Hidden in Plain Sight: The Formal, Informal, and Hidden Curricula of a Psychiatry Clerkship

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Abstract

Purpose
To examine perceptions of the formal, informal, and hidden curricula in psychiatry as they are observed and experienced by (1) attending physicians who have teaching responsibilities for residents and medical students, (2) residents who are taught by those same physicians and who have teaching responsibilities for medical students, and (3) medical students who are taught by attendings and residents during their psychiatry rotation.

Method
From June to November 2007, the authors conducted focus groups with attendings, residents, and students in one midwestern academic setting. The

sessions were audiotaped, transcribed, and analyzed for themes surrounding the formal, informal, and hidden curricula.

Results
All three groups offered a similar belief that the knowledge, skills, and values of the formal curriculum focused on building relationships. Similarly, all three suggested that elements of the informal and hidden curricula were expressed primarily as the values arising from attendings' role modeling, as the nature and amount of time attendings spend with patients, and as attendings' advice arising from experience and intuition versus "textbook learning." Whereas students and residents offered negative values arising from the informal and

hidden curricula, attendings did not, offering instead the more positive values they intended to encourage through the informal and hidden curricula.

Conclusions
The process described here has great potential in local settings across all disciplines. Asking teachers and learners in any setting to think about how they experience the educational environment and what sense they make of all curricular efforts can provide a reality check for educators and a values check for learners as they critically reflect on the meanings of what they are learning.

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A hidden curriculum is not something one just finds; one must go hunting for it.

—Jane Roland Martin, *Changing the Educational Landscape: Philosophy, Women, and Curriculum,* 1994

Some degree of disconnect usually exists between what we hope our students will learn and the learning that actually takes place. On one hand, we believe that trainees acquire knowledge, skills, and attitudes as a result of formal and informal instruction in lecture halls, seminar rooms, labs, tutorials, and all kinds of clinical settings. On the other, we know that what students learn is often in direct contradiction to our intentions and what the formal curriculum purports to teach. This is not an original or revolutionary thought; indeed, anyone

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who teaches in any setting is more or less aware of this phenomenon even as most of us proceed throughout our teaching lives as if the content and methods of our teaching *matter* in mostly positive ways.

This perennial educational conundrum appeared again, restated with more urgency, if not pathos, during a class focusing on students' narratives written during their psychiatry clerkship at the Northeastern Ohio Universities College of Medicine (NEOUCOM). In response to a required assignment to write a one- to two-page narrative reflecting a clinical event that was "puzzling, affirming, or disturbing," one student wrote the following about the mixed messages she had received from residents and attendings. She wrote her paper as a series of contradictory bits of advice she had received as a third-year student, some of it specific to psychiatry:

> Extreme optimism, personally or patient-directed, may not be in our best interest as it allows us to feel disappointment more sharply. . . . Pragmatism is the most destructive force in medicine—sometimes we are the patient's only cheerleader and optimism itself is strengthening.

> Touching invades a patient's personal space and should never be done. . . .

Touching can be an appropriate way to physically demonstrate connection and empathy.

> We should never be amused at a patient's expense. . . . The human experience is intrinsically humorous and should be experienced with full appreciation of its spectrum of emotions.

> We should never disclose personal information to patients. . . . Disclosure can be appropriate.

> [She mused]: My struggle is always in doing the "right thing": for the patients I anxiously await calling my own, for my family and friends, and most of all for myself. . . . Receiving most of the advice given to me in black-and-white is extremely anxiety provoking. I second-guess many of the actions I take. I feel guilty when I have broken one of the "rules." It shakes the framework I try to live by and it challenges the quality of my work.

After discussing her thoughts at great length in a class precepted by the psychiatry department chair and one of us (D.W.), we decided that the issues raised could be an important springboard for a department-wide examination of the formal, informal, and hidden curricula with three highly invested groups: faculty, residents, and students.

That is, we decided to "go hunting," as the quotation that opens this report suggests.[1] The purpose of our study, then, was to examine these curriculum phenomena in psychiatry as they are observed and experienced by (1) attending physicians who have teaching responsibilities for residents and medical students, (2) residents who are taught by those same physicians and who have teaching responsibilities for medical students, and (3) medical students who are taught by attendings and residents during their psychiatry rotation.

