The orthopedic surgeon was adamant that the Gram-positive cocci growing from the blood culture of a patient with hip pain represented a true infection and that the patient needed to be started on antibiotics. He told me this over the phone, and reiterated it to my team in no uncertain terms while I was out of the workroom. I was less convinced. The child had defervesced without treatment, and his inflammatory markers had remained low. The next day, when the culture was identified as coagulase-negative staph, and the child was discharged from the hospital without further intervention, I remarked to my team: “Surgeons are very concrete thinkers, who see the world in black and white. Hospitalists are abstract thinkers, who see the world in shades of gray.” I might as well have spouted off the old cliché: “Surgeons cut, but don’t think. Primary care physicians think, but don’t cut.” But inadvertently, I was telling my team something else: those who disagree with me are not worthy of my respect, and in so doing, I was indoctrinating them in a destructive verse of the “hidden curriculum” of medicine.

The hidden curriculum is defined as those values that are primarily implicitly, rather than explicitly, learned in the workplace, and they typically deal with issues of professionalism, or, often, the lack thereof. Medical students pick up these ideas from day 1: physician knowledge is superior to nurse knowledge; those beneath you on the educational ladder can be treated with less respect than those above you; questioning a superior is a sign of disrespect; psychiatric patients bring their diseases on themselves and deserve what they get; specialists are superior to generalists; and the list goes on. Certainly, none of these attitudes are part of the established, written curriculum of any medical school. Yet these powerful and destructive components of curriculum become ingrained and propagated in nearly every medical establishment worldwide. The reason for this lies in the culture of medicine and the social psychology of human beings. Clinical educators may not be able to address the latter, but they can begin to address the former by modeling constructive interactions with all members of the team. In so doing, they can begin to pass on to their learners the value that underpins all professionalism: respect.

I recently volunteered to facilitate a small group for our university’s interprofessional course. As students from the various colleges (nursing, medicine, nutrition, pharmacy etc) filtered in, I picked up a conversation between 2 medical students:

Medical student 1: “Are you ready for the anatomy test next Monday?”
Medical student 2: “No. I just can’t seem to understand the brachial plexus. It’s really complicated.”
Medical student 1: “I know. It's hard to come to these classes when I know I need to be studying.”

Medical student 2: “Totally.”

The goals of that day’s session were learning to communicate in teams and showing respect for colleagues from different professions. The medical students were appropriately engaged, although somewhat skeptical that “this” was truly what they came to medical school to learn. The students from the other professions were more engaged and better grasped the importance of the small group. Later, I reflected on the conversation I witnessed, and thought: If I had the choice between having my students learn the brachial plexus or learn to work more respectfully and collaboratively in teams, which would I choose? Which would make patients safer? The answer seemed obvious. Yet, in this instance, the medical community had done an inadequate job of conveying this to its learners. Clinical educators may openly acknowledge the importance of such values as teamwork and professionalism, but unless actions in the workplace (and classroom) reflect them, one can hardly expect students to develop into the compassionate, respectful physicians one would wish them to become.

Respect for all members of the health care community must be emphasized from the top down. Recently, our institution hired a new pediatric surgeon of a particular subspecialty. Before this point, the relationship between our services had been functional but strained. With her arrival came an attitude of cooperation and respect. The effect was not isolated to 1 provider, but filtered down to their residents, nurse practitioners, and even other attending physicians. This example of “trickle-down” professionalism can be seen across disciplines and industries and is typified by leaders who hold high degrees of emotional intelligence. This emphasizes the importance of hiring good leaders. But it also highlights the fact that the leaders of the future are the medical students and residents of today, and it is incumbent on clinical educators to pass on a culture of respect if they want to be led by good leaders in the future. Attending physicians help to establish the culture, and learners model this behavior. If this behavior is less than respectful, then one can hardly expect the culture to change.

This is hard work. As my earlier example illustrates, it is easy to lash out at another person or service when we are being questioned or attacked. It is much more difficult to respond constructively. The response to my team could have been: “There are different ways of managing every situation, but the important thing is to be comfortable with the way you choose, and be respectful of other approaches.” This requires discipline, and the ability to put aside emotion. But imagine how powerful this could have been for my learners: seeing their attending under attack by another attending and responding with respect and understanding, instead of hostility.

Modeling respect is one way to defeat the negative aspects of the hidden curriculum, but sometimes further steps must be taken. Sometimes it is necessary to be more direct and correct learners or even other attending physicians when they perform unprofessionally. One of the most valuable lessons I learned in residency came during my last rotation in the PICU. I was tired, burned out, and not in the mood to deal with nagging nursing requests. So I chose to delay addressing nursing demands that I deemed unnecessary or punitive. This did not go unnoticed. During the second week of my rotation, my attending took me aside, and gave me some brief but salient advice: “Quit being a [expletive] jerk.” He went on to explain that it was important for the function of the team and care of our patients that we have respectful relationships with everyone on the team. He explained that fostering this respect was what becoming an attending was truly all about. I listened, absorbed, and told him I would do better. And I did. Toward the end of the rotation, this same attending tracked me down and told me how positively the nursing staff had commented on my collegiality over the final 2 weeks of the rotation. I felt better too because the work environment became more collaborative and less confrontational. But it took a bold attending to give me unsentimental feedback to get there. Clinical educators owe their learners difficult, even painful feedback when it is warranted. Otherwise, a learner’s growth as a professional is at risk for being stunted. Sure, some learners will resent this, but I believe the vast majority will appreciate and embrace this feedback and have greater respect for those with the courage to give it.

Clinical educators not only help to set the culture, they are a crucial component of the culture. If they can model respect and professionalism for learners and be willing to give and take constructive feedback when needed, they will move closer to defeating the negative aspects of the hidden curriculum. In so doing, they will bring the medical community closer to its greater ideals. More important, physicians at all levels
of training and experience will function better as members of interprofessional teams; and most important, patients will be safer and better cared for because of it.

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