Beyond the hidden curriculum: The challenging search for authentic values in medical ethics education

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Since the practice of medicine is a moral enterprise, medical ethics education aims to produce 'good' doctors who are capable of self-reflective discernment of the many values at play in the clinical encounter, and of re-affirming the patient's human dignity. However, the caring and compassionate physician envisaged as the end-product of medical ethics curricula evidently remains elusive. I argue that this apparent failure of medical ethics education is traceable to a systematic de-emphasis of humanistic values since the pioneering stages of formal medical ethics curricula. The idea of 'the hidden curriculum' connotes a distinctive value-laden medical morality that is transmissible through socialisation and role-modelling in the medical school moral ecosystem. Further, the hidden curriculum is hampered by the challenging medical school workload, bad role models, and lack of appropriate evaluation and assessment methods, as well as the lack of consensus in bioethics on the key concept of human dignity. Properly conceived, the dignity of the human person is the ultimate source of human values. Optimising the hidden curriculum, therefore, demands an authentic and comprehensive enquiry into the concept of human dignity, as well as the nature of the human person, the true human good and what constitutes the unitary good of the patient.

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The ultimate aim of medical ethics education is to produce 'good' doctors capable of reflectively discerning the many values at play in the clinical encounter. In this regard, medical ethics education is centred on respecting the dignity of the human person,[1] which is the ultimate human value and source of all authentic human values. By 'value' I refer to the transcendental notion of the good, which is intended and affirmed through a process of deliberation.[2] The value system of medical professionalism is *teleologically* derived from the aim of medicine itself, which is the unitary good of the patient.[3] The practice of medicine is a moral enterprise, and its values include integrity, compassion, altruistic beneficence, continuous self-improvement, excellence, and working in partnership with members of the wider healthcare team.[4] Today, however, attaining these crucial values in medical education is hampered by serious challenges, which are traceable to the systemic de-emphasis of these values that has taken place since formal medical ethics education was pioneered.

Systematic de-emphasis of values

When medical ethics curricula first became formalised in the 1980s, the main focus was not on guaranteeing virtuous physicians, but rather on accepting medical ethics education as a formally structured component of the medical curriculum.[5] Because of the dominance of the scientific paradigm, fundamental concerns for humanistic values and meaning in medicine were considered unfashionable and were de-emphasised.[6] It was erroneously assumed that medical students were already morally adept, needing only to hone their ethical decision-making skills during medical training.[7] Thus, their eventual ethical practice would merely be a consummation of the pre-existing moral disposition that suited them to study medicine. Despite this misconception, formalising medical ethics education was meant to deliver self-reflective physicians who would re-affirm the human dignity of the patient.[8] Therefore, students were expected to achieve a practical understanding of the concept of human personhood, with its ethical and legal implications in terms of patient's autonomy and end-of-life choices.[8]

However, despite several reforms of medical ethics curricula, the patient-centred self-reflective physician has remained elusive. Arguably, the key reason is the high value attached to scientific research and technology in medical schools.[9] This emphasis on biotechnology is driven by these schools' relentless quest for funding, power, prestige and ranking, at the expense of person-centred medical education.[9] The belief in the supremacy of the scientific method in medical education is persuasive and deeply entrenched, thus blinding medical students to other critical domains and sources of knowledge, enquiry and understanding, such as philosophy, sociology and spirituality.[10] Because they are trained and moulded in the context of objective scientific language, physicians commonly find patients' narratives and value systems too subjective and therefore problematic, which impacts negatively on the fundamental physician-patient relationship.[10]

Nonetheless, the essence of medical ethics education is to enable aspiring physicians to appreciate the delicate balance of their own, their patients', and societal values in the practice of medicine.[11] However, the pioneering formal medical ethics curricula tended to present a value-neutral science-based medical training in the interest of presumed objectivity and trans-cultural political correctness.[12] References to humanistic values tended to be largely abstract and anecdotal, with minimal attention to the comprehensive moral

reasoning that underpins the desirable values-based healthcare.[13] Effectively, the formal medical ethics curricula de-emphasised values such as personal virtue, caring and the common good in favour of the abstracted Western value-complex of individualism. Thus ethics is taught as an add-on technique rather than as part of the core identity of the medical profession.[12]

The factors compounding the de-emphasising of humanistic values included: (*i*) the evolution of medicine from a simple physician-patient relationship into a pluralistic, commercialised healthcare industry;[7] (*ii*) the rise and dominance of *principlism*[14] in the wake of the unprecedented biotechnology revolution and the rise in socio-political awareness that followed the Second World War; and (*iii*) the philosophical erosion of virtue-based ethics. Accordingly, concern for the physician's personal virtue was eclipsed by the emphasis on general bioethical principles aimed at monitoring the broadened medical industry.[7] Therefore, the challenge remained: how to steer medical ethics education towards producing the desirable person-centred, value-sensitive physician, in view of the unprecedented, and potentially dehumanising, ethical complexities of the biotechnology revolution.

