The Hidden Curriculum: What Can We Learn From Third-Year Medical Student Narrative Reflections?
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Abstract

Purpose
To probe medical students’ narrative essays as a rich source of data on the hidden curriculum, a powerful influence shaping the values, roles, and identity of medical trainees.

Method
In 2008, the authors used grounded theory to conduct a thematic analysis of third-year Harvard Medical School students’ reflection papers on the hidden curriculum.

Results
Four overarching concepts were apparent in almost all of the papers: medicine as culture (with distinct subcultures, rules, vocabulary, and customs); the importance of haphazard interactions to learning; role modeling; and the tension between real medicine and prior idealized notions. The authors identified nine discrete “core themes” and coded each paper with up to four core themes based on predominant content. Of the 30 students (91% of essay writers, 20% of class) who consented to the study, 50% focused on power–hierarchy issues in training and patient care; 30% described patient dehumanization; 27%, respectively, detailed some “hidden assessment” of their performance, discussed the suppression of normal emotional responses, mentioned struggling with the limits of medicine, and recognized personal emerging accountability in their medical training; 23% wrote about the elusive search for personal/professional balance and contemplated the sense of “faking it” as a young doctor; and 20% relayed experiences derived from the positive power of human connection.

Conclusions
Students’ reflections on the hidden curriculum are a rich resource for gaining a deeper understanding of how the hidden curriculum shapes medical trainees. Ultimately, medical educators may use these results to inform, revise, and humanize clinical medical education.

Not all of what is taught during medical training is captured in course catalogs, class syllabi, lecture, notes and handouts…. Indeed, a great deal of what is taught—and most of what is learned—in medical school takes place not within formal course offerings but within medicine’s “hidden curriculum.”
—Frederic Hafferty, PhD (1998)

Since the 1960s, educators have described the power of a “hidden curriculum” in shaping the values and behaviors of learners, a concept initially introduced to the medical education community by Frederic Hafferty. Inconsistent—even dissonant—teaching from formal and implicit curricula creates tension for young doctors in the process of forging a sense of professional identity. In our work, we use the term “hidden curriculum” to refer to learning that occurs by means of informal interactions among students, faculty, and others and/or learning that occurs through organizational, structural, and cultural influences intrinsic to training institutions. The curriculum we seek to understand is buried in the lived experiences of learners. Understanding how learners experience and engage the hidden curriculum is fundamental to the work of medical education.

Medical educators, socialized themselves by the hidden curriculum, may not be able to fully see and hear beliefs, values, and implicit codes of behavior as they pass these on to the next generation; however, third-year medical students are uniquely positioned to observe the hidden curriculum. They are liminal operators—simultaneously both outsiders and insiders to medical culture. Students are an accepted part of the medical team. They dress the part and speak the language of medicine, yet they bring beginners’ minds and thus can observe and name cultural phenomena that become invisible to doctors over time.

Many have used anthropologic inquiry to describe the hidden curriculum in medical education. Several themes recur in these descriptions: the loss of idealism, the prominence of hierarchy, the adoption of a ritualized professional identity, and emotional neutralization. In attempts to further characterize the hidden curriculum, researchers and medical educators have employed a variety of empiric methods, including tape recordings of medical students and residents talking to one another informally about work; student reports of ethical dilemmas; focus groups of senior medical students discussing perceived lapses in professionalism; and semistructured, one-on-one interviews to characterize the teacher–student relationship and its significance in the hidden curriculum. Paul Haidet and colleagues have even developed a
validated survey instrument to assess the degree of patient-centeredness in the hidden curriculum of a medical school.

