Humanities

Valuable lessons learned through the "hidden curriculum" of medicine: one student's perspective

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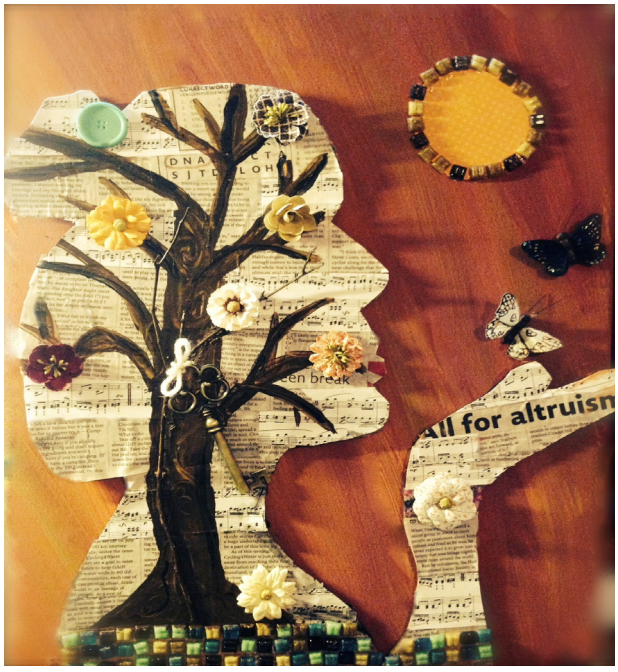
Currently, some level of undergraduate education is required to apply to North American medical schools. No particular degree is mandatory; however, some institutions do have necessary prerequisite courses. Many students even go above and beyond the minimum requirements by completing graduate school or other professional programs prior to beginning undergraduate medical training. As such, pupils enter medical school with varying educational backgrounds, differing expertise, and unique styles of communication. Yet, at the end of a Canadian undergraduate medical degree, students reach the finish line together and are prepared to begin residency training. How does this happen? The answer to this question is quite complex. In fact, medical schools have entire departments dedicated to ensuring students receive the best training and the most relevant curriculum (e.g., Dalhousie Division of Medical Education). In addition, the Dean, as well as his or her colleagues, guarantee that the institution meets accreditation requirements. These standards ensure, despite differences in the style of curriculum delivery, that all medical students meet regulated objectives and receive adequate education to begin a residency training program.

Although formal teachings are necessary for the acquisition of medical skills and knowledge, I would argue that the most important lessons are not found in books or through didactic learning. Instead, they are hidden within our curriculum and require the guidance of dedicated mentors as well as critical reflection by mentees to be realized. Dr. Stephen Workman and colleagues said this very well when they wrote "we encounter teachable moments precisely when we are trying to get a point across about an entirely unrelated matter."[1]

The concept of unplanned and informal learning has been thoroughly considered for nearly four decades. The term "hidden curriculum" was first coined by Jackson to describe the unwritten and undocumented lessons that students learn through the socialization process embedded within education.[2] The idea of students absorbing information not part of formal study has been extrapolated to the area of medicine and well-explored since. Hafferty[3] made a critical point that formal teaching does not take place in a vacuum, and therefore only a fraction of medical culture and learning is conveyed in structured curriculum hours. Congruent



with this idea, earlier writing by Hafferty and Franks[4] states that hidden curriculum is not only delivered by social actors (e.g., instructors, preceptors, peers), but is imbedded within the very structure of medical work and the entire learning environment. This type of unspoken learning is not rigid; it is dynamic and opportunistic in nature with appropriate lessons offered when learning occasions present.[5] Medical education would be incomplete without specific formal objectives learned through a multidisciplinary approach; however, in goal-oriented society we often forget about the implicit lessons that are learned through the socialization process of medical training.

Understanding that a "hidden curriculum" exists, we need to consider that it can be both beneficial and harmful for learners. Arguments have been made that the implicit lessons trainees receive from peers, preceptors, and other health care providers allow for the transmission of poor habits, and may in fact undermine the formal teachings of the medical curriculum.[5] However, medical students have reported that informal curriculum provides depth in their learning and allows them to acquire the skills necessary to be "good" doctors.[6,7] In this paper I would like to explore the beneficial learning experiences that

I have been exposed to through my own personal opportunistic hidden curriculum, while acknowledging that negative information and lessons can be transferred inadvertently through this informal type of curriculum.

Through my experiences in both formal clinical sessions and work in elective specialties I have learned skills that are not necessarily intuitive, I discovered ways to facilitate communication with patients, and I improved my ability to be a functional health care team member. Many would argue that these skills are acquired through clinical experience, which in part I would agree with. Nevertheless, my mentors encouraged me to think abstractly and to consider the details of a situation that are often overlooked in the busy emergency department setting or when dealing with complex patients. Four opportunistic learning experiences in particular shaped the way I will practice medicine, even though they were not part of my formal training.

