EVERYBODY TALKS ABOUT THE WEATHER, BUT NOBODY DOES ANYTHING ABOUT IT: HOW TO ASSESS AND CHANGE THE ENVIRONMENT FOR TEACHING ETHICS TODAY

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INTRODUCTION

Everybody "knows" that the environment and culture of schools of medicine, teaching hospitals, and departments influence the values and standards of conduct of students, interns, residents, and (to a certain extent) the faculty themselves. Everybody also "knows" that the explicit, or stated, values and standards of conduct that are taught by faculty in the formal curriculum often differ from the implicit, informal, and unstated values and standards of conduct that are exhibited and taught by example by interns, residents, and (much to our own dismay) faculty themselves. This latter phenomenon has become known as *the hidden curriculum* or, sometimes, *the informal curriculum* (1,2).

The 1978 novel, *The House of God*, by Samuel Shem, MD, contains a well-known depiction of the hidden curriculum (3). Described on the inside cover of the paperback version as "The wild, raunchy novel that teaches you the not-so-gentle healing arts and tells you what your doctors never wanted you to know," *The House of God* tells the story of an internship at a time when residents taught interns, who taught medical students—all with little supervision by the faculty. Patients, known as "GOMERS," were the enemy because they placed burden on the interns, who were taught by the wisest of the residents, the Fat Man, how to avoid patients by making "card rounds" in the conference room, during which patients' lab values and test results were reviewed, but the patients were rarely, if ever, seen, if it could be avoided. The "Laws of the House of God" (Table 1) explicitly stated the values of the hidden curriculum, and 30 years later it is still common to hear interns and residents quote them (e.g., If you don't take a temperature, you can't find a fever.).

Table 1. Laws of the House of God

I. GOMERS don't die.
II. GOMERS go to ground.
III. At a cardiac arrest, the first procedure is to take your own pulse.
IV. The patient is the one with the disease.
V. Placement comes first.
VI. There is no body cavity that cannot be reached with a #14 needle and a good strong arm.
VII. Age + BUN = Lasix dose.
VIII. They can always hurt you more.
IX. The only good admission is a dead admission.
X. If you don't take a temperature, you can't find a fever.
XI. Show me a BMS who only triples my work and I will kiss his feet.
XII. If the radiology resident and the BMS both see a lesion on the chest x-ray, there can be no lesion there.
XIII. The delivery of medical care is to do as much nothing as possible.

From Shem S. *The House of God: The Classic Novel of Life and Death in an American Hospital*. New York: Dell, 1979, with permission. GOMER, get out of my emergency room, "a human being who has lost—often through age—what goes into being a human being"—(the Fat Man); BMS, Best Medical School student.

Except for the anachronisms of the 1970s, the story line of *The House of God* remains an accurate depiction of graduate medical education, although card rounds have been updated and replaced by computer rounds (4). Contemporary portrayals of the hidden curriculum include the television show *House*, in which the title character, according to the show's Web site, is a brilliant diagnostician who is devoid of bedside manner and has an acerbic, brutally honest demeanor and behavior bordering on the antisocial (5). The Dean of Medicine and hospital

administrator of the fictional hospital is frequently in conflict with Dr. House because of his behavior, but the Web site says, “even she would admit that *his brilliance is worth the trouble”* [emphasis added] (5).

The portrayal of medical ethics and professionalism in fictional novels and television shows contains a kernel of truth. The culture of hospitals and academic medical centers is reinforced by the actions of role models such as the Fat Man or Dr. House. Recent evidence suggests that medical and nursing students watch television medical dramas, often in groups, and they discuss the ethical issues portrayed in the shows, which has led to the suggestion that these shows “may be an important part of ‘the informal curriculum’” (6). Viewing the television satire *Scrubs* has been suggested as a method for teaching ethics (7). Fortunately, perhaps, research suggests that for medical and nursing students, TV medical dramas are one of the least-used sources of information for bioethical issues, whereas medical and nursing schools are the top source (6). The purpose of this review is to provide learners with a brief overview of the research documenting the nature of the hidden curriculum, methods with which to assess ethical or professional culture, and methods by which to change the culture.