Student narrative essays provide a rich source of information about the hidden curriculum. Routinely assigned to encourage reflection and to support the professional development of medical trainees, narrative essays are underused as a source of data for curricular reform. Student essays provide both a useful window into the educational experience of learners and a potential substrate for faculty development and curricular enhancement. We hypothesized that student narratives on the hidden curriculum would identify positive curricular elements that curriculum designers could emphasize and negative elements that they could target for reform. We anticipated that analysis of these student narratives could provide not only insight into the cultural norms embedded in the hidden curriculum but also more subtle observations about the complex ways in which our learners understand and interact with it. We aimed to examine the hidden curriculum through students’ eyes and to consider the implications for medical education and the training of future physicians.

Method

Third-year students at Harvard Medical School are required to write three reflection papers as part of a longitudinal patient–doctor course. The yearlong course is taught in multiple small groups of approximately 10 to 12 students. We assigned the students in three such groups, selected to represent students doing clinical clerkships at a diverse range of teaching hospitals, to write one of their reflection papers on the topic of the hidden curriculum (Box 1).

The Harvard Medical School institutional review board determined the study to be exempt.

We deidentified the reflections and analyzed them using qualitative grounded theory in an iterative coding process described by Strauss and Corbin. Three of us (E.G., S.B., M.B.) read the papers independently and identified concepts in a process of open coding, and then we used the constant comparative method both to describe concepts and to group these concepts within themes. We completed multiple cycles of coding and discussion to clarify, refine, and rename themes until we fully described and categorized all the data within the narrative reflections. We ultimately identified nine core themes that illuminated a discrete aspect of student experience of the hidden curriculum. We created a coding manual which named and defined each core theme. Each of the three reviewers then independently coded all narratives, found only minor discrepancies, and revised the coding manual to reflect consensus-based definitions. To help ensure the trustworthiness of our analysis, we invited a fourth independent physician reviewer (R.S.) to code each narrative. Coding agreement between the independent reviewer and the original team was >95%. We ultimately coded each reflection with one to four of the nine core themes. In addition to the nine core themes, we identified several overarching concepts that were implicitly present in virtually every student narrative and seemed to function as operational definitions of the hidden curriculum (see Results). To further corroborate the trustworthiness of our analysis, we presented the themes for a “member check” to seven study participants (23%) who then confirmed that the themes resonated with their experiences.

Results

Thirty-three students (100%) in the three groups completed the assignment. Of these, 30 students (91%) consented to the study, representing roughly 20% of the entire third-year class.

Four defining concepts

Four overarching concepts appeared in some way in virtually every student reflection:

1. Medicine as culture,
2. Haphazard interactions,
3. Role modeling, and
4. Tension between the reality of clinical medicine and previously held idealized notions, including those acquired from formal curricular teachings.

These four concepts were so implicitly and pervasively present as to serve as definitional elements of the concept of the hidden curriculum.

Medicine as culture. First, students were quick to recognize that clinical medicine is a culture with distinct subcultures. Their notion of culture seemed consistent with classic anthropologic notions of a group of people who share a set of common values, beliefs, vocabulary, and behavioral norms. They noted that ingrained and sometimes idiosyncratic customs govern interactions among the health care team, and many focused their efforts on trying to decipher the unspoken rules of teaching hospitals. One student devoted her paper to the rules governing the ubiquitous phenomenon of “complaint”:

Patients in physical pain should complain no more frequently than approximately once an hour. Expression of pain should be limited to several acceptable formats, including strained but stoic requests for pain medications, direct response to queries about severity on the 1/10 pain
scale that never exceed 9/10…. Physicians, however, may never, under any circumstances, complain about the number of hours they work. To do so would be an egregious expression of a lack of commitment to the profession. While this rule applies to all physicians, lapses in adherence to it are particularly frowned upon in young doctors and female doctors. [Physicians] are encouraged to complain about insurance companies’ lack of appropriate reimbursement for any aspect of patient care and may complain about their patients, especially patients who keep returning with unmet needs.

**Haphazard interactions.** Students also described learning what they need to know through haphazard interactions and random events—that is, arbitrary team and patient assignments, chance or informal encounters, fortunate or unfortunate accidents.

