Speaking Up About The Dangers Of The Hidden Curriculum

A medical student’s fear of raising questions endangered a patient. Here, as a resident, he explores the dangers of this “hidden curriculum” with his advisers.

BY JOSHUA M. LIAO, WITH ERIC J. THOMAS AND SIGALL K. BELL

Andrea was thirty-five weeks into an uneventful pregnancy when we met in the prenatal clinic of the county hospital where I was working. I introduced myself as a third-year medical student working with her physician as part of my obstetrics rotation, and she kindly agreed to let me interview and examine her. We shared twenty minutes of enjoyable conversation: I learned that she was an otherwise healthy twenty-seven year old with a loving husband and daughter, and she in turn asked about my family and path to medical school.

A month later, while I was rotating through the hospital’s inpatient Labor and Delivery Unit, Andrea came in after developing strong, sustained cramps. She was admitted in preparation for delivery, and her labor continued to progress appropriately over the next ten hours. As the expected time of delivery neared, the supervising resident physician and I gowned to count her final contractions with her.

As we waited for Andrea’s final pushes, however, Dr. Johnson—the senior obstetrician assigned to Andrea’s case—stalked in, visibly upset. There was risk for shoulder injury given the baby’s size, she snapped, and she should’ve been notified. She shook her head briskly, muttered under her breath, and stepped in front of the resident, who then turned and sternly ordered me aside.

As I watched from the corner, Dr. Johnson and the resident delivered a healthy, vigorous baby girl. With Andrea holding her new daughter in her arms after fifteen hours of labor, Dr. Johnson ungloved silently and left.

Andrea had suffered a minor vaginal laceration, a common complication that many women experience during labor. The resident turned to close the tear, calling me back to the foot of the bed to deliver the placenta (that is, to remove the placenta from the uterus as a part of standard postdelivery care). I paused for several seconds. I’d never delivered one before, I eventually said aloud. I’d only observed.

“So?” she said tersely without looking up. I remained silent, and finally she turned toward me with a frustrated look. “You’ll do fine. You know how we learn in medicine: See one, do one, teach one.”

I stood, unmoving, trying to recall from memory the order and specifics of each step. Sensing my continued hesitation, the resident released an impatient, staccato sigh. “Look, I don’t have time for this,” she said. “Apply the clamp and give traction but not too much. Just get it done before Dr. Johnson gets more pissed!”

My pulse quickened, and I suddenly felt intensely afraid. I wanted further guidance, but I could sense that the resident was upset and embarrassed, having been scolded by the senior physician in front of everyone. I feared the resident’s disapproval more than my uncertainty, so I pushed the uneasiness out of my
chest with a long breath. I locked a clamp onto the umbilical cord and pulled.

The cord came out smoothly at first, coiling easily around my clamp. The resident glanced over without speaking, a quiet affirmation I was doing it correctly. I continued, gaining confidence as I went, until suddenly, without warning, the cord went slack. I glanced down in disbelief at its torn edge, dangling from my hand. Jets of blood sprayed across my gown.

“Oh my God,” the resident said from behind me.

She looked into my eyes. “You tore the cord.”

The next few minutes were a blur of voices and passing figures. The resident reached into the patient’s uterus to manually free the placenta. Nurses shuffled across the room with supplies. As I retreated to a corner of the room, the space suddenly felt small and suffocating. A pulse of heat swelled behind my ears, and I felt my heart pounding in my chest. A steady but afraid, and I looked away to thing reassuring in them or trying to tently into mine as if searching for some-

Even before Andrea’s incident, I had been involved in a number of patient safety efforts. I founded the first patient safety interest group at my medical school and worked with senior educators to create and lead a unique, semester-long safety course that all students were required to take. I mentored younger students with similar interests and served in national leadership roles for several patient safety organizations, including the Institute for Healthcare Improvement and the American College of Medical Quality.

None of those experiences, however, prepared me for Andrea’s case. Despite familiarity and experience with the concepts of patient safety, I was faced for the first time with the issues of hierarchy and culture and the real-world challenge of aligning teamwork and communication with safety goals. With Andrea, I had my first experience with the kind of harm that comes not from insufficient safety knowledge or understanding but from poor communication. Through that encounter, I experienced the harm that can occur when team members feel they cannot speak up.

The Aftermath
In the months that followed, I thought repeatedly about the incident with Andrea. I consulted with colleagues and studied related medical literature to try to process what had happened that day. I discussed the event with experi-

enced clinicians, mentors with whom I have written this essay. Ultimately, these exercises not only helped me better understand the experience but also helped me identify missed opportunities for safety, learning, and growth for me individually and for the system around me.

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Learning From The Hidden Curriculum
Educators around the country are trying to improve patient safety through formalized curricula. But there is a different, far more influential “teacher” that has been shaping the behavior of young and seasoned physicians alike. This force, described more than a decade ago by Frederic Hafferty, is collectively termed “the hidden curriculum.” It refers to the messages transmitted implicitly “on the job” through everyday verbal, practical, and habits, all of which have powerful effects on individual attitudes and practices. This phenomenon is particularly relevant to medicine, where longstanding, and often rigid, traditions about hierarchy allow the actions of senior physicians—positive and negative—to strongly influence student behavior. Of course, many physicians value their roles as teachers and role models, and generations of students have been inspired by masterful doctors. Unfortunately, some implicit lessons can contradict explicit teaching about safe practices—with dangerous results.