LEARNING OBJECTIVES

By the end of the presentation, learners will be able to:

1. Describe how tacit learning relates to the hidden curriculum
2. Show how the traditional needs assessment used in curriculum development can be expanded when applied to ethics education and cultural assessment
3. Describe several published tools for assessing ethics, humanism, and culture
4. Cite examples of successful programs that have changed their ethics culture

WEATHER REPORT: THE HIDDEN CURRICULUM

Although the term *hidden curriculum* is commonly understood to mean the teaching of values, attitudes, and practices that are contrary to the formal curriculum in medical education, and thus carries a negative connotation, the term theoretically is actually value neutral because it refers to tacit learning, which is “all those aspects of the curriculum and the socialization process that instill professional values and a sense of professional identity, but do so without explicitly articulating those issues” (1,2). The implication is that in the right setting, the hidden curriculum can be a positive feature of medical education that supplements and demonstrates the goals of the formal curriculum. Even so, the truth is that most tacit learning in the hidden curriculum of concern to educators is deleterious. Coulehan and Williams, in their article “Vanquishing virtue: The impact of medical education,” wrote:

> The explicit curriculum stresses empathy and associated listening and responding skills, the relief of suffering, the importance of trust and fidelity, and a primary focus on the patient’s best interest. Tacit learning, on the other hand, stresses objectivity, detachment, wariness, and distrust of emotions, patients, insurance companies, administrators, and the state (2).

Tacit (implicit) learning is more powerful than explicit learning because it is reinforced more frequently and because it involves expected or accepted behaviors rather than mere words; i.e., it is experiential learning (2). Whether for good or for ill, role models provide the greatest influence in the hidden curriculum and its impact on students and residents (1).

In truth, it is fallacious to suggest that the hidden curriculum is a curriculum. Considering that a curriculum is defined as “a planned educational experience” (8), it is difficult to imagine very many role models who deliberately plan to teach learners the types of attitudes and conduct associated with the hidden curriculum. A more apt description would be “curricular deconditioning,” considering that the behaviors associated with the hidden curriculum usually arise from inattention and inadequate efforts to support and maintain the goals of the formal curriculum. Nonetheless, the term *hidden curriculum* is widely recognized and will be used here.

Because the hidden curriculum comprises tacit learning, its content can either be concordant or discordant with the formal curriculum, which has been well delineated by the Association of American Medical Colleges (AAMC), the Accreditation Council for Graduate Medical Education (ACGME), and the American Board of Psychiatry and Neurology (ABPN), among others, by their codification of the attributes of professionalism and the core competencies (Table 2) (9,10,11).

Table 2. Professionalism Core Competencies of the Core Competencies for Neurologists

1. Physicians shall demonstrate responsibility for their patients' care, including responding to communication from patients and other health professionals in a timely manner.
2. Physicians shall demonstrate responsibility for their patients' care, including the following:
    A. Using medical records for appropriate documentation of the course of illness and its treatment
    B. Providing coverage if unavailable, e.g., out of town, on vacation
3. Physicians shall demonstrate responsibility for their patients' care, including the following:
    A. Coordinating care with other members of the medical and/or multidisciplinary team
    B. Providing for continuity of care, including appropriate consultation, transfer, and termination
4. Physicians shall demonstrate ethical behavior and personal and professional attitudes of integrity, honesty, compassion, and confidentiality in the delivery of principal or consultative patient care.
5. Physicians shall demonstrate respect for patients and colleagues as individuals, including their ages, cultures, disabilities, ethnicities, genders, socioeconomic backgrounds, religious beliefs, political leanings, and sexual orientations.
6. Physicians shall demonstrate appreciation for end-of-life care and issues regarding provision or withholding of care.
7. Physicians shall demonstrate commitment to the review and remediation of their professional conduct.
8. Physicians shall participate in the review of the professional conduct of their colleagues
9. Physicians shall appropriately acknowledge medical errors

From American Board of Psychiatry and Neurology. *Core Competencies for Neurologists*. Boston: Butterworth-Heinemann, 2003, with permission.

