EDITORIAL

Challenging the Hidden Curriculum

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J Gen Intern Med 23(5):652-3
DOI: 10.1007/s11606-008-0564-6

The findings of Dr. Santen, Dr. Rotter, and Dr. Hemphill[1] regarding physician disclosure of training level to patients may well contain few surprises for most readers. Not surprisingly, they found that such disclosure is rare and vague at best, and that patients consequently have little sense of their physician's level of training. They also found that patients did indicate, when asked, that it was important to them to have such knowledge, which is also not surprising once you think about it for a moment.

There can be merit in documenting something in black and white, however, and I believe there are considerations here that are disturbing enough to emphasize by way of an editorial comment. In sum, I submit that this research highlights an area of physician behavior that merits serious challenge. On the face of it, such behavior is disingenuous, if not deceitful, and fails to properly respect patients as fellow human beings with their own clear informational needs. If any of us were patients, we would surely require such information, if it was not otherwise apparent.

Now as Santen et al. notes, the American Medical Association[2] and the American College of Physicians[3] have long since made clear that such disclosure should be regularly supplied to patients. Why, then, is such disclosure not occurring? One might suspect this is so because of the fear that patients may be less cooperative and compliant with treatment offered by residents, that patients (and families) may inconveniently insist on only dealing with the attending physician, that they may refuse to be treated by residents, or simply that such disclosure will trigger all sorts of further questions from the patient and waste valuable time. One might also worry that medical training and credentialing might suffer, as patients reject the idea of procedures being done by physicians in training. In short, medical education might come to a screeching halt and valuable time be routinely wasted.

Not that any of these potential downsides have been documented, especially as to their frequency and actual disruptiveness, but one can imagine that if one challenged any particular non-disclosing physician, one would get some version of the above, an appeal to the fact that patients are routinely informed on admission to teaching hospitals that medical students and residents will be involved in their care and, perhaps, something about seeing no advantage to going there.

One might hope that such unsubstantiated views not be allowed to so quickly overrule the desiderata of being respectful to and candid with patients, but Santen et al. have done us the service of documenting that this is the case. They have also provided us with the citations that show that, as a matter of fact, patients do not tend to reject care by physicians in training when they are aware of this, even to the point of allowing inexperienced residents to do spinal taps on them.[4] But what should we think of this state of affairs?

The point of this editorial is to argue that there is a good deal more at stake here than just being respectful of and honest with patients, even though I personally feel this should be decisive. In sum, such behaviors also heighten litigation risk, can undermine patient trust, and teach physicians in training that it is permissible to be disingenuous with patients for the sake of expediency. More specifically:

1. Heightening litigation risk*:* The distorting effects of the current malpractice climate are clear; defensive medicine is pervasive. It thus becomes alarming when one sees physician behaviors that further heighten such risk, and this is one such behavior. Consider the common patient who suffers a complication. What will their tendency be, as the complication is explained to them, if they also learn that (unbeknownst to them, as Santen et al. have documented) the procedure that generated the complication was performed by someone who was still in training? I submit it takes little imagination to conclude that it will significantly heighten the patient's tendency to feel abused and mis-treated, etc. A conversation that might often (and in my experience does) result only in an acknowledgment that a known risk has occurred, and something about how anyone can make a mistake gets redirected to the patient searching his or her memory for where that billboard is with the word "injured?" featured so prominently. This point relates not only to how this will play in court; it also keys to the arguably more important issue of whether the patient even considers litigation in the first place.
2. Undermining trust: Volumes have been written about the crucial need for patients to trust their physician. Just the other day, a surgeon friend of mine was marveling out loud about how interesting it is that patients remain so willing to trust complete strangers and allow them to perform all sorts of profound and dangerous procedures. But whence

Published online February 26, 2008

goes trust for the patient above, now or in the future? Part of trust surely involves the belief that the other person will be honest with oneself; it also involves believing that that person will not allow simple expediency to trump one's own interests and concerns. Such nondisclosure risks jeopardizing all this. I recently accompanied a family member through trauma care and noted that the receiving resident spoke as if he would be managing that care, with no reference to the attending at any point; I was left wondering what else he might later be disingenuous about; in effect, I no longer trusted him.

Somehow, the most alarming feature of all this, to my mind, is that we are training our future colleagues to be disingenuous with patients for the sake of expediency or convenience. Never mind that it is not clear that how expedient any of this is, the punch line seems to be that this is all right, part of the hidden curriculum regarding how one can and should practice. I used to see this in case conferences with medical students where they reported being uncomfortable with being introduced as a doctor. At least in my area, this behavior has mainly evaporated but not so the somewhat more subtle behavior that Santen et al. document. My suggestion to these students is generally as follows: "You should all recognize by now that medical education involves seeing both how and how not to practice. Please consider that this behavior falls in the latter category and that your discomfort is not something to grow out of, but to hold onto until you are more your own masters. Much more than expediency and convenience are at stake here." Another way I have approached this is to comment: "Generally respect for and honesty to other people is considered the rule, what is expected. Rather than begin medicine with the opposite default, please consider starting off with respect and honesty and see if patient care and medical education can still proceed effectively. You may find that, as some studies have suggested, that it does and will have no need to incorporate behaviors that your patients would surely condemn if and when they become aware of them."

For such reasons, I commend the article by Dr. Santen, Dr. Rotter, and Dr. Hemphill to you all.

Acknowledgment: *There was no funding of this research.*

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