Subsequently, it became evident that despite numerous reforms, medical ethics education was inadequately served by formalised coursework curricula,[15] which did not produce the caring and compassionate physician envisaged. It became evident that medical education essentially consists in moral enculturation, which entails the transmission of a distinctive medical morality.[12] Moreover, moral enculturation occurs mainly in a distinctive 'hidden curriculum' rather than in the formal coursework.[16] Hence, the concept of the hidden curriculum emerged as a pivotal one in medical ethics education.

The emergence of the hidden curriculum

Hafferty[16] identifies three distinct curricula in medical education. First there is the formal curriculum, which is 'the stated, intended, and formally offered and endorsed curriculum'. Second, there is the informal curriculum, essentially 'an unscripted, predominantly *ad hoc*, and highly interpersonal form of teaching and learning that takes place among and between faculty and students'. In other words, the informal curriculum is embodied mainly through the day-to-day interpersonal interactions among students and faculty. Third, there is the hidden curriculum, which is 'a set of influences that function at the level of organisational structure and culture'.[16]

The hidden curriculum does not imply 'hidden agendas' in medical education, and does involve more than just the informal curriculum.[16] Although it occurs mainly during the informal curriculum, the hidden curriuclum also occurs within the formal curriculum, as it 'includes the hidden transmission of the dominant culture during formal classes'.[17] It also encompasses the morality and culture in the 'life-space' of medical education, which define and distinguish ethical medical practice.[16] Indeed, the hidden curriculum has its own distinct dynamism.

The dynamics of the hidden curriculum: Socialisation and role models

Every medical school has a distinctive medical culture that all its medical students encounter via their training, and which is transmitted from one generation of physicians to another during the hidden curriculum, through a process of socialisation.[12] Through this process, the medical values, beliefs, attitudes and behaviours that characterise the medical profession progressively transform a medical student from a lay person into a physician.[12] Medical ethics cannot be *taught* but rather, can be *learnt* through observational and situational learning, and through experiential participation.[7] The hidden curriculum is a dynamic phenomenological reality rooted in the intangible moral behaviour exemplified by role models. Hence, its success critically depends on the exemplary virtuous character of the entire faculty as role models. Thus, students will acquire authentic ethical competence through knowledge, socialisation and role models, and it will become an internalised, qualitative professional identity rather than a mere add-on tool or technique.[12]

Moreover, it is within the hidden curriculum that medical students 'increasingly adopt and create the values, attitudes, and beliefs of the community as they are spoken and enacted by their more experienced colleagues'.[7] The active participation of the medical faculty in programmes aimed at enhancing the teaching of caring values and attitudes is extremely effective.[18] According to Swick,[19] the values and behaviours that individual physicians demonstrate in their daily interactions with patients and their families, and with physicians and other professional colleagues, become the foundation on which medical professionalism rests. Therefore, at the centre of effective medical ethics education is the need for a value-laden hidden curriculum.

The need for authentic values in medical ethics education

To achieve its aim of producing good physicians, medical ethics education must prioritise the transmission of coherent professional values.[11] According to the premise of the Physician Charter,[20] professional values are under threat from the changing healthcare delivery systems, especially in the industrialised world. A review of medical ethics education over the last four decades indicates that it has become imperative that humanistic values be articulated and integrated into the traditionally science-based medical education curriculum.[13] Integrating the humanistic values with biomedical science from the beginning of medical training highlights and reinforces the indispensability of these values in medicine.[21]

Consequently, medical ethics education today must be geared towards promoting value-laden, person-centred healthcare delivery systems that address the daily needs of patients and their families.[22] Since the moral culture of medicine is mainly transmitted through the hidden curriculum, it becomes imperative that medical schools espouse a value-laden moral environment. Kenny *et al.*[7] rightly observe that the transmissible moral culture of the medical school is constituted in the values of its moral ecosystem. Indeed, to view moral enculturation as the basis of the hidden curriculum is to recognise a qualitative value system inherent in medicine as a profession, and which cannot be captured by the formal curriculum.[12] Therefore, the challenge is how to articulate medicine's *teleologically* derived moral value system in the dynamics of the hidden curriculum.