Additional guidance on ethical conduct and professionalism specific for practicing neurologists can be found in the AAN Code of Professional Conduct (12). The attributes promoted by formal curricula are matched by patients' expectations of physicians. The Mayo Clinic interviewed 192 patients and, based on review of all transcripts, identified seven "ideal physician behaviors" or behavioral themes: confident, empathetic, humane, personal, forthright, respectful, and thorough (13).

What are the lessons, concepts, or behaviors of the hidden curriculum? Haidet and Stein list several that stem from the culture of medicine: a demand for ''right'' answers (avoidance of uncertainty); intimidation, public shaming, and humiliation (doctors must be perfect); the treatment of students as objects to be ''filled up'' with knowledge and facts (outcome is more important than process); unhealthy competition (medicine takes priority over everything else); and deference to experts, regardless of their teaching abilities (hierarchy is necessary) (14). An analysis of the ethical content of 620 papers in which medical students at SUNY Upstate Medical University described and analyzed a clinical case in which they were involved found that deliberate lies and deception were the single-most commonly described issue out of the 40 primary ethical issues identified in the analysis (15). In 73% of the papers reviewed, the students explicitly mentioned reluctance to speak out about their concerns for fear of reprisal (15). Making fun of patients is another example that especially occurs in operating rooms, but it is not limited to the OR. The most frequent objects of humor, according to a survey of medical students, are obese patients, patients whose health problems are "their own fault," difficult patients, and suspected hypochondriacs (16). According to students, the primary rule of the "humor game" is that making fun of patients is off limits unless initiated by someone more senior than they are, especially residents; on the other hand, attending physicians' use of derogatory comments, or tolerance of such comments by the residents, can make students uncomfortable (16).

In brief, whenever we hear students or residents refer to toxic behavior, conditions, or culture in their clinical training, they are referring to the hidden curriculum.

CHANGING THE WEATHER

If a goal of improving medical education is to attain concordance between the formal and hidden curricula, then we must focus on the factors that result in the hidden curriculum and, specifically, turn its tacit learning into a true curriculum with a planned educational experience that matches the formal curriculum. Efforts are necessary to assess the degree of discordance, the major contributing factors, and methods by which to address deficiencies or to enhance the attributes that are already concordant with the formal curriculum (17).

A major difference between formal and hidden curricula is that formal curricula are written from the perspective of the entire profession and reflect universal values, concepts, principles, goals, and conduct, whereas hidden curricula reflect the local culture and "actors" within a given academic medical center and can vary from department to department or even from division to division. Therefore, the work of assessing and addressing the hidden curriculum—changing the weather—must be accomplished locally.

The assessment process for the hidden curriculum is similar in some respects to the needs assessments of formal curricular development (Table 3) (8). Most of the existing research on the hidden curriculum constitutes the first assessment, which is ***problem identification and a general needs assessment***, defined as the "difference between the ideal approach and the current approach" (8). The general needs assessment should also be performed at the local level, which would constitute a cultural assessment. The second assessment is the ***needs assessment of targeted learners***. The third assessment—not generally considered in curriculum development—is an ***assessment of the teachers***, which can be considered as part of the curricular development step of identifying educational strategies. The fourth assessment is ***evaluation and feedback based on implementation*** of the curricular change.

Table 3. Six-Step Approach to Curriculum Development

1. Problem identification and general needs assessment
2. Needs assessment of targeted learners
3. Goals and objectives
4. Educational strategies
5. Implementation
6. Evaluation and feedback

Data from Kern DE, Thomas PA, Howard DM, et al. *Curriculum Development for Medical Education: A Six-Step Approach*. Baltimore: Johns Hopkins University Press, 1998.

