Decoding the Learning Environment of Medical Education: A Hidden Curriculum Perspective for Faculty Development

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Abstract

Medical student literature has broadly established the importance of differentiating between formal-explicit and hidden-tacit dimensions of the physician education process. The hidden curriculum refers to cultural mores that are transmitted, but not openly acknowledged, through formal and informal educational endeavors. The authors extend the concept of the hidden curriculum from students to faculty, and in so doing, they frame the acquisition by faculty of knowledge, skills, and values as a more global process of identity formation. This process includes a subset of formal, formative activities labeled “faculty development programs” that target specific faculty skills such as teaching effectiveness or leadership; however, it also includes informal, tacit messages that faculty absorb. As faculty members are socialized into faculty life, they often encounter conflicting messages about their role. In this article, the authors examine how faculty development programs have functioned as a source of conflict, and they ask how these programs might be retooled to assist faculty in understanding the tacit institutional culture shaping effective socialization and in managing the inconsistencies that so often dominate faculty life.

What Is the Hidden Curriculum?

All learning involves both formal-explicit and informal-tacit elements. For at least the past century, educators have shared this view of learning. Examples include John Dewey’s concept of collateral learning as well as more contemporary concepts such as workplace learning, situated/cognition learning, peripheral participation, and communities of practice. Although educators have used a variety of terms to differentiate between the formal (e.g., explicit, written, curriculum on paper) and the informal (e.g., hidden, implicit, unwritten, meta, latent, shadow, tacit, tested) dimensions of medical learning, the basic distinction all of them make is that social life in general is governed by a complex interplay of formal laws and/or cultural traditions and informal norms, stereotypes, and social practices. Whereas medical educators and others tend to view or describe the learning environment as a simple dichotomy between the formal and hidden curricula, the reality is that social learning is a more complex phenomenon. Regardless of the labels used, three critically important arenas of influence remain: (1) those social activities formally structured and intended, (2) those social activities that are more informal, unplanned, and unscripted, and (3) those influences, such as organizational culture and place, that are more invisible and ethereal in their presence and impact. We suggest that these three arenas exist not only for students but for faculty as well, and we will use the term “hidden curriculum” to globally capture all of the nonformal
influence one another.16,17

subordinates, rather than how they might
senior group members impact their
and faculty tends to emphasize how
focusing on graduate medical education
when resident physicians play the conflicting
role of both student (to faculty) and
resident physicians play the conflicting
learning environments, and they must
navigate networks of hidden, often peer-
based, learning processes.15 The rather
extensive hidden curriculum literature
focusing on graduate medical education
and faculty tends to emphasize how
senior group members impact their
subordinates, rather than how they might influence one another.16,17

Faculty, residents, and other teachers are
both subject to, and active participants in,
their own hidden curriculum. Faculty
are not born faculty. “To be faculty” is
both to take on a specific social identity
and to follow a set of social roles. Faculty
learn this identity and its related roles
over time. Both the identity and the
attendant roles are infused with social
expectations including those held by in-
group members (i.e., other faculty) and
out-group members (e.g., students,
administrators). Learning the rules
governing “faculty life” involves formal
and informal, direct and tacit, learning
processes. For example, faculty may have
“protected” time for educational
activities, but may find themselves called
called for clinical work. Accordingly, the
individual faculty may begin to learn or
understand that the policies of protected
educational time may not actually
translate into real hours of protected
time. The message is that his or her
department values clinical service more
than educational service. Whereas faculty
are important drivers of the hidden
curriculum as it pertains to students, the
hidden curriculum as it pertains to faculty
may be more driven by the institution itself, and it may be translated
and transmitted to individual faculty
members by their peers.

The literature has depicted faculty
members as deliverers of pedagogy, role
models, and/or repositories of
institutional power, but rarely, in terms
of their development, as objects of critical
inquiry in their own right. This lack of
acknowledgment as learners has become
so routine that, when studies of “medical
school socialization” are published, the
peripheral status of faculty as learners
often slips by unnoticed. In this way,
faculty learners have become bit players
in a provocative drama about
development and the formation of future
physicians.

Although a vibrant body of literature
focuses on the socialization of graduate
students to academic life,18,19 and a
separate body of scholarship focuses on
the socialization of occupational
newcomers,20 including the role of tacit
knowledge in organizational (including
medical) learning,21 virtually no studies
are specific to the training and/or
maturation of medical school faculty.
Exceptions are Blankenship’s22 early
edited work on “colleagues in
organizations” and two more recent
works by Trowler and Knight23 and by
Pololi and colleagues.24 Some
publications provide focused
examinations of scientific collaboration
and faculty productivity,25–27 including
the impact of teaching scholar28 and
faculty development programs,29 but
these studies are not designed to answer
particular questions about the hidden
curriculum. Similarly, a burgeoning body
of literature examines career
development and advancement within
academic medicine,30,31 with a particular
focus on faculty discontent and
burnout,32,33 faculty retention,34 and the
particular case of women and minorities
in academic medicine,35,36 but, once
again, most of these studies answer
specific empirical questions about the
prevalence of certain trends or
phenomena, or they call for changes
without an underlying theoretical
framework or reference to the impact of
the hidden curriculum.