The search for authentic values

Harnessing a value-laden hidden curriculum in medical ethics education poses many challenges. First, the heavy workload during medical training limits the necessarily time-consuming process of ethical enquiry. The overburdened medical students fear they will

fail to cope, which fosters a sense of inferiority and inability to pursue authentic ethical inquiry. Therefore, there is a tendency towards ethical compromise, aggravated by the students' role as novices in a medical team hierarchy.[12] Because of their relative medical ignorance, students are expected to comply with tradition and try their best to unquestioningly please their examiners.[23]

Second, and perhaps most critical, is the issue of the suitability of faculty as role models for the medical students. Evidence has shown that virtuous role-modelling, as effected through the hidden curriculum, is profoundly more effective than formalised medical ethics coursework in transmitting medical morality.[15] Thus the faculty, as virtuous moral agents who reflect authentic professional values, underpin the success of the hidden curriculum. The main challenge is that faculty members are primarily recruited based on academic, research and clinical achievements rather than on personal character or professional behaviour.[24]

Understandably, the intense scrutiny of faculty members for personal virtue might be neither feasible nor prudent – particularly given today's morally pluralistic society. Nonetheless, in light of the centrality of the hidden curriculum, each medical school should specify and articulate at least the minimum standards and processes (including targeted continuing professional development) necessary for the desirable moral ecosystem. Therefore there is an urgent need to devise and implement faculty recruitment criteria that prioritise professional values in medicine. As Kenny *et al.*[7] point out, there is no doubt that medical ethics education requires good role models, who must not only demonstrate enthusiasm and good practice, but also be able to articulate the reasons for their good behaviour.

Conversely, the greatest challenge to reaffirming students' acquired patient-centred values is the conflicting behaviour of bad faculty role models.[25] Bad role-modelling may occur through case presentations, stories, jokes, slang or personal anecdotes that portray and perpetuate forms of discrimination or biases based on gender, disability, culture, ethnicity or race.[12] Moreover, observing unethical behaviour from role models greatly contributes to the students' acquiring unethical behaviour.[25] Consequently, the pivotal role of the hidden curriculum in transmitting medical morality demands unequivocal advocacy for value-laden role-modelling. The general function of the role model is to try and clarify the complex process of professional character formation, which requires a review of personal values and beliefs, and this role unequivocally calls for personal virtue.[7]

The third major hurdle in harnessing the hidden curriculum is methodological. It relates to the lack of appropriate methods for assessing and evaluating competency in medical ethics, as instilled in students through the hidden curriculum. The dominant medical education evaluative tools are based on scientific methodology, which contrasts with the experiential and phenomenological humanistic values that characterise the patients' and physicians' lived narratives. By its nature, the hidden curriculum is not amenable to methodology: in attempting to formalise it, one automatically loses it.[17] Hence, although there is a general consensus that medical ethics, like all other core competencies, should be formally assessed, it is unclear to what extent the internalised ethical values, such as compassion, can be subjected to formal assessments.[15]

Above all, since the ultimate aim of medical ethics education is to re-affirm the human dignity of the patient,[1] there is an urgent need to appraise and clarify the concept of human dignity in contemporary bioethics. The resurgent debate on the concept of human dignity in bioethics[27,28] reflects the lack of consensus on what constitutes human nature and the human good. However, properly conceived, the dignity of the human person essentially arises from the inalienable intrinsic value of the human being, for simply being a member of the natural kind of embodied rational nature that constitutes the human person.[26] The dignity of the human person is the source of all authentic human values and is rooted in a comprehensive account of human nature and the notion of the human good.

Conclusion

Evidently, there has been a systematic de-emphasis of humanistic values in the formal curricula of medical ethics education. The hidden curriculum has emerged as a dynamic, phenomenological reality that is pivotal if we are to transmit the distinctive morality of the medical profession. It is critically dependent on socialisation and role-modelling in a value-laden medical school moral ecosystem.

However, the optimal harnessing of the hidden curriculum is hampered by the overwhelming medical training workload; uncertainty about whether faculty will act as good role models; and the lack of appropriate evaluation and assessment methods. Above all, the search for authentic values in medical ethics education is critically limited by lack of a conceptual consensus in bioethics on the dignity of the human person, which is the ultimate source of all authentic human values. Thus, beyond the hidden curriculum beckons a deeper inquiry into the concept of human dignity, the nature of the human person, the true human good and what constitutes the unitary good of the patient.

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