Assessment of Culture

The role of an institution's culture in creating and sustaining role models should not be underestimated. "Powerful messages are mediated not only by individuals. For example, a medical center that gives important leadership roles predominantly to individuals who do not espouse or exemplify the practice of humanistic care may lead students to conclude that these functions of the physician are less valued than biomedical knowledge or technical competence, regardless of explicit statements to the contrary" (18). This means that the values espoused and enacted by an institution's most senior leadership can influence the values and behaviors of students, residents, and others who may be far removed from the offices of the dean, the hospital president, or the department chair. Furthermore, research from the field of business ethics, which is applicable in the organizational setting of medical schools and hospitals, suggests that leaders at institutions that have codes of ethics, who are themselves ethical or moral persons but who do not explicitly speak and act in their leadership role to promote the organization's ethical culture (termed *ethically neutral leaders*) may inadvertently send the message that ethical behavior is not important (19). The best leaders not only talk the talk, but they walk the walk.

Examples of institutional cultural assessment and change for medical schools are emerging. The C^3 Instrument, by the Communication, Curriculum and Culture (C^3) Study Group has been used to compare the patient-centered care at nine medical schools (20). The major content areas for the C^3 Instrument are role modeling, students' experiences, and support for students' behaviors. Contrary to their expectations based on research about the hidden curriculum, i.e., that all of the schools would be similar, the researchers found significant variation in the strength of the schools' content areas, thus highlighting the importance of assessing and addressing the hidden curriculum locally. The authors note that "The implication for administrators and educators is that gaining an understanding of the unique nature of one's institutional learning environment is important, because it can inform one's efforts at change" (20).

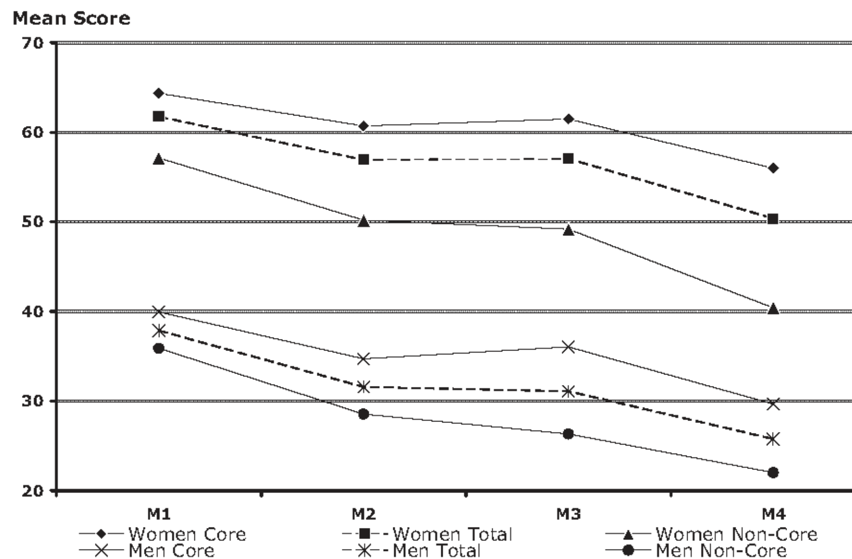
Indiana University School of Medicine (IUSM) presents an excellent example of sustained cultural and curricular self-assessment and change (21,22). Their change was initiated in 1996 with a formal review of the curriculum and was sustained by both formal administrative support and change (i.e., complete reorganization of the education administrative infrastructure to develop, implement, and manage the curriculum) (23) and by the efforts

of a handful of committed individuals to change the culture (22). The IUSM curriculum is based on competencies and involves competency directors and competency teams. Recognizing that revision of the formal curriculum was necessary but not sufficient, IUSM began to address the informal curriculum in 2003, with support from the Fetzer Institute, creating a relationship-centered care initiative. The efforts have produced tangible results. Student satisfaction scores on the overall quality of their medical education in the AAMC graduation questionnaire summary reports rose from 77% (below the national mean) in 2003 to 96% (above the national mean) in 2006. Less objective but no doubt as tangible or as important to IUSM faculty and students is their description that a new organizational culture has begun to take hold (23).