The first implicit lesson I learned was that diverse communication abilities in a medical setting are crucial. Of course, we are taught this from day one of medical school; but it was not until working in the pediatric emergency department that I truly realized the importance of both verbal and non-verbal communication skills. I had the opportunity to meet a young male patient who presented with abdominal pain. You would expect a routine history and physical to occur, with further investigations and treatment, if warranted. But what happens when your patient will not speak to you? Are they embarrassed? Have you developed sufficient rapport for them to give you private information? These are all questions that were running through my head as my preceptor patiently attempted to interview a young man who would not speak. We later learned that he had a previous diagnosis of selective mutism, and has great difficulty communicating with words. I learned through observing my preceptor that critical information is not always easy to obtain. Fortunately, with a great deal of patience and collateral information, we were able to determine that our patient was suffering from testicular torsion. Had my preceptor not been patient and attentive throughout this clinical experience there may have been a truly adverse outcome for our patient who we initially thought "refused" to speak.

Along the lines of communication skills, I recently learned a valuable lesson from an internal medicine physician. He made the point that we should use open-ended inquiry, to encourage the patient to tell their story without burdening it with our own personal bias or suggesting a certain answer. However, more importantly, when responding to what a patient has said we should provide a reply that not only shows we care about their answer and are listening, but also we want to learn more. He highlighted this idea by providing an example that resonated with me. For instance, if you ask a patient if they smoke and they tell you yes, how should you reply? Many trainees and even attending staff will say "okay" and move on. But, what does "okay" mean to a patient? This particular physician felt that "okay" could mean three things: 1) I am acknowledging that I heard you, 2) I feel that your smoking is okay and I will not chastise you for it, or 3) I understand that you smoke but it is not important enough for me to further address it. None of these responses provide any more information to the patient encounter, and therefore "okay" acts as a filler. A more appropriate response would be "are you interested in quitting?" or "do you understand the risks associated with smoking?" Not only does this implicitly show you have heard their answer, but additionally is demonstrates that you care and are motivated to help them quit smoking.

He further emphasized that medicine is not about leading patients in one direction or another, or propelling patriarchy; but instead, it is about supporting patients through their narrative and using their story to gain insight into their illness. Although we need to ask the correct questions, and steer patients back to a focus when they move away on tangents, we must value that they know their own story best.

The third important lesson that I learned through my clinical experience was about cultural competence. These two words encompass "the body of knowledge, skills, attitudes and behaviors that physicians ought to be trained in to adequately deliver sensitive, empathetic and humanistic care" to all patients regardless of their cultural or ethnic background.[8] This is an emerging topic in the area of North American medicine as our society becomes more diverse, and thus something with which I was familiar from formal academic teaching. In an attempt to apply my cultural competency in the clinical setting, I decided that it was okay for a young girl to not remove her headdress while I was conducting her physical examination. I simply did not want to burden or embarrass her. Where was my downfall in this clinical examination? In an attempt to be culturally respectful I may have missed key information regarding the diagnosis including visible lymphadenopathy, hair loss, or skin eruptions. When reporting my physical findings to my preceptor she explained to me that it is important, despite it being uncomfortable, to complete a thorough physical examination. This includes examining sensitive areas, and areas that patients prefer to keep covered, if the investigation is justified. I learned a fundamental lesson on this day, that delivering culturally competent care should not prevent physicians from identifying key findings regarding patient health.

Lastly, and perhaps the most important lesson that I learned during my pediatric emergency elective, was the importance of being confident while exercising humility. I stumbled upon this lesson after examining a small boy with a week old wrist fracture. While waiting for a referral appointment to orthopedic surgery his discomfort and pain progressed to the point that his mother brought him back for a second visit to the emergency department. As a medical student I went into the room, examined the splint and dressing, talked to the boy and mom, and concluded to myself that mild analgesic medications should be sufficient to make the boy comfortable until he could see a surgeon. When describing my findings to my preceptor she also seemed to be convinced. However, almost immediately during her clinical examination she determined that this patient was experiencing compartmental pain due to his dressing being wrapped far too tightly. Being a naïve medical student with very little knowledge of the musculoskeletal system, I completely missed this diagnosis that would have been quite obvious to any practicing physician. It was at this moment I realized that even though it is important to be confident in clinical settings to ensure patients feel you are competent in your role, it is more important to acknowledge that all medical practitioners are lifelong learners. This is especially true for medical students and we must remain humble in order to reach our full learning potential.

Medical faculty and trainees often overlook the "hidden curriculum" of medicine, as it is not explicitly stated as objectives in syllabi. Although it can confer negative habits through the socialization process, it also has the ability to teach students incredibly important lessons regarding medical knowledge and clinical practice. Through my second year clinical experiences I was able to indirectly learn how important it is to be patient and thoughtful when communicating, despite the chaos occurring around you. I also learned that it is imperative to conduct a full physical examination and to explain to patients that what you are asking and doing may seem inappropriate given their values, but that everything you are doing is for the benefit of their health. Finally, it is paramount to realize that in all stages of a medical career you will continue to learn and therefore it is important to maintain a humble demeanor that allows you to absorb new information. These important lessons were not acquired through formal teaching, books, or course notes; they were assimilated through opportunistic experience and the direction of dedicated mentors. Going forward, I believe that medical education departments should incorporate the advice of Hafferty and Frank[3] to "create structures that allow learners to reflect upon the larger structure picture of which they are a part" to produce well-rounded and compassionate physicians.

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