I don’t blame the resident. How could he know that he would show up Sunday at 6 AM and have “ushering a naive medical student through death and dying” [as] part of his 28-hour shift?

After three years of discussing the ethics of abortion, I saw three in one day during my ob/gyn rotation. Nobody planned it that way. It just happened.

My most profound lesson of compassion was given over a plain bagel with onion and chive cream cheese and a medium cup of coffee.

**Role modeling.** Students recognized the powerful influence of positive and negative role models on their learning.

The fact that this doctor cared so much for his patients that he would visit them on a weekend before an out-of-town trip was the most surprising part of this experience. Maybe it was less of a surprise or shock and more of an awestruck admiration that comes when you find a role model in your future career—someone you want to be like when you “grow up” to be a doctor.

**Medicine as ideal vs. medicine as reality.** Finally, students routinely recognize tension or misalignment between their prior idealized notions of medical practice, as often conveyed through the formal curriculum, and their actual experiences in clinical training:

I always thought my first time would be different. I took extra time through first and second year to hear about what it was like to have dying patients, going to seminars, hearing from professors, even researching music in palliative care. But when a 42-year-old man with terminal Gardner syndrome was admitted to my surgery team, I followed everyone else’s lead and avoided him.

**Core themes**

Nine core themes characterized discrete elements of the hidden curriculum. Of the 30 students who consented to the study, 15 (50%) focused on power–hierarchy issues in training and patient care; 9 (30%) described patient dehumanization; 8 (27%), respectively, detailed some “hidden assessment” of their performance, discussed the suppression of normal emotional responses, mentioned struggling with the limits of medicine, and recognized personal emerging accountability in their medical training; 7 (23%) wrote about the elusive search for personal/professional balance and contemplated the sense of “faking it” as a young doctor; and 6 (20%) relayed experiences derived from the positive power of human connection.

1. **Power and hierarchy.** Half of the students’ reflections focused on use and abuse of power in the hierarchy of medical training and health care. Students highlighted the effects of abusing hierarchy on two sets of subordinate–superordinate relationships: student–teacher and patient–doctor. Medical students described feeling disempowered and disrespected; they identified intense pressure to “knock their place” in the medical hierarchy and endorse the dominant culture.

Almost everyone in the room smirked, knowing this attending was not using his best clinical judgment; however, no one said a word to him because of his rank as an attending. . . . Because of the hierarchical structure of academic medicine, it is often assumed that the person at the top of the chain has the most knowledge and is, in essence, untouchable.

Several suggested that patients, too, felt pressure or were otherwise inclined to unquestioningly accept physician authority.

I had found myself indignant that the residents had selected him [a particularly vulnerable patient] to be part of bedside rounds…. I feared that he had consented more out of obligation than desire, and I was concerned that it would hurt his already wounded heart to be examined so sterilely.

Some students, while naming their own powerlessness within the hospital hierarchy, also recognized the power they held over patients. They lamented the need to practice clinical skills on patients who were pragmatically powerless to refuse.

I am standing before an anxious, supine woman, holding a glistening large metallic object that I am about to place into her vagina. Right now only two things stand between me and an unpleasant encounter with law enforcement. One is the remarkable prerogative bestowed upon medical professionals to do such strange things. The other is my patient’s half-hearted consent. “You’re letting the novice do it?” the patient groans to my intern. “I’ve done a couple of these already.” I offer her in the way of feeble reassurance. But really, I can only sympathize with her—I wouldn’t want me doing my pelvic exam either.

2. **Patient dehumanization.** Students observed patients disrespected, coerced, and dehumanized in the day-to-day practice of medicine. One student described a neurology “patient rounds” conference at a tertiary care teaching hospital:

It was during the physical exam that I became most uneasy because I usually had no idea what the attending was going to say or do next. There were several times when a patient was called “demented” or “frontal” without having any explanation given to them…. The most horrific thing I saw was when the attending asked the patient to turn over and then proceeded to demonstrate the anal wink reflex to us without warning the patient of what he was going to do.

