The Contemporary Hidden Curriculum in Medical Education

Vijay Rajput[1], Anuradha Lele Mookerjee[2], Consuelo Cagande [3]

Abstract

There is a renewed interest in teaching and cultivating compassionate patient-centered care among trainees and faculty. Much of the erosion in medical professionalism can be attributed to what has been labeled the "Hidden Curriculum." We have identified eight archetypal areas where the Hidden Curriculum exerts influence on trainees and faculty. These include: Lack of Accountability to Patients, The Influence of Legal Phobia, Physician and Nursing Overload (how documentation and busy work detracts from patient-centered care), Negative Attitudes and Apathy from Teachers, The Influence of the Electronic Health Record (EHR) in Patient Depersonalization, The Negative Effect of "Work-Life" Balance, The Concept of the "Difficult Patient," and the Negative impact of Evidence-Based Medicine on a Patient-Centered Approach. We believe that we need to focus and assess the residents and faculty's knowledge and attitudes towards the Hidden Curriculum. We believe that reflective learning can enhance professionalism, humanism and compassionate patient-centered care. Reflective learning with specific focus on hidden curriculum can also contribute to the continuous improvement of care in our complex health care environment. In addition interprofessional seminars debating impact of Hidden Curriculum can increase awareness among health professionals on the hidden curriculum in daily practice and education.

Keywords: Hidden Curriculum, Medical Education

Introduction

There is a renewed interest in teaching and cultivating compassionate patient-centered care because of the growing influence of technology and a perceived trend towards the depersonalization of medicine due to myriad complex factors. Drs. Louis Arnold and David Stern underscore the complexity inherent in the multiple definitions of professionalism and suggest the following definition: "Professionalism is demonstrated through a foundation of clinical competence, communication skills, and ethical and legal understanding, upon which is built the aspiration to,
and wise application of, the principles of clinical excellence, humanism, accountability and altruism.” (1) Much of the erosion in medical professionalism can be attributed to what has been labeled the "Hidden Curriculum". The Hidden Curriculum refers to a concept that has evolved as medical educators have come to understand and recognize that there is a great difference between what is being taught and what is really being learned. Accordingly, the Hidden Curriculum can be defined as that which creates the difference. The practice of medicine does not take place in a cultural vacuum. The practice of medicine and especially medical education, involves a practice socialization which has evolved in the clinical environment created by our diverse, multicultural and pluralistic society.

Practice Socialization can be defined as "the process by which residents, students, faculty and other health professionals acquire the values and attitudes, the interest, skills, and knowledge, i.e. the culture of the groups to which they are, or seek to become, a member" (2). Medical educators have also long been concerned that something happens during the education of medical students that tempers the idealism that almost all of them bring to the study of medicine. During their residencies, they have the dual roles of student and practicing physician. Residents quickly accept the culture (Hidden curriculum). They see the patient as disease, object of learning, and subject of research. The pressure of throughput, stress and an environment with conflicting messages transform patient care into work and a source of frustration and antagonism. We submit that this is the consequence of the Hidden Curriculum, and recognizing this cause and effect relationship is key to identifying and understanding the Hidden Curriculum, and defining what can be done about it. Social scientists have provided explanation for their social cognitive theory. Residents struggle with time constraints, fatigue, and juggling too many roles and responsibilities, which can make them "cognitive misers” forcing them to draw upon stereotypes and biases in making clinical decisions. This theory of social cognition suggests that individuals have limited or restricted capacities to process and integrate information. When faced with circumstances that exceed cognitive reserves, humans frequently rely upon automatic heuristic approach. These cognitive processes do not occur out of laziness, but to maintain efficiency, although the outcomes are usually suboptimal, inaccurate, and biased. (3) In truth, there are a multitude of widely variant issues that come under the umbrella of the Hidden Curriculum, which on a daily basis, serve as important and very threatening obstacles to the provision of compassionate and patient-centered care. The following is a noninclusive list of some of the most important elements of the Hidden Curriculum:

The Elements of Hidden Curriculum

1. Lack of accountability to patients - Myriad factors have led physicians and nurses to no longer feel they have a sense of personal accountability to their patients. These factors include the bottom line effects of our broken health care system, which force patients to change doctors frequently, coupled with the fact that our society is increasingly peripatetic. Hence, long term relationships between patients and their physicians are increasingly rare. Compounding this is the fact that within the hospital system, patients are cared for by hospitalists they have never seen before, often working eight to twelve hour shifts, so that the patient may have three different physicians in a 24 hour period. Team after team of subspecialists may also see the patient, none with any previous relationship to him or her. They are all too frequently not interested in the patient as an individual human being, as opposed to an intense interest in his medical problem or disease state. Then, there are the current work rules applying to hospital trainees, and the anxiety-based over concerns of program directors, which have a markedly negative effect on accountability. In the past, a conscientious and concerned house officer stayed on duty, to take care of a sick patient with whom he had developed a relationship, and of whom he had a thorough and intimate knowledge. Now, he or she goes off duty at an inappropriate moment in the patient's course, because he has been told that he must, conferring dangers inherent in the handoff that are far more serious than the dangers of alleged physician over-fatigue.

