A FACULTY GUIDE

A Guide for Teaching in Clinical Settings

PART II
The Hidden Curriculum in Health Care Education
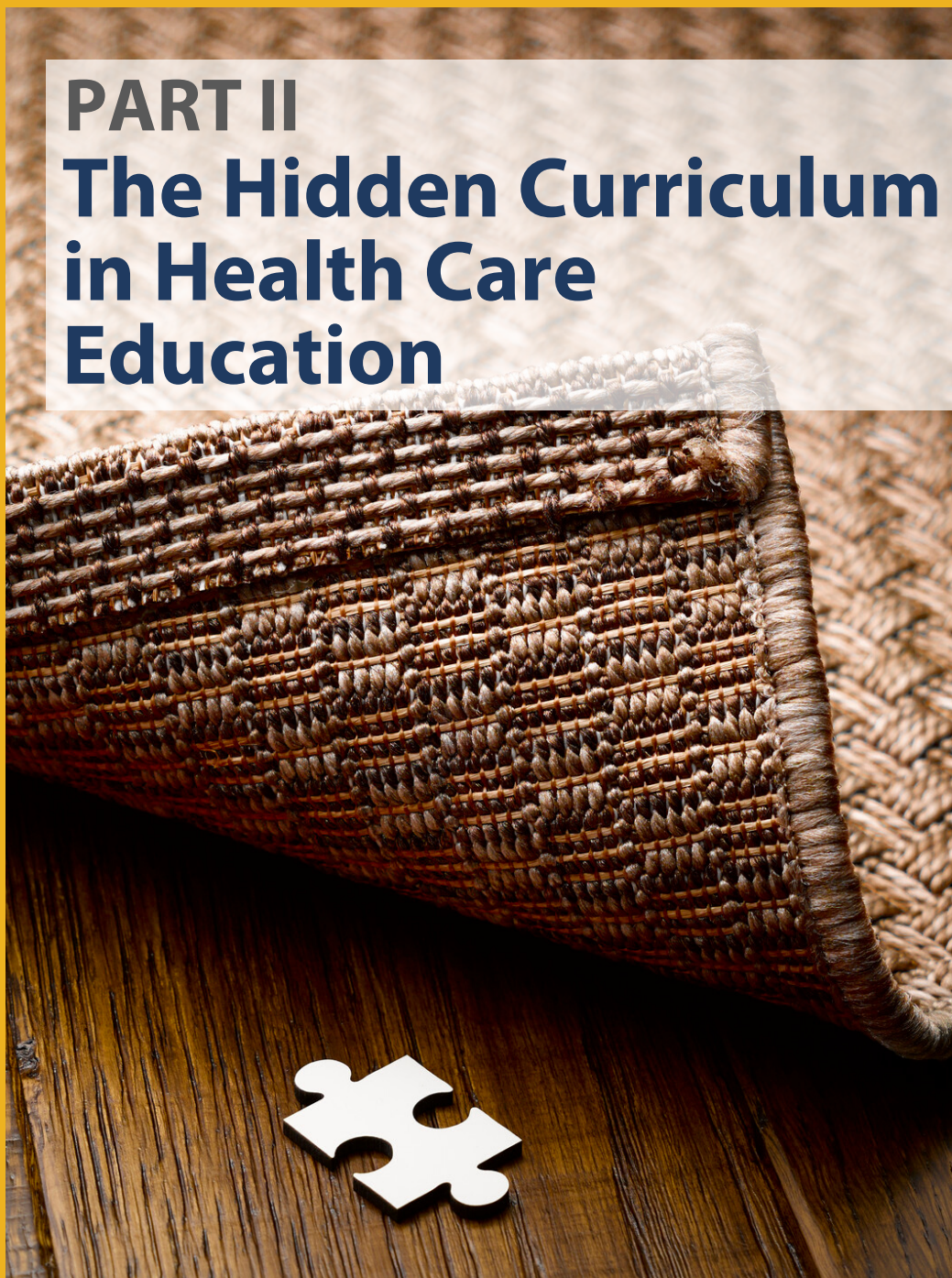
Queen's UNIVERSITY

FACULTY OF HEALTH SCIENCES
FACULTY DEVELOPMENT

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INTRODUCTION

While the "formal" curriculum consists of the courses, lessons, and learning activities students participate in, and the knowledge and skills educators intentionally teach to students, the "hidden curriculum" is defined as a set of influences that function at the level of the organizational structure and culture that affect learning. It refers to the unwritten, unofficial, and often unintended lessons, values, and perspectives that are communicated to the learners (Mackin, 2019).

The "hidden curriculum" is the discrepancy between what is taught to learners in formal settings and what students learn in the informal flow of professional practice. The "hidden curriculum" includes the norms, values, and practices that are conveyed through role modeling and can have a profound effect on student learning. It runs parallel to the formal curriculum and is a process of socialization to the complexities of relationships with the patient and their caregiver, interprofessional team, and community (Hall, 2012). Much of the socialization occurs outside formal learning environments, in corridors and call rooms, but is considered more memorable than the explicit formal curriculum. Every word spoken, every action performed, every joke, and every silence inform values we might never have intended to inform. The hidden curriculum consists of what is implicitly taught by example day to day, not the explicit teaching of lectures, grand rounds, or seminars. (Mahood, 2011). "Hidden" is a suitable adjective to describe the complex social and political manifestations that we knew about but had never made a strategic effort to address. Educational practices that were in a sense "hidden" (MacLeod, 2014).