The difference between what we say we do and what we actually do as doctors and teachers can be stark. For decades, students have described mistreatment by superiors—instances in which superiors treated patients in dehumanizing ways or directed harsh derogatory language at them and at patients. Some have even seen superiors falsify charts or feign medical proficiency when obtaining patients’ consent for treatments and procedures.

Trapped between these experiences, pressured to accept a “team player” ethos, and fearful of academic repercussions, many students acquiesce, doing things they believe are wrong to fit in with the team. Students can become so rapidly assimilated into this kind of culture that they begin perceiving such behavior as acceptable just months into clinical rotations. Later, they are at risk of propagating these practices to future generations of doctors.

Perhaps this explains, in part, why patient safety has improved more slowly than hoped. According to experts like Robert Wachter, progress in patient safety will likely continue to lag unless strong cultures of teamwork and communication are established in medicine. By hindering communication, especially between clinician-educators and students, the hidden curriculum can promote unsafe behavior. Addressing the
hidden curriculum, in turn, may be one
missing link to achieving much safer
care.

A Persisting Challenge

Why does tackling the negative aspects
of the hidden curriculum remain such a vexing problem? On the one hand, the medical community is emphasizing a renewed commitment to professionalism, and health care organizations are earnestly trying to address the kind of problematic behavior that can threaten patient safety. Many institutions now advocate zero-tolerance policies for unacceptable behavior (for example, profane language, throwing objects, bullying) and provide mechanisms for reporting disruptive physicians.

However, when we think about the more subtle team dynamics exemplified in Andrea’s case, we realize that egregious behavior is just the visible tip of a much larger iceberg. Far more prevalent are the subtle behaviors that threaten patient safety but go largely unnoticed and unaddressed. It could be a sarcastic joke about students who ask too many questions. Or a physician muttering under her breath that she “doesn’t have time for this.” Or a supervising doctor responding to a student’s hesitation with impatient, even angry, sighs. Progress in patient safety may be hindered as much by such subtle behaviors as by overtly inappropriate physicians. In fact, enabling doctors-in-training to speak up and making them feel safe while doing so may prove far more challenging than getting rid of disruptive doctors.

We must also resist the temptation to write off cases like Andrea’s to inadequate supervision or stress and fatigue. Those factors are indeed important, but beneath them lies the bigger challenge: A culture that makes students more fearful of their supervisors’ responses than their own uncertainty. The hidden curriculum can teach students that asking for help can be viewed as a sign of weakness and that fitting in with their teams is more important than raising concerns about patient safety.

Students can also quickly learn that speaking up against supervisors may translate into negative evaluations. We do not have to tell trainees not to contradict their superiors; they simply know. In addition, well-intentioned concepts such as “See one, do one, teach one” can be used inappropriately to pressure learners to conform to a culture of boldness over caution.

Change begins with awareness. Incidents where errors are made should be occasions for reflection and improvement. But these incidents will fail to produce meaningful improvement if they are not recognized as learning opportunities. Faced with another risky delivery and lacking feedback about how her behavior affected the team, senior physicians such as Dr. Johnson may act similarly. In turn, supervising residents may worry about their own evaluations and feel convinced that teaching students is too risky or time consuming. Students may witness blame-based culture and lose important educational opportunities by being taken off patient cases. Ultimately, patients are left to wonder, without answers, about what went wrong. Adverse events that could have become powerful teaching tools—by involving all team members as patient safety advocates—are instead ascribed to student inexperience and swept under the proverbial carpet.

Better Ways Forward

Thankfully, there are better ways forward.

First and foremost, medical schools and teaching hospitals should raise awareness about the hidden curriculum and its impact on safety. Teachers and students should be trained together, with sessions that emphasize effective communication strategies and allow clinicians to reflect on their everyday
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clinical experience or curricular interventions, or both. Narrative reflections can also help educators understand students’ experiences and guide curricular reform. It is hard to either improve or reinforce what we are not measuring.

Armed with greater information, educators can then pursue meaningful educational reform around these issues. Many recognize the danger that can arise when concepts such as “See one, do one, teach one” are misused. To truly drive improvement, formal curricula must be recalibrated to educate students and senior physicians alike about the link between the hidden curriculum and patient safety. For example, longitudinal rather than episodic teaching about safety, ethics, and professionalism—woven throughout the curriculum, with emphasis on how classroom teaching differs from clinical experience—may prove helpful.

Ultimately, students, clinicians, schools, and health care organizations must take collective responsibility for culture change. Despite growing awareness of the hidden curriculum, many within the medical community understand it as something passively absorbed from the ambient behavior of others. Leaders play integral roles in creating positive organizational culture change. But culture is also actively shaped by choices of all team members, including students, residents, senior physicians, nurses, and others. Each individual decision to speak up or remain silent, or to promote unprofessional behavior or pursue nobler alternatives, is an important part of shaping the learning environment. Progress will require each of us to step forward and create a new culture—one that enables students, residents, faculty, and even patients to speak up safely.