We believe that a better understanding of
the hidden dimensions of faculty
formation will allow organizations to
become more sensitive to the tacit and
more informal dimensions of
organizational culture. For example,
faculty and administration may be well
able to list the teaching awards and
recognitions given out each year.
However, they may be less able to
articulate the characteristics of those
awards relative to core school values.
Further, they may not be aware of the
school’s entire universe of awards or of
the larger picture of meaning that this
universe conveys to the institutional
community about core organizational
values. Indeed, a school that has
purposefully reviewed its universe of
awards is rare. For example, the Arnold
P. Gold Foundation provides a
Humanism in Medicine Award, but not
all schools receive it. What is the message
for the schools that do not receive this
award? Is humanism less important to
those schools?

Understanding the hidden curriculum
can sensitize faculty and administrators
to the existence and impact of such meta-
messages, even if—perhaps especially
important if—these messages are
previously unseen and unintended by
the sender or unrecognized and
misinterpreted by the audience. Knowing
the meta-messages is important because
such knowledge provides the foundation
for leveraging positive messages and
minimizing negative messages and their
unintended outcomes (e.g., high rates of
faculty turnover, low faculty morale,
decreased faculty productivity, decreased
student satisfaction [with faculty], and
ultimately poor organizational
performance).32–36

Reconstructing Faculty
Development From a Hidden
Curriculum Perspective

The medical education literature often
employs the term “faculty development”
to indicate a particular set of educational
activities, typically aimed at building
skills in specific areas, such as grant and
manuscript writing, curriculum
development, and teaching.37–39 In terms
of the hidden curriculum, faculty
development exists not only as specific,
formal skill-building experiences but also
as generic processes tied to the broader
concept of socialization. In other words,
becoming a faculty member is a process of occupational enculturation that involves a broad range of social practices infused with both formal/explicit and informal/implicit learning dimensions. From this perspective, efforts to improve the instructional value, impact, and/or relevance of formal faculty development programs will be dictated in part by the broader array of cultural messages that faculty encounter as they go about learning what being a “good faculty member” means and what they really need to attend to in order to advance their careers.

To quote long-time Speaker of the House Thomas P. “Tip” O’Neil, “all politics is local.”40 In the case of medical education, all learning, be it at the student or faculty level, is context dependent.41 Thus, when a medical school invests in formal faculty development programs to increase the effectiveness of its faculty as teachers,37,38 it must also consider the broader cultural supports for teaching as a valued faculty activity, such as the presence (or absence) of a teaching track that includes tenure. If faculty members are receiving countervailing messages from their work environment that teaching is relatively undervalued, then the formal faculty development efforts to improve teaching skills are being undermined by the broader culture of the institution. For example, one of our home institutions initiated an educators’ journal club as part of a formal faculty development program. After a few months, very few faculty were attending the sessions. Faculty members were not able to secure the time away from their clinical and research activities to attend. Furthermore, those junior faculty who attended did not see senior faculty in attendance and may have interpreted the journal club as less valued in the schema of academic life at the institution. In this case, a planned activity created as part of a formal faculty development program was less effective in meeting its objectives because the broader culture, as demonstrated by the behaviors of seasoned teaching faculty, ran counter to the goals of the formal faculty development program.

Review of the faculty development literature41 makes many of the same points we have advanced above, but these works do not reference a hidden curriculum framework. For example, Steinert and colleagues41 note that most faculty development programs target teaching and instructional improvement or they target a particular type of faculty, such as practicing clinicians, primarily those within family medicine and internal medicine programs (basic science faculty members receive far less attention). They further note that faculty development often lacks context and fails to establish “a direct link to teachers’ ongoing educational activities.”41 Compounding this problem, many faculty development interventions lack a theoretical (e.g., experiential learning, reflective practice) framework. Studies of impact also focus more on learners’ reactions to the experience (e.g., favorable versus unfavorable) and/or changes in learners’ attitudes, knowledge, and skills rather than actual changes in the learners’ behavior or changes in the systems in which faculty and learners work.42 Reflecting the idea that politics is local, Steinert and colleagues41 conclude that “context is key” and that faculty development efforts must include more attention to organizational culture. More important, these authors41 conclude that whereas formal faculty development is able to address the first two of Kirkpatrick’s four necessary conditions of change (e.g., a personal desire to change and knowledge regarding the whats and hows of change), it is not able to create a supportive occupational environment or rewards tied to change (the last two of Kirkpatrick’s necessary conditions for change).