2. The influence of "legal phobia" - The collective negative effect of legitimate medical legal concerns, is
compounded by the much more pernicious and pervasive effects of perceived legal concerns and the resulting overzealous interpretation of "the rules and regulations" governing physician and nurse behavior. What has been labeled as "defensive medicine" is not only extremely expensive, but also insidiously affects compassionate care. Increasingly, there are "policies" which adversely affect our thinking, and daily decision making. Even the well intentioned HIPPA laws, which are aimed at protecting our patients' privacy, have become increasingly problematic, largely due to overzealous interpretation and application. Lost in the process is the ability of young doctors and nurses to exercise the practical wisdom that underlies common sense decision making.

3. Physician and nursing overload - the amount of effort directly going into the provision of good and compassionate care, has been replaced by a plethora of "busy work". Every minute that a physician spends tending to documentation, much of which is dictated by the need to justify a billing code, and every minute spent filling out yet another form, collectively constitute an important obstacle to providing compassionate patient–centered care.

4. The effect of negative attitudes on the part of our teachers - traditionally, attitudes are communicated, silently, or otherwise, down the hierarchical chain in a teaching hospital. The department chair sets a certain tone, and above that level, the Board and hospital CEO may/should influence the tone. The faculty teach the residents and students on rounds and then the residents spend much of the day with the students, during which time there is much opportunity for the insidious effect of overwork, negative attitudes, jaded cynicism, and what we often label as "burnout", to be passed on to the students, all too often via snide remarks, body language and other subtle messages. There are numerous examples. A newly admitted patient is called a "hit", or a "gomer". The house officer may communicate his callous and judgmental feelings about a chronic pain patient in a variety of ways. Disturbingly, it appears that some residents are teaching students that it is acceptable to just check off the boxes on the computer, without actually examining that body part. Nurses don't have time, any longer, to spend a quiet moment comforting an emotionally needy patient, and a back rub is an historical anachronism. We even teach our trainees that they shouldn't "get too close" to their patients, with the stated or implied message that enforced detachment" is necessary to maintain objectivity in decision making.

5. The influence of the computer and the electronic health record (EHR) - now we are typing while we are trying to listen to patients and talk with them, hardly providing a milieu for the delivery of compassionate care. Dr. Varghese summarized it very well in his the New England Journal of Medicine article, where he noted that we have one patient (i.e., the "I-Patient") in the computer, and another patient in the bed, and the problem is that the doctors are trying to fix the I-patient. (4)

6. The effect of the "work-life balance" - This is a generally laudable concept, but it must be asked whether it has become a preoccupation. Certainly, it is part of the Hidden Curriculum, and is one of the main reasons that Medicine increasingly has become a job, rather than a career.

7. The concept of "the difficult patient" - This label may reflect that the patient is angry, or emotionally needy, or just asks too many and too difficult questions, but the negativism of those caring for the patient, is part of the Hidden Curriculum that is communicated to the junior members of the health care team. The end result is that caregivers tend to avoid such patients, when they really need more time, attention and compassion.

8. The negative side of "Evidence-based Medicine" is now part of the Hidden Curriculum - The overzealous emphasis of this otherwise positive concept can result in the delivery of culturally and personally suboptimal care for that individual patient. Clinical decisions in a patient-problem centered approach require evidence, knowledge, intuition, clinical experience and an understanding of organizational influences. In the fast-paced tertiary care environment, faculty members and residents do not routinely witness the steps in the decision making process that are necessary for experiential, transformative learning by them. In order for this type of learning to occur, the
essential components of this process must be made apparent to learners. The cognitive critical decision and reasoning processes of senior faculty must be analyzed and demonstrated for students and residents at the bedside and/or in all educational activities. They should understand that these processes should occur both with and without the support of evidence from the literature. Capturing the synergy between evidence, experience and an organization influences in clinical-decision making allows the diffusion of some of the Hidden Curriculum related to Evidence-based Medicine.