Before describing the methods used in this project, we first provide background on the formal, informal, and hidden curricula, particularly as they relate to medical education.

The Formal, Informal, and Hidden Curricula

William Pinar,[2] arguably the most important North American curriculum theorist of the last 25 years, unravels tidy definitions of curricula that seem to abound in medical education. In his synoptic text *Understanding Curriculum,* Pinar notes the shifts in how educators have used the word *curriculum* over the past century, from a term to denote the actual formal document to all the experiences planned and unplanned that occur under the auspices of an educational entity. Here, we use the term *formal curriculum* narrowly to mean the actual course of study, the planned content, teaching, evaluation methods, syllabi, and other materials used in any educational setting from lecture halls to labs to seminar rooms. Also included are formal policy statements, regulations, expectations, and competencies for every educational cohort conceivable.

We use the term *informal curriculum* to denote much of what occurs in clinical settings—the opportunistic, idiosyncratic, pop-up, and often unplanned instruction that takes place between anyone who is teaching (attendings, residents, other health care professionals) and trainees. The informal curriculum also takes place in nonclinical settings such as faculty offices, hallway interactions, or the countless other settings in which teachers and other health care providers interact with trainees. Like the content of the countless lectures students face during the first two years, the informal

curriculum reflects what teachers believe trainees should acquire in terms of knowledge, skills, values, and attitudes.

A considerable literature exists on the *hidden curriculum,* which includes the ideological and subliminal messages of both the formal and informal curricula. The hidden curriculum can be both human and structural; that is, it can be transmitted through human behaviors and through the structures and practices of institutions. Most of the literature on the hidden curriculum exists not in medical education but in educational and curriculum theory. Some educational historians trace the concept back to philosopher John Dewey,[3] who, in the early 20th century, referred to the "collateral learning" that goes on in educational settings that may have more of a lasting effect on learners than the formal curriculum. Most would agree, however, that the name most associated with the concept is Philip Jackson,[4] a scholar who first used the word in 1968. In his classic ethnographic study of an elementary school, *Life in Classrooms,* he described

> a distinctive flavor to classroom life [that] collectively form a hidden curriculum which each student must master if he is to make his way satisfactorily through the school. The demands created by these features of classroom life may be contrasted with the academic demands— the "official" curriculum so to speak—to which educators traditionally have paid the most attention.[(p34)]

As a vast network of unwritten social and cultural values, rules, assumptions, and expectations, the hidden curriculum shapes behavior so much that mastery of the hidden curriculum is as important as mastery of the formal one. As Jackson[4] [(p33)] points out, "It is certainly possible that many of our valedictorians and presidents of our honor societies owe their success as much to institutional conformity as to intellectual prowess." Moreover, he wonders whether mastery of the formal and hidden curricula requires compatible or competing personal qualities.

The concept of the hidden curriculum was brought to academic medicine by Hafferty and Franks[5] in their 1994 landmark article in *Academic Medicine,* "The hidden curriculum, ethics teaching, and the structure of medical education," which, at the time of this writing, had

been cited 211 times. Other articles on the hidden curriculum have appeared since that time, most of them focusing on the disconnect between what we formally teach medical students and residents in lectures and syllabi and how things really operate in clinical settings, most often related to the attitudes and behaviors of attendings and residents in informal teaching situations.[6–11] Most of the research to date has been generally focused on the undergraduate and graduate medical curricula in general, although some of the medical specialties have concentrated such inquiry in their particular fields, such as Gofton and Regehr's[8] recent work in orthopedics. This study will concentrate specifically on the formal, informal, and hidden curricula of psychiatry education.

Method

After receiving approval from our college's institutional review board (IRB), we conducted six focus groups from June to November 2007. One of us is a full-time nonclinical faculty member in a behavioral sciences department (D.W.); the other (J.S.) was chief resident of psychiatry at a major teaching hospital of the college. We conducted four such groups with third-year medical students during their psychiatry rotations (J.S., n = 60) and one each with psychiatry residents at all levels (D.W., n = 13) and with teaching faculty in the department (D.W., n = 5). Thus, participants included half of a graduating cohort of NEOUCOM students, 76% of all psychiatry residents, and 54% of core teaching faculty in psychiatry in one hospital system.