End-of-life (EOL) care is often considered paradigmatic of ethics education, although it is worth emphasizing that the area of ethics is much larger than just EOL care. At the institutional or cultural level, the concordance of the formal and hidden curricula in EOL care can be assessed (17).

Assessment of Learners

How does assessment of learners work in the area of ethics? Within the realm of medical education, the purpose of teaching ethics is said to be twofold: 1) creating virtuous physicians and 2) providing students and residents with the knowledge, skills, and competencies to recognize, analyze, and resolve common ethical dilemmas (24). Jordan Cohen, former President of the AAMC, described the realization of these purposes as linking professionalism and humanism (25). Cohen describes professionalism as a way of acting, fulfilling the expected conduct of physicians toward patients and the public. On the other hand, he says that humanism “is a way of being. It comprises a set of deep-seated personal convictions about one’s obligations to others, especially others in need. Humanism manifests itself by such personal attributes as altruism, duty, integrity, respect for others, and compassion” (25).



Mean scores, by medical school year, specialty preference, and students’ gender, for 419 men and women in the classes of 2001–2004, the University of Arkansas for Medical Sciences. Scores are for students’ vicarious empathy (i.e., to have a visceral empathic response); responses were to a well-established measure of the various emotional qualities of empathy, administered at the beginning of each medical school year. The figure shows that vicarious empathy significantly decreased during medical education (P <0.001), especially after the first and third years. Students choosing core careers had higher empathy than did those choosing noncore careers. ***Core*** refers to core specialties (i.e., internal medicine, family medicine, obstetrics–gynecology, pediatrics, and psychiatry, which have greater patient contact), and ***noncore*** refers to all other specialties, where patient contact is less. From Newton BW, Barber L, Clardy J. Is there hardening of the heart during medical school? Acad Med 2008;83(3):244–249.

Humanism, or at least some of its attributes, can be measured. The Balanced Emotional Empathy Scale (BEES), is a measure of vicarious or emotional empathy (an individual’s emotional response to the perceived emotions of another) (26,27). Using the BEES, a longitudinal study of four consecutive classes of medical students at the University of Arkansas for Medical Sciences revealed that vicarious empathy significantly decreased during medical education, especially after the first and third years (Fig. 1) (28). Contrary to what might be expected, upon admission to medical school, male medical students’ empathy scores were higher than population norms, and female medical students’ empathy scores were comparable to population norms. By the end of medical school, both groups were below population norms. As expected, students who eventually chose core specialties for residency (family medicine, internal medicine, obstetrics–gynecology, pediatrics, and psychiatry) had higher scores than those who chose “noncore” specialties (all other specialties, which in this study, include neurology). A cross-sectional study of all medical students at Boston University School of Medicine, using the Jefferson Scale of Physician Empathy–Student Version (JSPE-S) (29), revealed a similar drop in empathy scores after the third year of medical school (30). These studies support anecdotal reports of loss of empathy by medical students and can serve as a baseline assessment for curricular change. A recent systematic review of tests of empathy concludes

that tests of empathy can be used to assess medical training but are not valid for selecting medical school candidates on the basis of empathy (31). The consultation and relational empathy (CARE) measure (32) in which patients use a 5-point Likert scale to answer questions such as "How was the doctor at showing care and compassion?" was found to be an especially valid and reliable tool (31).