Students saw patients stripped of their uniqueness (stories, personality, culture) in service to “objectivity”:

It’s like I just took all those real human feelings . . . and I crammed them, reorganized them, and dehydrated them to fit in a succinct little box. “This patient fits into this rubric.” I get angry just thinking about it.

3. **Hidden assessment.** Students described feeling “under the microscope” and expending significant energy discerning the elusive criteria by which their clinical instructors evaluated them. Students felt their superiors judged or evaluated them on unnamed criteria in addition to—or instead of—the explicitly stated criteria for evaluation. One student described the “opportunity to learn” during a bronchoscopy:
As I continued to struggle with positioning of the camera, he laughed and said, “Whoo, somebody has a short attention span ... did you listen to my directions on how to work this thing” ... “Are you having a seizure?” he asked at one point, as I struggled to center the camera. “No,” I said in the most confident voice I could muster. I didn’t want to give him any pleasure out of his joke. He got some anyway. The second-year resident burst out laughing.

Ultimately, the student received plaudits on the good job he had done. He concluded,

What a bizarre experience. I felt like a complete failure while harassed throughout the procedure. Contrast that to the near high I felt after I was congratulated at the end ... I felt as if I had survived some kind of psychological test. I now know that it really didn’t matter what I did with the scope. It was more important that I didn’t fold under the criticism, and that I didn’t quit.

Attributions of success or failure by superiors may have little to do with how well a student learns clinical skills or medical knowledge; rather they may reflect acquiescence or assimilation to the culture of the particular rotation. Fear of a negative evaluation may even compel students to suppress medical knowledge or avoid advocating their own safety. One student wrote with anger about the impact of implicit assessment criteria on the student’s own learning:

Do I know not to challenge a surgeon about using disproved regimens or prescribing aminoglycosides for a single post-op fever? Do I know not to make a fuss about needle sticks, especially when there’s no postexposure prophylaxis? Do I know how to appropriately raise my concern that our chosen surgical technique risks seeding a tumor and how to keep quiet when these literature-supported concerns are rejected so that the wrong procedure can be undertaken simply because that’s what the surgeon wants to do? Absolutely.

4. Emotional suppression. Some students’ reflections described the need to actively suppress emotions in response to the powerful experiences of hospital life; other students wrote of distracting or disassociating oneself from “normal” emotional responses to suffering and death, and still other students wondered about their own lack of emotions. One student recalled observing an abortion, during which the attending physician and the nurses were behaving “as if nothing had happened.” She wrote an ode to the aborted fetus:

We dump you into a pan to weigh our prize
Rubbing our hands together, greedily,
Count your limp appendages, record them in a ledger
Our backs turned to the emptied mother.

Another describes his first pronouncement on a busy call night:

How could I spend hours in my first two years discussing imagined deaths, wondering about the scale of life and life’s end, only to see a patient die and have it feel like one more box on a to-do-list?

5. The limits of medicine. Students frequently grappled with the uncertain role of the doctor in dealing with the nonmedical dimensions of patient well-being. They pondered the limits of medicine in addressing the human condition—existential states of suffering and social deprivation. They lamented the inadequate focus on prevention. Students seemed to be asking, “How broadly are we supposed to define our role as healers?” and “How do I reconcile the ‘drop-in-the-bucket’ effect of my limited interventions?”

One student who made a home visit to an elderly patient pondered,

It is not the wet stench of cat urine, not the pitiful sight of dust and grime and garbage, not the meanness of the metallic throne upon which my patient slumps—it is the powerful weight of loneliness that fills me with despair. Today’s home visit does not feel like a medical exercise, and I have no desire to go through the checklist of health concerns in the thick patient file that sits listlessly in my bag. True, my patient has a long laundry list of scary health problems, and she deserves counseling about lifestyle modifications and the importance of medication compliance in order to decrease her risk of developing a myriad of future complications. But all of these things strike me as ridiculous in the moment. My patient’s problem list, in my opinion, consists of a single item heading the unimaginable suffering of isolation.