We selected the focus group as a method for several reasons. First, it typically promotes interaction among participants and provides an opportunity for addressing sensitive topics. Second, it is the most practical method to bring together groups of busy individuals. In a focus group, individuals can use the method itself to interact with each other, challenging and questioning each other's ideas or positions, exchanging stories, and thinking out loud with others who have similar experiences. The focus groups took place in hospital conference rooms where each participant received and read an information sheet approved by the IRB. We used the same semistructured interview format in all focus groups,

adapting the language depending on the type of individuals in each group. After providing several examples of the kinds of curriculum phenomena we sought to identify, we asked participants a series of open-ended questions designed to prompt thinking about how they perceived and experienced the various enactments of the formal, informal, and hidden curricula reflected in the teaching environment of the psychiatry department.

The interviews were audiotaped and transcribed by both of us; we removed all personal identifiers in the written transcripts. We both read each transcript independently as an inductive process to discover categories and themes that describe and explain the curriculum phenomena under study. Our analysis focused on phrases, explanations, and observations made by all three groups that illustrated particular incidents, behaviors, attitudes, and other environmental cues. We then compared our results and formed common agreement for the themes that frame the discussion below. Everything found below in quotation marks or in an indented format reproduces the language that participants actually used. We make no claims for generalizability in this study, but we do provide one snapshot of several groups of students, residents, and attending physicians in one midwestern teaching hospital health system, along with our interpretive efforts.

Results

We divided this section into two parts: the formal and informal curricula of psychiatry, focusing primarily on the hidden dimensions of the latter. We include the perspectives of students, residents, and attendings relative to each type of curriculum.

The formal curriculum in psychiatry

Based on their levels of training, students and residents obviously experience a different formal curriculum in psychiatry. Nonetheless, we wanted to see whether a common value orientation pervaded the department and how it was manifested and perceived not only by students and residents but by attendings as well. In general, the value orientation of the department—one recognized by all three groups—was the high value placed on building relationships with patients.

Students were most articulate and specific about the knowledge, skills, and values of the formal curriculum that lead to building relationships with patients. In addition to "good psych H & P," the mental status exam, DSM-IV criteria, and pharmacology, students often characterized it as "just observing, really" and getting "more into social background." One believed it was gaining a better understanding of people and human behavior in general:

> I think back to our first and second years of medical school [when] they taught us . . . how to become more efficient at interacting with patients and how to get more out of the interview and dig deeper. With NEOUCOM being . . . [a] more patient-oriented medical school, I think that's one of the things they really expect and want us to get out of this rotation: to be able to sit down and talk with the patient and get deeper into a conversation.

Both residents and attendings gave obligatory responses to the content of the formal curriculum, with residents referring to everything mandated by the residency review committee and attendings responding more globally with everything that was prescribed or endorsed by the psychiatry community. Residents did, however, note the emphasis on psychotherapy—again, on *relationships* with patients—versus a pharmacological/biological focus in their residency education, an observation that has implications across the formal, informal, and hidden curricula. That is, the presence *or* absence of a particular topic or skill reflects not only the actual content of the formal, informal, and hidden curricula but also the value orientation suggested by the hidden curriculum.

The informal curriculum in psychiatry

Recall that the informal curriculum "is the process by which a learner's knowledge and skills become situated in the context of daily work. It is not structured but is opportunistic, with appropriate lessons being offered when appropriate learning opportunities arise."[8] The hidden curriculum refers to the unwritten and sometimes unconscious values, rules, behaviors, assumptions, and expectations that commingle with both the formal and informal curricula. Regardless of this distinction, most students, residents, and attendings generally focused on the

hidden dimensions, both positive and negative, of the informal curriculum. When describing the informal, unstructured interactions between and among attendings, residents, and students, each group invariably described such interactions with value-laden terms, often using the terms *hidden curriculum* and *informal curriculum* interchangeably. In particular, residents and students most often viewed the informal curriculum as *itself* a series of rules, values, assumptions, and expectations emitted from the behaviors of attendings. For that reason, in the following section we report this perceived seamlessness of the informal and hidden curricula as the *hidden informal curriculum,* organized around the three reoccurring themes of role modeling, functions of time, and experience/intuition versus textbook learning.