Literature supports the significant impact of the hidden curriculum on all levels of learners (Mackin, 2019). The hidden curriculum can either support the formal curriculum, or it can go against it, exposing inconsistencies between the affirmed mission, values, and beliefs of an institution and what students experience and learn. Its effects include loss of idealism, adoption of ritualized professional identity, emotional neutralization, change of ethical integrity, and acceptance of hierarchy. This powerful feeling 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 (Mahood, 2011).

Meanwhile, role modeling emerged as a positive influence on the hidden curriculum as educators have constant opportunities to teach positive lessons in the hidden curriculum (Sudhir, Santhosh, Darcy-Mahoney, & Gundersen, 2018).

DIMENSIONS OF THE HIDDEN CURRICULUM

Macleod described three dimensions for hidden curriculum:

1 Represent any of the contexts of health care education: learner-teacher communication, learning setting (i.e. – clinical, classroom), and the administrative design of the school as a small-scale version of the social value system.

2 Depends on a number of processes operating in institutions, including values acquisition, socialization, and maintenance of class structure.

2 Embrace differing degrees of intentionality, and of depth of "hiddenness," ranging from unintended by-products of curricular arrangements to outcomes deeply embedded in the historical social function of health care education.

The hidden curriculum has become an integrated and mandatory part of undergraduate health care education in North America for several years (Hopkins, 2016). As described by Hopkins 2016 , the impact of the hidden curriculum has been organized into three main categories:

1 Being critical to the professional and emotional growth of trainees.

2 Benefiting patient care as supported by the opportunity to develop more meaningful patient-healthcare provider relationships when a patient can trust their healthcare provider.

2 Providing resilience to burnout and increasing the productivity of trainees by generating awareness and strategies to overcome the hidden curriculum.

Poor modeling, unresolved ethical dilemmas, excessive and draining academic stresses, and emotional and physical annoyance are among the issues faced through the hidden curriculum (D'eon et al., 2007). Attending clinicians model for residents, who model for students, and so on down the line. As day-to-day experiences are more influential than formal curriculum content, we need to pay careful attention to the hidden curriculum.

RECOMMENDATIONS TO ADDRESS THE HIDDEN CURRICULUM

Professionalism is an essential competence for health professionals. There is often inconsistency between the obvious knowledge of good professional behaviour gained by the formally taught curriculum, and the students' perception of the "real life" behaviour in clinical settings. It is likely due to the unacknowledged organizational rules, the atmosphere, and the culture in the clinical environment: the hidden curriculum, to which they are exposed daily. Developing strategies to limit the potentially negative influence of the hidden curriculum, and to prepare students to make the proper choices of appropriate behaviors and role models is clearly a priority to improve standards of professionalism in our students (Joynt, 2018).

Several authors agreed that student observations of behaviors are of greater influence than prescriptions for behavior offered in the classroom. They stressed the importance of modeling of professional relationships with patients and colleagues, but they failed to acknowledge the importance of the values inherent in the role of the professional educator. This includes relationships and associated behaviors that result from the responsibilities of being an educator based on cultural and institutional expectations, (Glicken, 2007).

Reforming the Learning Environment

(Restructuring learning environments rather than modifying curricula.)

Hafferty (1998) emphasized that we need to prioritize the "learning environment" and that reform initiatives must be undertaken with a focus on what students learn instead of what they are taught. He distinguished three interrelated components of medical training: the formal curriculum, the informal curriculum, and the hidden curriculum.

Unveiling the Hidden Curriculum

To unveil their institution's hidden curricula, he suggested that educators and administrators examine four areas: institutional policies, evaluation activities, resource-allocation decisions, and institutional "slang." Hafferty prescribed three recommendations for moving beyond curriculum reform to reconstruct the overall learning environment of health care education, including the hidden curriculum: Create structures that allow individuals to reflect upon the larger structural picture of which they are a part. "Think big picture, think against the grain."

Maintaining, Nurturing and Embracing the Content and Values Advocated for

Lamiani 2011 stated that it is not enough to reform medical school curricula by merely incorporating courses on communication skills, ethics, and professionalism if the content and values that are advocated are not maintained, nurtured and embraced in everyday clinical practice. Medical educators should consider more seriously the content and process of their institutions' hidden curricula, especially considering promoting professionalism and quality care.

Several actions should be taken to align the messages of the hidden curriculum with the formal curriculum. Collaborative learning opportunities with medical faculty and senior clinicians will offer students a more comprehensive learning experience in which communication and relational skills are integrated with clinical practice.

Creating a Safe and Brave Space

Creating a safe and brave space to express emotions is important for both learners and educators. Creating this space also contributes to a culture of safety—where everyone, including and especially learners, feels comfortable speaking up whenever needed (Sudhir, Santhosh, Darcy-Mahoney, & Gundersen, 2018), and better understand the nuances of the hidden curriculum.

Role Modeling

Individual role-modeling is a primary method for shaping the hidden curriculum, (Weissman et al., 2006).

CONCLUSION

In conclusion, Mahood 2011 suggested:

• To make the hidden curriculum a topic of explicit discussion, in topics such as medical mistakes, subspecialisation and fragmentation of care, inter-professional disrespect, the experience of illness, truth telling, prejudicing of patient care, and power dynamics and hierarchy in healthcare.

• To develop Faculty development courses to support modeling professionalism and pedagogic approaches that help.

• To minimize brief and fragmented clinical training schedules and to maximize the extended experiences known to preserve patient-centred attitudes.

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