Many tools can be used to assess ethical or professional attributes (1,33), but a 2005 review of the literature on ethics education in medical schools found a "lack of systematic analysis of the measurable elements of ethical skills and the best means for assessing them" (24). Coulehan, one of the leading proponents of teaching ethics and professionalism, has warned about placing too much emphasis on measurable conduct, stating,

> My criticism of the professionalism movement is that, in the attempt to render professionalism more quantifiable, it may use skills and practices as surrogates for virtue. Becoming a physician involves witnessing, and not just behaving. To the extent that professionalism becomes a list of required practices, it is an example of H. L. Mencken's neat and simple, but wrong, solution (34).

The tension between the goals of creating virtuous physicians and providing students and residents with the skills and competencies to address ethical dilemmas suggests that a combination of objective and subjective assessment and feedback tools is necessary for assessment of ethics and professionalism. Some recently published tools for assessing medical students or residents on neurology services have not explicitly included ethical or professional conduct (35), but others have (36).

Assessment of Teachers

The assessment of teachers is not usually considered a part of curriculum development, although this mind set is changing with the emerging movement in medical faculty development to teach teachers to teach (37,38) and the corollary rejection of the assumption that one acquires the requisite skills to teach simply by completing medical school, residency, and fellowship. Attention has even been given to teaching residents the skills to teach; however, a 2004 review of the role of neurology residents in education did not address ethical or professional issues (39).

In didactic courses, ethics teachers may have backgrounds in medicine, philosophy, the divinities, or the law, but no studies compare teaching or learning outcomes of teaching by the different disciplines (24). However, the focus for the hidden curriculum is not the ability to lecture effectively, but rather the ability to be an effective role model. Therefore, nearly all ethics and professionalism role models in the clinical setting are physicians. Using observational, qualitative methodology, researchers studied 12 clinical faculty at four different medical schools and identified key elements or skills that were demonstrated to learners, including nonverbal communication, overt demonstrations of respect toward patients, building a personal connection to patients, eliciting and addressing patients' affective responses to illness, and demonstrating self-awareness to learners (40). As a general rule, these master teachers did not explicitly tell their students when they were role modeling; they counted on them to recognize and absorb the teaching on their own. In fact, some teachers consciously withheld overt statements of humanistic learning goals, fearing that doing so would be "preachy" or "overkill" (40). This passive role-modeling approach is contrary to the more active approach that has been promoted (18,41); however, the active role-modeling approach is likely to be more time consuming for teachers because of its basis in rigorous educational theory.

A similar though somewhat simpler active model was elicited from interviews of faculty at the Laval University Faculty of Medicine in Quebec, Canada. The training activities associated with teaching, and thus learning, the physician–patient relationship were: 1) believing in it, 2) demonstrating it, and 3) teaching it (42). "Believing in it" means teaching learners to believe in the power of the physician–patient relationship by talking about it, emphasizing its importance, and including it in learning objectives. "Demonstrating it" is self-evident, meaning to explicitly "demonstrate the physician–patient relationship to learners." "Teaching it" means believing that the physician–patient relationship can be taught ***and*** learned and taking the time to do so through direct or indirect observation and feedback (42). Teachers who are cognizant and respectful of their relationship with learners, including the affective components of learning and not just the content to be taught, are more likely to trigger their students' intrinsic motivation to learn (14).

While beyond the scope of this presentation, research suggests that ethnic and racial similarities or differences between role models and learners may influence the effectiveness of role modeling (43).

SUMMARY

The task of assessing and addressing the hidden curriculum in medical education can seem as impossible as changing the weather. Although assessment tools and methods exist for institutional culture, for students, and for teachers, development of better tools is necessary. The task of changing the hidden curriculum can only be accomplished locally and cannot be solved merely by promotion of a formal national curriculum for change. All involved in medical education must summon the courage, commitment, and stamina to change the curriculum, and the leaders of our medical schools, hospitals, and departments must both commit to the same goals and provide the tangible support and resources necessary to change the weather that is the hidden curriculum.

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RECOMMENDED READING

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