Students' perspectives

Theme one: The hidden informal curriculum as role modeling. Students believe that the hidden informal curriculum is based on role modeling, which thus depends on which attending they are with; that is, the informal curriculum does not uniformly present a consistent, department-wide set of values, beliefs, behaviors, and other orientations to patient care. Students in each of the four student focus groups repeatedly noted such specificity:

> I think it's the [attendings'] personality, really. They are all just very different. Some are done at 10:30 and I don't know what that teaches you— do they just have a lot of outpatient work to do in their office later or are they just fast? While others don't even have time to eat lunch and go to the bathroom. . . . I think it's a person by person thing.

Students offered many other examples of both positive and negative role models found in the informal curriculum. One of the most important factors in their characterization of "good" role models was the attention they give to students as learners (e.g., "some attendings allow the students to do lots or some just have you shadow"). Some students were acutely aware of whether or not attendings even read their notes, and good ones do:

> [Our attending] reads our notes every day. We go in before he does and he'll ask us what's going on with the patients and while we're telling him he'll be reading

our note. He fascinates me with his ability to multitask. He'll be reading something while writing orders and listening to you at the same time and you may think he's not listening but then he brings it up to the patient so you know he's really listening. He'll read our notes and circle things in the plan . . . and put a check mark saying he wants to do that.

Another student described rounding with her attending who would clearly communicate to patients the important role of students:

He'll go in and say "Hi, I'm Dr. _____. We're here as a team" and introduce each of us. . . . If we talked to the patient earlier he'll say [to the patient], "Well, I know you've talked to the team earlier today but we're just going to go over some things."

In contrast, some students characterized negative role models as attendings who rarely give feedback or those who place students in "sink or swim scenarios from the first minute of the first day." A particularly unhappy student disclosed that, for him,

most of the time you just kind of sit there and follow around and sometimes I go talk to the patient and check the labs and talk to the nurses and the attending doesn't even care what I have to contribute. . . . In five weeks nobody ever asked me my assessment or treatment plan.

Theme two: The hidden informal curriculum as a function of time. The second theme we identified from students' observations of the informal curriculum focused on the issue of time. Most believed that both teaching and patient care are related to time, and often there isn't enough time for either. "Most of the time we're just holding up the wall," one student observed, while another argued that it was a quality versus quantity issue with attendings, noting that students can spend large amounts of time with an attending who never really interacts with them. One student expressed the belief of many, that "it's all just based on whether the attending wants to teach. I've been with other doctors who are just as busy and stressed, but they've taken the time to explain things."

For some students, time factors directly influence patient care. One argued that being crunched for time means "treat and get to baseline . . . the informal curriculum is get your diagnosis, treat it and move on quickly." Others worked

with attendings who seemed to overcome the restrictions of time, such as one student who compared his attending with the one with whom his peer was working:

My doctor takes a lot of time with individual patients. Say we both [referring to both their attendings] had five patients to see. He'd be done in an hour and we'd be done in three hours because [my attending] takes a very long time to get to know what's going on and he cares about the patient.

Theme three: The hidden informal curriculum as experience/intuition versus textbook learning. Students recognized that attendings' experience and intuition are reflected in the informal curriculum and that they are at least as important as the formal curriculum. They recognize this in light of their *lack* of experience and intuition even as they are learning basic psychiatric concepts and skills through textbooks, lectures, and bedside checklists. One student, aware that his initial perceptions of a patient were often dashed by an attending who would come out of the patient's room "and have a very different view of the patient," recognized how his idealism and inexperience affected his clinical judgment. In addition, understanding what his experienced attendings brought to the care of psychiatric patients taught him

to ask the patient more analytical questions. Instead of just accepting what [patients] say, maybe asking, "Well, how are you going to do that, how are you going to stay away from drugs, how are you going to improve your relationships?"