Another wrote,

Throughout the past five months I’ve been struck so much more than I could have ever imagined by the reality of the inequities that exist. How can we talk about bootstraps when some people’s boots are made of sand, and crumble with a glance, let alone a tug?

6. Emerging accountability. Reflections highlighting students’ growing awareness of their duties to their patients and their own learning focused on the importance of personal responsibility and self-direction in the training process. Students recognized the need to actively seek out medical education rather than “letting it happen to you.” They described an emerging sense that the student must sculpt professional virtues, values, choices, and behaviors for him- or herself:

I spent a good part of the beginning of this educational sojourn waiting for someone to clue me in on how I would best be able to learn the things that I needed to. The advice never came ... what changed was me. The month of November was an awakening to the fact that the learning was only going to come if I sought it out myself.

7. Balance and sacrifice. Several reflections focused on the elusive quest for personal/professional balance across the trajectory of medical training; often, medicine received priority over even basic human needs and safety. One student writing her paper while home on maternity leave described two fundamental roles in conflict:

My friends who have already had children and pumped [breast milk] while working their nonmedical jobs have heard my description of the clerkships and advised early weaning as my only option. It would be sad if working in the medical profession kept me from doing the medically recommended thing for my kid.

The difficulty in managing such priorities is even more difficult when role models are unable to achieve balance themselves:

One preceptor had been complaining about not having the time to go to important doctors’ appointments with her elderly mother. I had actually misheard her and thought she was unable to go to her own doctor’s appointment—“Ha!” she said, “Take care of myself! I definitely don’t have time for that!”

Students observed a culture that at times seemed to expect sacrifices approaching martyrdom:

I’d been working to quell sharp reactions, the too rapid movement of my hand to catch a falling instrument or the too quick jerk of my head to avoid blood from a pumping artery ... The flying needle was the first of dozens ... [After a] flying needle driver bounced off my knuckles ...
I glanced around, and then slowly drew my hand to surreptitiously examine my right thumb where the needle had poked me. I rubbed the spot. Yes, there was blood underneath the glove.

**8. “Faking it.”** Many reflections indicated awareness of the need to first “act” like a doctor and/or expressed variable degrees of confidence that the doctor role would eventually be internalized. Students who described “faking it” implied a theatrical quality to the medical training experience involving the use of scripts, costumes, and other props—often juxtaposed with authenticity. One student discussed her relationship to her white coat:

I felt vaguely like a child “playing dress-up,” and frequently wondered whether patients could see through the cheap costume in order to scrutinize my actual competency. Still, I clung to the white coat as an official uniform, perhaps as proof to reassure both myself and the patient I belonged in the room, that I had the capability to assume responsibility for the lives of patients (who often appeared much older and wiser than I). Even now, the white coat still offers me a sense of validity, of entitlement. It is essentially a façade, but I confess with a visceral twinge of chagrin that it heightens my confidence in my abilities to perform.

**9. Human connection.** Several reflections described the importance of authentic human connection for both patient healing and student learning. Such connections may be between peers, between students and teachers, or between clinicians and patients. After a preceptor shared with a student something of his own personal struggle, the student wrote,

There is a Hebrew term, Talmid Haver, which means “a student who is a friend and colleague.” By disclosing something personal and important, Dr. T. was able to help me to feel like a colleague, an equal who could problem solve with him and listen to his problems. As I felt more like an equal, it was—notably—easier to admit what I didn’t know and to ask for help, to be a conscientious student.