**A Conceptual Model for the Hidden Curriculum With Respect to Faculty Development**

Figure 1 constitutes an initial attempt to describe some of the factors that may impact the hidden curriculum as it pertains to faculty (as well as students). Factors that influence the hidden curriculum, as it pertains to students, include the behaviors of faculty and residents, advice from senior students, and feedback and evaluation. Factors such as the processes for granting promotion and tenure, the allocation of space, and salary structure or merit increases are elements of the hidden curriculum impacting faculty. An example of this is mission-based budgeting with respect to education. An institution that pursues this type of budgeting will funnel dollars to its departments based on the time devoted to teaching. This structure, on the surface, may seem to value time spent teaching; however, if the allocation of those funds is left up to a departmental chair who chooses to funnel the money to researchers or other departmental activities, then what does this say to the teaching faculty within that department? Although Figure 1 portrays the hidden curricula for faculty and students as separate entities, they are actually both

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**Figure 1** Many factors affect how faculty and students understand the tacit institutional (i.e., organizational) culture that may shape socialization and faculty and student life. Figure 1 depicts how some factors within the hidden curriculum may impact faculty and students within the institutional culture. The authors have highlighted a select few of these factors, and these are represented in the two hidden curriculum boxes. The factors and influences circle back and influence the institutional culture.
mechanisms for viewing how the overall institutional culture is operationalized for either students or faculty.

Looking Ahead
In this article, we have attempted to take the concept of the hidden curriculum, at least as it appears within the medical education literature, and use it to reframe the concept of faculty development, so that faculty development includes not only formal activities but also the broad array of experiences, including those that are tacit and unintentional, influencing faculty life. The likelihood for faculty to encounter a variety of conflicting messages about the nature and goals of their educational undertakings is not well understood, nor is it well documented in either the medical education hidden curriculum literature or the faculty development literature. We suggest a critical need for empirical research to address important questions with respect to institutional culture and faculty development. Faculty face inconsistencies in the culture and structure of their workplaces, ambiguities about the nature of their work, and questions related to their professional identities. How can medical educators design faculty development programs that address these aspects of the hidden curriculum? How can the academic medicine community align faculty development programs with both the culture of the organization and the faculty experience within the organization? How can the community link, integrate, and reconcile the various bodies of literature on faculty life (including how faculty learn to be faculty) so that the formal curriculum of faculty development assumes a meaningful and influential presence within the overall milieu of health science institutions?

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References
and for this we are forever grateful.

on to us the foundation of our education, graciously accept. The cadaver has passed the gift of life, and we reach out to cadaver willingly extends a hand to give cadaver and student. Through death the exchange that occurs between cadaver and student. Through death the human beings—human beings who have given us our first class in medical school, and the beginning? We begin our long path to becoming doctors in gross anatomy. It is a third-year medical student, Florida State University College of Medicine, Tallahassee, Florida; e-mail: jjr04c@med.fsu.edu

I looked at my cadaver with awe and appreciation. When that person died, one life was lost, but in that death, life has been given to countless other people through the care I will give someday. There is an exchange that occurs between cadaver and student. Through death the cadaver willingly extends a hand to give the gift of life, and we reach out to graciously accept. The cadaver has passed on to us the foundation of our education, and for this we are forever grateful.

This exchange of knowledge begins in the anatomy lab, but continues throughout the entire medical school experience. It lives in every classroom, study hall, and library. This is the place where death delights to help the living, and it is our responsibility and our honor to make sure that the death of our first patient will be a help to all those we serve. The tremendous amount of knowledge we gain from our silent teachers is the first step in our pursuit and our conviction to become protectors of life. We must always continue to learn, for there is no limit to our abilities, but it is important to never forget where we began, and those who helped us along the way.

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Cover Art

Artist’s Statement: This Is the Place Where Death Delights to Help the Living

What better place to start than at the beginning? We begin our long path to becoming doctors in gross anatomy. It is our first class in medical school, and the cadavers that we dissect are often called our first patients. They are also called our silent teachers. We learn more from them than any professor’s lecture or any picture in a textbook could ever teach us. Studying our cadavers is not like reading words on a page or looking at an image on a screen. It is actual interaction with human beings—human beings who generously donated their bodies so that we could begin to learn to be doctors.

I looked at my cadaver with awe and appreciation. When that person died, one life was lost, but in that death, life has been given to countless other people through the care I will give someday. There is an exchange that occurs between cadaver and student. Through death the cadaver willingly extends a hand to give the gift of life, and we reach out to graciously accept. The cadaver has passed on to us the foundation of our education, and for this we are forever grateful.

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