Some students interpreted attendings' experience and intuition as a signal communicating to them, "That's what you learn in textbooks but here's the way you really do it." One student found it helpful when attendings say, "This isn't what [you're] told to do, this isn't what the DSM says, but this is how you need to approach a situation like this because otherwise it just doesn't work." In fact, students sometimes figuratively lined up these "morsels" their attendings gave them alongside their textbooks, syllabi, and lectures. Some noted that the informal curriculum seemed more "realistic" than the formal curriculum, with the former "actually emphasiz[ing] what's important . . . what you actually need to do to assess the situation" and the latter suggesting "how we treat a patient

if we had all the time in the world." One student summarized these conflicting curricular worlds:

The way we are graded is if we don't know the formal curriculum then we fail because if you fail the shelf copy, you fail the clerkship and if you do really well you pass and maybe get honors. . . . We just learn more by watching our attending interact [with patients] and the little tidbits about things that aren't "FDA approved" that are done because in past experience attendings had seen it work. . . . that kind of talking through things and going through the thought process instead of memorizing the DSM. The DSM just doesn't always apply . . . you can't always make a clear, definitive diagnosis.

Residents' perspectives

We derived the same three themes surrounding the hidden informal curriculum from close readings of residents' observations of these phenomena, although some of the themes had different derivations from those arising from students' reflections.

Theme one: The hidden informal curriculum as role modeling. Similar to students, residents were clear in their descriptions of attendings who were positive and negative role models. The positive ones were "very inspirational," one resident remarked, "and they do their job with pleasure. It's very interesting to work with them." One resident spoke at length about the value orientations of positive and negative role models she had encountered, each with spoken and unspoken agendas:

One (kind) is really ideological in terms of care for the poor and uninsured. With them they say . . . you can see a patient in the ER and you can really bond with them, you can see them in your clinic, you can see them for therapy even if they're uninsured, make great strides with them. There's that view. And then there's the other view which you get . . . this really cynical view of the poor, they're not worth taking care of, sort of disgusting. One is really an idealist, the other is cynical and harsh. The former includes the more prominent teachers, but there are the others you deal with on call. Two extremes.

Agreeing with this comment, another resident said, "I don't think we're supposed to pick up on the cynical one but it just can't be hidden. People can't help when they're burned out, giving that

off." Such cynicism doesn't necessarily "rub off" even though it is observed by trainees, as one resident noted:

> Clearly I'm not going to incorporate *that* style, [but] will *this* style. How they treat staff and students, all that, I'll just make mental notes—"God, I don't want to be that guy," or "Wow, that's a really good way to do that."

Some residents also provided thoughtful comments about the role modeling they consciously provide to medical students, all remarkably consistent. One said that he "tries to put a *really really* human face on patients with psychoses. I try to make [this person] a human being for students, the psychotic patient with human feelings," and another added, "I constantly do that. They're people first. The reason we can help them is because we're both people, not because we're doctors . . . we're people. That's the magic part." Another resident noted that even though most students will not go into psychiatry, she still stresses that

> what they're learning will help them no matter what kind of medicine they'll be doing because having a relationship with a patient is important . . . that's what people want. They don't necessarily want pharmacology, they don't necessarily want psychotherapy; what they do want is a relationship, [to know] that they're cared for, and you're going to help them.

Theme two: The hidden informal curriculum as a function of time. "Think about it," one resident said, "the easiest way to save time on the floor is not to talk to the patient. All the other parts I can control, how long I sit at the computer, how long it takes me to write a note . . . but when I sit there talking to a patient . . . [it] is a potential black hole." Other residents agreed that time pressures *can* influence the quality of patient care, that there is "only so much time and energy," even as they recognized that, in the end, how one spends one's time involves *choices* that are saturated in values.

Theme three: The hidden informal curriculum as experience/intuition versus textbook learning. Some residents identified a conflict between the values of the formal and informal curricula in terms of the goals of the residency program and the "real world." A few specifically noted that psychopharmacology and neurology were given less importance because of the

program's emphasis on psychotherapy, an acknowledgment that what is *not* taught is also a hidden curriculum phenomenon. One consequence of this was that residents observe attendings who

> prescribe the same drug every time with minor variations . . . [so] you don't get into a pattern learning about all kinds of drugs . . . you just kind of pick your favorite drug; another noted that this pattern was learned through the formulary at the hospital. One said that this message was also to "just wing it, you don't have to know a lot about medications."