Another student made a conscious choice to focus her reflections on the positive aspects of human connection, the potential for caring. She wrote,

I could hold a grudge against the resident [who] once lamented, “Why can’t they go die somewhere else?” or another who, after smiling widely at a patient, nonchalantly shrugged out of earshot, “He’ll be dead in six months.” I could find endless inhumanities in my hospital experiences—things that would make me sad and frustrated, every day. But it would be short-sighted to say that this is all that I have seen worth noting.

She went on to recount a precious moment in which she surreptitiously observed one of her peers return to a dying patient’s bedside to engage him in conversation:

> It is lovely to watch someone get it right. And it is appropriate that I could learn that lesson best from a peer, one with no more or less knowledge of medicine than me, but with endless humanity he was willing to share.

**Internal transformation: Students as active learners within the hidden curriculum**

In the experiences they recounted, students emerged as active agents in their own learning. Their candid sharing of emotional reactions and interpretive reflections allowed us to begin the work of understanding how external influences shape students’ internal transformations. As important as the socializing forces that acted on them were the active decisions students made in adopting or rejecting messages they internalized from the hidden curriculum. Some wrote with anger and explicit resistance to the values they saw espoused in the hospital. Others noted their own developing respect for the culture they observed:

While I was taken aback at first, I’ve slowly begun to realize that the “surgical persona” donned by some needs to be examined in the full light of the profession and the surgeon’s role in patient care…. Distancing oneself from the situation seems to be the best way to achieve proper judgment at times, allowing one to appropriately and courageously minister to the needs of the patient.

The occasional student was able to embrace paradox and acknowledge simultaneous resistance to and resonance with the culture.

I tell my chief that Ms. Kelly is doing all right…. “The whale?” she asks. I pause for a millisecond, feeling trapped between righteousness of confrontation and the ease of assent. I’d rather fit in than make a scene. “Yes,” I say. It would be easier if things were black-and-white, if I could loathe them for calling the obese patients on our service hefilalumps, whales, and porpoises. But the truth is far more gray, and my team’s harsh comments are accompanied by an obvious commitment to their patients.

Many reflections revealed students making their own meaning of events and articulating their own resolve. After telling a story about discomfort with the need to feign confidence in order to win trust, one student pragmatically articulated his own belief:

Frankly stating when one has reached the limit of one’s knowledge … is good practice both ethically and intellectually. A similar policy might be followed by medical students—when the duties assigned seem inappropriate to one’s level of training or knowledge, the student should share this feeling with superiors, who can then reevaluate the assignment or offer encouragement.

Feeling emotionally spent after long days on a pediatrics rotation, one student opined,

I think the onus is now on me to find what recharges me…. It is true that the two feed-forward on each other—the more happy I am outside the hospital, the happier I am at the hospital, which makes me even happier outside. I think the key is to stay mindful of this cycle, knowing that it can flow positively and negatively. Finding a renewable energy source is important to maintaining a rewarding career in medicine, as coffee and candy can only get one so far.

**Discussion and Conclusions**

Recent work has advocated examination of student critical incident reports18 and narratives on professionalism to gain new information about the hidden curriculum19; our study takes the next step by explicitly asking students to write about the hidden curriculum. Our discovery within the narratives of four overarching and pervasive concepts—medicine as culture, haphazard interactions, role modeling, and tension between “ideal” and “real” medicine—aligns with the concept of the hidden curriculum as commonly described in the literature, and affirms that our students understood the prompt and assignment.

Our thematic analysis of student reflections provides a window into our students’ lived experiences and adds to the existing literature by offering three novel aspects: (1) richly detailed and nuanced descriptions of the hidden curriculum by liminally positioned participant–observers, (2) insight into
the external influences that students encounter as well as the diverse ways they engage those influences in the process of internal transformation, and (3) a framework to guide curriculum reform directly informed by student experience.