Mitigation of Hidden Curriculum

We have a unique opportunity to try to do something about the recognition of the Hidden Curriculum and its insidious effects on medical students, more senior trainees, faculty physicians, nurses and the hospital administration. The medical students are the one who get influenced initially by hidden curriculum. How to affect that which is learned, as opposed to that which is taught and how to counteract that which is learned by unintentional supplementation and reinforcement by hidden signals? Of real concern is the fact that no matter how vigorously we attempt to teach humanism as part of the formal medical curriculum, or how vigorously we advocate for patient-centered, humanistic care, the trainees are being bombarded by the conflicting messages of the hidden curriculum. Accordingly, the only potentially successful way to accomplish, to try to inculcate institutional culture, that we have an obligation to recognize, and resist, the temptations of the Hidden Curriculum. It is, therefore, our hope to make this effort an institution-wide thrust, from the Quality Committee of hospital and Board of Trustees, to the Senior Administrative officers, to the faculty, to the nurses and residents, and to the medical students. The underlying principle of approach will be that we must, at every level, always strive to recognize in each patient care instance, what the effects of the Hidden Curriculum may be, and how they may be adversely affecting care. Only by recognizing its subtle negative influence, can the Hidden Curriculum be positively dealt with. Countering the Hidden Curriculum will be a formidable undertaking, with the task made more complex by the realization that many of its components cannot be wished away. It is our hope that they can be minimized with recognition and reflective practice and discussion. Reflective learning can enhance professionalism, humanism and compassionate patient-centered care. It also contributes to the continuous improvement of care in our complex health care environment. (5, 6) Louis Aronson describes critical reflection: "as the process of analyzing, questioning and reframing an experience in order to make an assessment of it for purpose of learning (reflective learning) and/or to improve practice (reflective practice)" (7) We must encourage resident to write a brief narrative following each reflective seminar detailing a personal experience (8)

Take Home Messages

We must understand the specific elements of the Hidden Curriculum as described above and their relationship with professionalism. There is aneed to explore the gaps in the understanding, by different health professionals, of the foundations and pillars of professionalism vis.a vis the Hidden Curriculum. There is room for a better understanding of the Hidden Curriculum to minimize the impact on the delivery of compassionate patient-centered care. We must have all physicians, nurses and other health care providers be aware of the insidious effects of the Hidden Curriculum.
Notes On Contributors

Dr. Vijay Rajput, MD is a Associate Dean of Student & Academic Affairs at Ross University of School of Medicine (RUSM). He also serves as Professor & Chair of Medicine and Director for Office of Student Professional Development for RUSM at Miramar, Florida, USA.

Dr. Consuelo Cagande, MD is Associate Professor of Psychiatry and Program Director for Psychiatry Residency at Cooper University Hospital and Cooper Medical School of Rowan University at Camden, New Jersey in USA.

Dr. Anuradha Lele Mookerjee, MD, is Associate Professor of Medicine and Senior Hospitalist at Cooper University Hospital and Cooper Medical School of Rowan University at Camden, New Jersey in USA.

Acknowledgements

I will like to thank Dr Edward Viner, MD and my daughter Meera Rajput who helped in developing this manuscript. This project was supported by the Arnold P. Gold Foundation for Humanism.

Bibliography/References

1. Stern DT. What is Medical Professionalism? In Measuring Medical Professionalism. Published by Oxford University Press. 2006; 19

2. Hafferty FW. Franks R. The Hidden Curriculum, ethics teaching, and the structure of medical education. Acad. Med. 1994; 69; 861-871

https://doi.org/10.1097/00001888-199411000-00001

3. Fiske ST, Taylor SE. Social Cognition. Boston, MA: Addison-Wesley; 1984.

4. Varghese, A. Culture Shock- Patient as Icon, Icon as Patient. N Eng J Med 2008; 359:2748-2751

https://doi.org/10.1056/NEJMp0807461

5. Mann K, Gordon J, Macleod A. 2007. Reflection and reflective practice in health professions education: A systematic review. Adv Health Sci Educ Theory Pract 14:595–621.

https://doi.org/10.1007/s10459-007-9090-2

6. Sanders J. 2009. The use of reflection in medical education: AMEE Guide No. 44. Med Teach 31(8):685–695.

https://doi.org/10.1080/01421590903050374

7. Louise Aronson. Twelve tips for teaching reflection at all level of medical education. Medical Teacher 2011; 33: 200-205

https://doi.org/10.3109/0142159X.2010.507714
8. Wald HS, Davis SW, Reis SP, Monroe AD, Borkan JM. 2009. Reflecting on reflections: Enhancement of medical education curriculum with structured field notes and guided feedback. Acad Med 84(7):830–837.

https://doi.org/10.1097/ACM.0b013e3181a8592f

Appendices

None

Declaration of Interest

The author has declared that there are no conflicts of interest.