Some residents viewed this as a deficiency; one in particular did not:

> Drugs change every three years. Grow up; as a doctor you're going to have responsibility for educating yourself. Ten years out, your knowledge will be gone. You can't depend on your residency for your pharmacology.

One resident who used the word "implicit" to refer to the messages of the hidden informal curriculum believed that

> it's just the real world. And the explicit curriculum is lip-service to some social ideal that we aspire to, and we should aspire to. . . . Life has a lot of leeway in making decisions, and [the formal curriculum] is just a statement of purpose, a focus. But it's not realistic to make every decision through it.

Attendings' perspectives

Theme one: The hidden informal curriculum as role modeling. As one attending described the phenomena, there are as many hidden informal curricula in psychiatry as there are individuals in the department. Its content "runs the gamut," yet faculty usually do not talk about it explicitly with each other. One attending thinks of the formal and informal curricula as aligned with the concepts of *backstage* and *onstage:* onstage is when attendings are with patients; backstage is everywhere else that is "unstructured" and "informal" where they talk explicitly about issues such as trust and intuition regarding patients. This includes their conversations with students and residents that focus on, for example, what makes them "sweat," about making mistakes, about what's not in the textbooks; it involves talking to trainees about the extraordinary amount of time spent on paperwork, insurance, or other aspects of medicine that are

often hidden, particularly to students. One attending disclosed that he consciously exhibits vulnerability, frustration, and uncertainty and tries to be transparent about these feelings and how he attempts to deal with them. Most of this occurs with residents, whom he thinks of as "junior colleagues."

One attending elaborated extensively on the supervisory experience in psychiatry and the values he hopes are present there. In particular, he wants to create an environment in which residents "feel free and safe to talk about anything they want, including their own emotions about their work . . . [and] what they bring to each situation . . . [to] see the doctor–patient relationship from a position previously blinded to them." In short, all his curriculum efforts—formal and informal, and to the extent the hidden is known to him—focus on the "power of the relationship"; he wants residents "to notice it, to use it, to wake up to it." When they do, he continued, residents become acutely aware of the "impact of a safe place for learning about oneself" and "how one's own feelings become a vital part of one's work."

Theme two: The hidden informal curriculum as a function of time. Attendings generally characterized the hidden informal curriculum as their availability to residents and their attempts to create an environment of collegiality, as the clinical environment in which students and residents observe a variety of styles all focusing on the same end, and as a series of choices physicians make regarding how they spend their time (e.g., med checks completed in minutes versus a half hour).

Theme three: The hidden informal curriculum as experience/intuition versus textbook learning. One attending alluded to the theme expressed by residents and students surrounding the apparent disconnect at times between the role of experience/intuition and textbooks/checklists. "Rules are there and rules are often good," she stated, "but they often miss the richness of experience if you don't follow rules, which sometimes leads you to better understand the depths of how wounded patients are." Another referred to it as "We don't teach this but here's what I want you to know." For example, one noted that

the issues of shaking patients' hands or accepting gifts, how each attending does this and how each communicates beliefs about this is part of the hidden informal curriculum. Much of this has to do with our individual beliefs about healing that we then use as teaching points with students and residents.

Finally, and in contrast to most of the attendings' beliefs about the hidden informal curriculum, one reflected on the possibility that it may actually be just that—"unknown to us."

Discussion

Most medical educators, not just those in psychiatry, can describe the strikingly predictable formal curricula found in North American medical education with only slight variations. Most can also describe well-documented, mostly negative, hidden informal curriculum phenomena that have been identified by scholars during the past 20 years. Here, we wanted to examine these taken-for-granted phenomena from students', residents', and attendings' perspectives without imposing restrictive parameters on their observations and understandings of the curriculum they were seemingly teaching and learning. One significant limitation of this study was that the attendings who participated were all very committed to teaching and thus not likely to exhibit the range of behaviors and attitudes reported by both residents and students.