Student lessons from the hidden curriculum

We were struck by the pervasive moral challenges described in student reflections. Many reflections recounted critical decision points about assimilating to the dominant culture or holding fast to personal and professional values in conflict. Such “microethical” challenges—taking short cuts, acknowledging mistakes, engaging bias—are ever present for trainees on the wards and in clinics. As others have noted, the list of real-world ethical dilemmas that students face every day does not correlate well with topics on the syllabi of most traditional ethics courses. Our student vignettes resonate with Feudtner and colleagues’ findings that 40% of third- and fourth-year medical students reported doing something wrong or improper for fear of poor evaluation or in an effort to “fit in” with the team.

Such challenges are further confounded by power and hierarchy, the most prevalent theme in our analysis. Several reflections illustrating hierarchical relations of power also illustrated dehumanization of patients and hidden assessment of learners, underscoring Brainard and Brislen’s assertion that power and hierarchy may serve to maintain and reinforce unprofessional behavior. Those at the top of the hierarchy have the dual privilege of defining “professionalism” and evaluating students on the basis of these definitions. All too often, student “professionalism” is simply equated with subservience within the hierarchy. Specific efforts to evaluate professionalism merit further attention. Roughly half of U.S. medical schools have explicit methods to assess professionalism, and only about a third conduct specific faculty development sessions in this arena, a reality echoed in students’ views on hidden assessment and subpar role models.

The hierarchical nature of medical culture has frequently been compared to the military. But unlike the military, these student narratives underscore that expected behaviors in medicine are rarely made explicit, and accountability of superiors is not always defined. The unwritten rules of engagement make medical recruits’ ability to understand and excel in their environment difficult. Students’ focused attention on decoding expectations, rules of conduct, and rotation-specific behavioral nuances may come at the opportunity cost of time otherwise spent on learning medicine and patient care.

Other maladaptive aspects of medical culture include emotional suppression as our students’ reflections poignantly express. The rapid pace at which medical practice moves, combined with the sheer magnitude of human suffering, can be overwhelming. Though suppression of emotion is a pragmatic short-term survival strategy, the long-term consequences—for doctors, for patients, and for the wider health care system—are potentially grave. Multiple studies demonstrate the erosion of empathy over the course of medical training, possibly, distancing from self leads to distancing from patients. Equally concerning are recent data suggesting that it may not be the traumatic clinical content of medicine but, rather, student mistreatment and poor role modeling that lead to depression, anxiety, and lack of psychological well-being among medical students.

As important as the themes we encountered are those we did not. Perhaps the even more challenging aspects of the hidden curriculum are those that lurk below the surface of detection, those influences that students

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Table 1
Themes From the Hidden Curriculum Derived From Third-Year Harvard Medical School Students’ Narrative Reflections Linked to Curricular “Solutions,” 2008

<table>
<thead>
<tr>
<th>Core theme</th>
<th>Solution</th>
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<tbody>
<tr>
<td>Power/hierarchy</td>
<td>Emphasize multidisciplinary teamwork and thoughtfully define meaningful roles for all team members, including students. Develop mechanisms of accountability within hierarchical relationships, particularly pertaining to professionalism.</td>
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<tr>
<td>Patient dehumanization</td>
<td>Incorporate patient voices as often as possible into medical education. Make bedside rounds. Design patient-centered educational experiences for students.</td>
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<tr>
<td>Hidden assessment</td>
<td>Be transparent about expectations and methods of evaluation. Develop routine and legitimate ways to support students who find their own values and learning goals to be in conflict with hidden curricular pressures.</td>
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<tr>
<td>Emotional suppression</td>
<td>Foster safe havens where students can reflect on (rather than suppress) their experiences and mature in their ability to engage the emotional work of doctoring.</td>
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<tr>
<td>Limits of medicine</td>
<td>Review the formal curricular offerings and consider the messages that are communicated about what is and what is not within the scope of the doctor’s concern. Periodically review work rounds and hold precepting conversations with students to understand how patients’ social and emotional needs are addressed. Make accessible physicians who are positive role models, who engage social justice and take on health system challenges.</td>
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<tr>
<td>Emerging accountability</td>
<td>Design educational experiences that expect, encourage, and reward independence, initiative, and self-determination.</td>
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<tr>
<td>Balance/sacrifice</td>
<td>Sponsor constructive and honest conversation among physicians at every stage in training about choices, consequences, and compromises in balancing personal and professional lives. Advocate benefits/rules that protect family life and personal time.</td>
</tr>
<tr>
<td>Faking it</td>
<td>Explicitly seek ways to calibrate student responsibilities in a gradual manner, and support students as they present themselves to patients. Help students mitigate the tension of playing new and unfamiliar roles. Ask about, and then help students negotiate, the “microethical” challenges of their day-to-day clinical experiences.</td>
</tr>
<tr>
<td>Human connection</td>
<td>Cultivate the conditions in medical institutions that are conducive to growing and nurturing longitudinal relationships. Organize work in small units; learn everyone’s name; eat together; celebrate beginnings, endings, and transitions.</td>
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do not perceive and therefore did not name, or those that students recognize but do not feel comfortable discussing. For example, only one of our students mentioned the role and status of nurses or other nonphysician colleagues on the health care team. Only one student mentioned the impact of the device industry on medical practice. None wrote about politics or the pressure to get ahead by competing with peers.

