to the hidden curriculum in the "real" world. Good plants need nourishment or they wither. Long hours, intense and conflicting demands, lack of emotional support, and poor role modeling are some of our defoliants.

What must change

Individual change also requires organizational change in institutional policies supporting the hidden curriculum. Resource allocation reflects an institution's true values. Do we recognize research dollars generated or role modeling for students? Evaluation tools and accreditation guidelines can also facilitate the hidden curriculum if they encourage medical educators to avoid confronting problems with professionalism to please or recruit learners.

We need to break the silence and challenge behaviour that does not meet professional standards and ethical expectations. We need to make the hidden curriculum and its messages a topic of explicit discussion and strive to model different messages. We need to discuss such issues as medical mistakes, subspecialization and fragmentation of care, impaired colleagues, interprofessional disrespect, the experience of illness, truth telling, prejudicing of patient care by personal beliefs, and power dynamics and hierarchy in medicine. We need faculty development courses on consistently modeling professionalism and pedagogic approaches that help. We need to minimize brief and disjointed clinical training schedules and to maximize the longitudinal experiences known to preserve patient-centred attitudes. We need to emphasize the value of generalism, of continuity, of consistent relationships and knowledge of patients and colleagues, and of a shared mission. We need more focus on professionalism and ways to assess it in action.

We are sometimes unconscious of the hidden curriculum, but even when conscious of it we are silent or reluctant to act. We need a frank dialogue with students, residents, and each other about the lived experience of a career in medicine as the struggle it often is; about the challenges of living up to our profession's stated ideals; about the dangers of technological expertise without caring human relationships; about conflicts of interest and the difficult professional challenges of dealing with unprofessional colleagues; and about behaviour that imperils patients. We need to add "Above all be not silent" *(Primum non tacere)*[17] to "First do no harm" as tenets to live by, and we must emphasize to students that what they are like as physicians is just as important as what they know. Thus will we build resistance to the hidden curriculum and reclaim our authenticity as trusted generalists whose knowledge is attached to values we truly uphold, model, and reproduce.

Dr Mahood is Associate Professor in the Department of Academic Family Medicine at the University of Saskatchewan, and is Unit Head in the Regina Family Medicine Unit at Regina General Hospital.

Competing interests
None declared

Correspondence
Dr Sally Mahood, Regina Family Medicine Unit, Regina General Hospital, 1440 – 14th Ave, Regina, SK S4P 0W5; telephone 306 766-4059; fax 306 766-4041; e-mail **sally.mahood@usask.ca**

References

1. Jackson PW. *Life in classrooms*. New York, NY: Holt, Rhinehart and Winston; 1968.
2. Hafferty FW. Beyond curriculum reform: confronting medicine's hidden curriculum. *Acad Med* 1998;73(4):403-7.
3. Gofton W, Regehr G. What we don't know we are teaching: unveiling the hidden curriculum. *Clin Orthop Relat Res* 2006;449:20-7.
4. Coulehan J, Williams PC. Vanquishing virtue: the impact of medical education. *Acad Med* 2001;76(6):598-605.
5. Feudtner C, Christakis DA, Christakis NA. Do clinical clerks suffer ethical erosion? Students' perceptions of their ethical environment and personal development. *Acad Med* 1994;69(8):670-9.
6. Hojat M, Mangione S, Nasca TJ, Rattner S, Erdmann JB, Gonnella JS, et al. An empirical study of decline in empathy in medical school. *Med Educ* 2004;38(9):934-41.
7. Haidet P, Dains JE, Paterniti DA, Hechtel L, Chang T, Tseng E, et al. Medical student attitudes toward the doctor-patient relationship. *Med Educ* 2002;36(6):568-74.
8. Lempp H, Seale C. The hidden curriculum in undergraduate medical education: qualitiative study of medical students' perceptions of teaching. *BMJ* 2004;329(7469):770-3.
9. Baldwin DC Jr, Daugherty SR, Rowley BD. Unethical and unprofessional conduct observed by residents during their first year of training. *Acad Med* 1998;73(11):1195-200.
10. DesRoches CM, Rao SR, Fromson JA, Birnbaum RJ, Iezzoni L, Vogeli C, et al. Physicians' perceptions, preparedness for reporting and experiences related to impaired and incompetent colleagues. *JAMA* 2010;304(2):187-93.
11. Paice E, Heard S, Moss F. How important are role models in making good doctors? *BMJ* 2002;325(7366):707-10.
12. Witte FM, Stratton TD, Nora LM. Stories from the field: students' descriptions of gender discrimination and sexual harassment during medical school. *Acad Med* 2006;81(7):648-54.
13. Brainard AH, Brislen HC. Learning professionalism: a view from the trenches. *Acad Med* 2007;82(11):1010-4.
14. Lingard L, Reznick R, DeVito I, Espin S. Forming professional identities on the health care team: discursive constructions of the "other" in the operating room. *Med Educ* 2002;36(8):728-34.
15. Papadakis M, Hodgson CS, Teherani A, Kohatsu ND. Unprofessional behavior in medical school is associated with subsequent disciplinary action by a state medical board. *Acad Med* 2004;79(3):244-9.
16. Burack J, Irby DM, Carline JD, Root RK, Larson EB. Teaching compassion and respect. Attending physicians' responses to problematic behaviors. *J Gen Intern Med* 1999;14(1):49-55.
17. Inui TS. *A flag in the wind: education for professionalism in medicine*. Washington, DC: Association of American Medical Colleges; 2003.