We were struck during the focus groups themselves, during transcription, and during our analysis, how similar each of the three groups was in their perceptions of the curricular phenomena under study. This was particularly true in the realm of the formal curriculum: There was virtually no disagreement between and among the three groups on the knowledge, skills, and values associated with it. This was also true regarding the vehicles for transmission of the hidden informal curriculum (i.e., role modeling, uses of time, intuition/textbook differences), which were apparent to all, with differences based on whether one was a learner or a teacher. Clearly, role modeling was by far the most comprehensive source and explanation of the hidden informal curriculum, and, at least in this setting, attendings were looked to as role models more than residents. Moreover, the themes of

"time" and "experience/intuition versus textbook learning" could easily be subsets of role modeling. For residents and students, attending role models were the most significant influence on their beliefs about the practice of psychiatry. That is, attendings' values, dispositions, and behaviors were anything but hidden; they were, along with the perceived goals of the clerkship and residency program, *in plain sight.*

Many students and residents repeatedly cited the importance of establishing relationships with patients as the most important value orientation pervading both the formal and informal curricula even as others offered a disconnect between the values of the two (e.g., attendings who were cynical, spent little time with patients and trainees, etc.). Attendings, however, did not acknowledge this disconnect that some students and residents observed but, rather, described only positive or useful values they believed they modeled. It could be that the small core teaching faculty present at the focus group were indeed those whose behaviors, attitudes, and values were more formally aligned with the formal curriculum, and that the faculty whom students and residents identified as negative role models were not.

But Haidet and Stein[10] prod us to ask *how* "the relational behaviors of influential role models shape the relational behaviors of students with current or future patients. . . . What characterizes the inner, unconscious elaborations of students' interactions with their teachers?" Their question raises others: If indeed some, possibly most, of the hidden curriculum is at the level of "'white noise' in the background, shaping behavior without being noticed,"[10] how do we know the learning produced by that "white noise" is the same for every learner? Everyone who participated in this study was asked to identify this figurative "white noise," and it became clear that although everyone heard it, not everyone heard the exact same pitch and tone. These focus groups, then, acted not only as a research method but also as a reflective exercise prompting trainees and attendings to talk about their clinical experiences, weighing what they believe is textbook "correct" (and/or morally right) with the sometimes competing demands of the "real world."

Although the call has been made repeatedly in the pages of this journal and elsewhere, our inquiry prompts us to restate it again: More role models are needed to foster the kinds of physicians we say we want, and, whenever possible, *they,* rather than those whose values work against our goals, should spend more time with trainees. Coulehan[12] has been a consistent proponent of role modeling and urges environmental change in training sites explicitly through it:

> The first requirement for a sea change . . . is to *increase dramatically* the number of role model physicians at every stage of medical education. By role model physicians I mean full-time faculty members who exemplify professional virtue in their interactions with patients, staff, and trainees; who have a broad, humanistic perspective; and who are devoted to teaching and willing to forego high income in order to teach. . . . Their presence would dilute and diminish the conflict between tacit and explicit values, especially in the hospital and clinic. The teaching environment would contain fewer hidden messages that say "Detach" while at the same time overt messages are saying "Engage." What trainees need is time and humanism.

These individuals are role models whose behaviors and attitudes speak loudly to trainees. They are not hiding; they are in plain sight. Moreover, these role models, like the attendings we interviewed in this study, engage in ongoing conversations with trainees regarding *what* they are doing and *why.*[13]

Residents and students in this study had no trouble identifying positive and negative role models and the messages each sends to trainees through their behaviors. These, too, are aspects of the hidden curriculum in plain sight. But there are vast areas of the hidden curriculum that were not identified or addressed by any participant. Jackson[4 (P4)] points out features of the elementary school classroom that apply to medical training in most sites, among them "learning to wait quietly, exercising restraint, trying, completing work, keeping busy, cooperating, showing allegiance to both teachers and peers." Similar expectations in medicine include trainees' acquiescing to a rigid medical pecking order, keeping quiet even in the face of abuse, staying silent regarding peers' incompetence, and so on; nothing resembling these areas was mentioned by anyone in our study as being part of

either the informal or the hidden curriculum. These expectations may remain unarticulated or hidden to most trainees even when they are enacted right before them in the clinical environment and they consciously or unconsciously acquiesce. But, as Martin[1] reminds us, "If a hidden curriculum is harmless, what we do with it will not matter very much. It is when the one we find is not harmless—when it instills beliefs, attitudes, values, or patterns of behavior which are undesirable—that our question takes on urgency." This is the ongoing question we ask ourselves: What kind of environment do we really want to create, and to what end?