External forces and internal transformations

In their reflections, many students identified their own active role as learners, metabolizing or rejecting the messages of the hidden curriculum. While the reflections convey the students' sense of powerlessness to effect change in the external (learning and patient care) environment, they actively struggle with choices: One student wrestles to keep his hands in the surgical field despite flying sharps; another grapples with ambivalence, recognizing that her team's behavior in caring for obese patients is at once loathsome and dedicated. Many students write with sophisticated insight regarding their chosen stance in the story they tell. From this lens—students as active learners in the hidden curriculum—we propose a paradigm shift. Students—indeed, each of us, independent of level of training—is not a passive victim but an active contributor to the hidden curriculum. Every time we make a choice—react or don't, repeat unprofessional behaviors or seek out more admirable ones—we are feeding something back into medical culture. Our collective actions and reactions create the culture in which we work and learn. Though limited by the hierarchical structure of medical education, students do have choices, and educators can help.

Curricular reform

By providing insight into what students are actually learning, these reflections offer guidance for curricular reform. First, this work reaffirms the power of student reflections to initiate a conversation about the hidden curriculum.28 Explicitly asking students to be anthropologists of medical culture, as this assignment requires, may in itself help students cultivate a useful critical distance. We used excerpts from these papers to facilitate small-group conversations with medical students, thereby exposing "hidden" influences and permitting students to strategize together about ways of responding. Sharing these reflections up the hierarchy and allowing these student voices to speak to residents, faculty, and administrative leaders may also be critical components of meaningful change. Interestingly, the disconnect between espoused values and lived experience apparent in student papers is also described by senior physicians.29 Attention to what is working well is as important as attention to what is not. Some medical educators have effectively used an "appreciative inquiry" approach,30,31 that is, collecting, analyzing, and disseminating positive examples from the hidden curriculum to inspire cultural transformation in medical institutions.

Beyond simply exposing the hidden curriculum, we can work intentionally on remediating problematic dynamics. Each of the nine themes identified in our student narratives invites a response from medical educators (Table 1).

Limitations of our study include the small sample size from a single academic health center. Our students are likely affected by exposure to a common culture during the first two years of medical school, despite completing clinical rotations at many different hospitals. Although the hidden curriculum they describe may be different than the hidden curriculum at other schools, our findings resonate with other qualitative studies on the hidden curriculum.4–6,11,12 Furthermore, we continued to discover these same nine themes (and no new themes) in informal review of dozens of hidden curriculum narratives written by subsequent groups of third-year medical students over the next two years.

As medical educators, we do well to listen to our students. Their reports of what they are learning reveal what we are actually teaching.

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