Conclusions

Definitional imprecision and sometimes carelessness surrounds curriculum terminology. If medical educators look to domains outside academic medicine for guidance, particularly in the fields of curriculum theory and curriculum studies, they will find that the terms used within medical education, although seemingly precise, do not necessarily hold up in those larger scholarly arenas. The division into formal, informal, and hidden curricula can be useful, but when we study curricular phenomena from attendings' and trainees' perspectives (i.e., apart from our theoretical discussions of such phenomena), these distinctions may be confusing, difficult, or even unnecessary to make. Pinar[2] acknowledges that definitional issues abound throughout the field of curriculum studies, but he would clearly find questionable the restrictions and distinctions of what we commonly refer to as the "formal" and "informal" curricula in academic medicine. In fact, he mentions informal curriculum only once in his thousand-page text *Understanding Curriculum,* using it to denote what we normally call extracurricular activities, preferring to view *curriculum* as an umbrella term that encompasses *all* educational experiences, planned and unplanned. Indeed, most curriculum theorists might drop the distinction between formal and informal and would instead use a more comprehensive definition of curriculum that includes *all* the experiences learners have under the auspices of an educational setting,[2,14,15] with significant attention to what learners bring individually and

culturally to the educational setting while keeping the useful term *hidden curriculum* intact.[16,17] Indeed, the very terms *formal* and *informal* suggest that one is "real," the other a more casual, unsystematic enactment of the real thing when, here and elsewhere, trainees focus far more on the latter for their actual learning and socialization. It is anything but informal.

The takeaway message from this inquiry may offer no real surprises. That is, some aspects of a particular clinical culture are apparent to and internalized by trainees because of and in spite of various attendings' values and behaviors; other aspects may remain hidden even as they are absorbed. Similarly, the curriculum medical educators believe they offer may not always be the curriculum trainees internalize. Still, we believe the process described here is a valuable one that has great potential in local settings across all disciplines, taking curricular phenomena out of the abstract domain and into our own backyards. Asking all inhabitants of any educational environment—faculty, residents, students, other caregivers or administrators—to think about what's going on educationally can provide a reality check for educators *and* a values check for learners as they critically reflect on the meanings of what they're learning and what they're not. Another way to examine these environmental issues would be to *begin* inquiry with questions to students, residents, and attendings (or other invested persons) about the explicit and implicit values of a department or unit and how such values are manifested. During data analysis, investigators might be better able to make fine distinctions by sorting responses into *formal curriculum* and *informal curriculum*. Such a method may be more useful to those who believe the distinctions between the informal and formal curricula are important to maintain as theoretical constructs. It may also be useful to expand conceptions of curriculum beyond formal and informal instructional phenomena to include other environmental factors such as relationships between medicine and other health professions and support staff; the physical location of the department and other space issues; department-specific customs, rules, and protocols; and the composition of the department regarding race, gender, or ethnic identity. These

also send powerful but often hidden messages to inhabitants of any environment regarding what and who is valued.

As the title of her article, Martin[1] asks educators the following question: "What should we do with a hidden curriculum when we find one?" She answers her own question with wide application throughout academic medicine by suggesting that concentrated efforts be made to identify and reflect on hidden curricula phenomena. She suggests that these efforts can be aimed at "those in a setting, those about to enter it, or those who once were in it . . . [as] a form of self-defense against the onslaught of unasked-for learning states. . . . [Yet] knowledge of hidden curricula will not provide a defense against them if those subject to hidden curricula do not *want* to resist."[1] Similarly, such knowledge will not provide an argument against *perpetuating* particular values for those attendings and residents who believe it is their job to impart the "real-world" underbelly of medicine to trainees without the hope that change is always possible.

Maxine Greene[18] implores everyone in educative projects to "think about what they're doing, to become mindful, to share meanings, to conceptualize, to make varied sense of their lived worlds." This is what our project aspired to do, and, in the end, it is what we offer here: a belief that thinking critically and reflectively about what we hope to achieve and what we think we're doing with and for trainees is one of the most important activities we can do as educators.

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