

Measuring the “Iceberg” - Quantifying the hidden and informal curriculum in clinical rotations using the Hidden Informal Curriculum Assessment Tool (HICAT)

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Abstract

Introduction: The study aimed to develop and validate an instrument- the Hidden Informal Curriculum Assessment Tool (HICAT) to quantify both the frequency of positive and negative aspects of the hidden / informal curriculum and the “impact factor” of these experiences for medical students.

Methods: The authors developed a questionnaire which was distributed to medical students undergoing a clinical rotation over the course of an academic year. To examine internal validity the authors compared the results of the HICAT for students based on their gender, level of entry in the course and overseas status.

Results: 99 students participated in the survey (response rate 60%). The most influential student experiences were positive examples of the hidden/ informal curriculum. The commonest negative experience which had a significant influence on the students was the experience of being disadvantaged due to gender. Males more often felt disadvantaged by their gender than female students. International students more often felt disadvantaged by their ethnic background than domestic students.

Conclusions: The HICAT was user friendly and demonstrated internal validity. Further research is needed to determine external validity. HICAT may be a useful instrument for educational and health professional organisations to benchmark and identify the strengths and weaknesses of their hidden/ informal curricula.

Practice points

- The hidden/ informal curriculum can be likened to an iceberg- not easily visualised or measured, but acting as a major force in the learning environment
- There are no validated tools for measuring both the frequency of exposure to, and impact on the person of the positive *and* negative aspects of the hidden/ informal curriculum
- HICAT measures both the frequency of exposure to positive and negative aspects of the hidden / informal curriculum *and* the “impact factor” of these experiences
- The HICAT is user friendly and demonstrates internal validity (e.g. detecting gender discrimination for males). Further research is needed to determine external validity.
- HICAT may prove to be a useful instrument for educational and health professional organisations to benchmark and identify the strengths and weaknesses of their hidden/ informal curricula

Keywords: Assessment and curriculum.

Article

Introduction

The hidden and informal curricula are increasingly recognised as the formative crucibles where medical students are first exposed to and start to learn the true practice of medicine (Karnieli-Miller, Vu, Holtman, Clyman, & Inui, 2010).

The terms hidden and informal curriculum (F. Hafferty, 1994; F. W. Hafferty, 1998; E. Hundert, Hundert, & Douglas Steele, 1996) describe the interpersonal processes, organisational structures and culture that influence both students learning and socialisation to professional behaviours and attitudes. These influences, often instrumental in student development, occur outside of the formally stated and endorsed syllabus. If we use the analogy of an iceberg- the hidden curriculum is below the surface, not easily visualised or measured, but acting as a major force in the learning environment. Examples of some of these processes and structures are: interactions with patients, health professionals and teachers; norms and implicit rules learnt to survive in the system; and immersion in the clinical culture. Students may be exposed to both positive and negative experiences in their encounters with the hidden/ informal curriculum. Day-to-day examples of these experiences may include watching a skilled clinician work with a distressed patient or being a member of a well-functioning multidisciplinary team. Conversely the student may witness a staff member behave in a discriminatory fashion to a patient, or be made to feel unwelcome in a clinical placement.

The hidden/ informal curriculum cannot be eliminated, but it may be shaped to maximise its' positive role and reinforce the desired goals of the formal curriculum (Chuang et al., 2010; Karnieli-Miller et al., 2010). However to change something, one must first be able to measure it. Based on our review of the medical education literature in this area, we could not find any validated tools for measuring both the potential positive *and* negative aspects of the hidden/ informal curriculum. There is a substantial body of work examining the effect that adverse experiences in medical school have on medical students (Billings, Lazarus, Wenrich, Curtis, & Engelberg, 2011; Gaufberg, Gaufberg, Batalden, & Sands, 2010; Heidi & Seale, 2004; E. M. Hundert, Hafferty, & Christakis, 1996; T. J. Wilkinson, Gill, Fitzjohn, Palmer, & Mulder, 2006) but there is less published work assessing the impact of positive experiences on the students or the relative proportion of positive and negative experiences during a students' medical course (Paul Haidet, Kelly, Chou, & The Communication, 2005; P. Haidet et al., 2006; Karnieli-Miller et al., 2011; Thiedke, Blue, Chessman, Keller, & Mallin, 2004; Zhang, Peterson, & Ozolins, 2011).

In this study, we sought to develop an instrument- the Hidden Informal Curriculum Assessment Tool (HICAT), which could be used to quantify both the frequency of positive and negative aspects of the hidden / informal curriculum and the "impact factor" of these experiences for medical students in a clinical rotation at the University of Western Australia. In particular, we wanted to evaluate whether the instrument had internal validity by assessing whether the tool detected different exposures and experiences of the medical student cohorts based on the student's gender and other demographics.

Methods:

UWA is a mixed undergraduate and post-graduate entry medical degree course with approximately 150 students per academic year in the Perth metro clinical school. The students rotate through clinical rotations every 10 weeks during their 5th year.

We designed and implemented a survey questionnaire (HICAT- Appendix 1) for distribution to the year 5 medical students undertaking their ten week rotation in obstetrics, gynaecology and new born medicine. Ethics approval for the study was provided by the University of Western Australia Human Research Committee.

The Hidden Informal Curriculum Assessment Tool (HICAT) questionnaire was developed using an iterative approach. The authors first reviewed the medical education literature for any surveys or questionnaires examining the hidden/ informal curriculum (Billings et al., 2011; Blackall et al., 2007; P. Haidet et al., 2006; Hicks, 2001; E. M. Hundert et al., 1996; Kassebaum & Cutler, 1998; Rentmeester, 2007; Zhang et al., 2011). Any relevant papers were scrutinised and references checked to identify any hidden/ informal curriculum scenarios which demonstrated either positive or negative aspects of the hidden/ informal curriculum. Based on the literature review, the authors then modified or scripted a wide variety of educational and/or clinical hidden/informal curriculum scenarios. The scenarios were developed to ensure that they could be used to measure both the potential frequency that they were experienced and the impact they may have had on the individual.

Medical students from the preceding year to the cohort used for the study were then invited to form a focus group to further refine the scenarios. A representative sample of males, graduate entry and students from overseas were part of the focus group to avoid potential selection bias. The focus group students were given information on the purpose of the study and on the positive and negative aspects of the hidden/ informal curriculum in medical education. The focus group were then asked to select from the wide variety of hidden/informal curriculum scenarios scripted by the authors those scenarios that the students perceived were most relevant to their personal experience of the hidden/ informal curriculum. The most frequent focus group selected scenarios (ten positive and ten negative) formed the basis of the HICAT.

The authors then incorporated a rating scale for the frequency of occurrence of the 20 scenarios using a modified Likert scale. As part of the HICAT questionnaire, an “Impact rating” was also included by asking students to list the three scenarios which had the greatest impact on them during the clinical rotation. This could be either positive or negative and was not based on the frequency that the students had experienced it, rather how much the experience had impacted on them.

The HICAT questionnaire (Appendix 1) was then piloted on another rotation of medical students to ensure that the survey was user friendly- that is, the survey questions were easily understood and the survey could be completed within 10-15 minutes.

Information about the study was given to the medical students prior to sending them the HICAT questionnaire. This included providing them with a definition of the hidden and informal curriculum, an assurance that confidentiality would be maintained and that participation would have no impact upon their individual academic outcomes. Although demographic information such as gender, under-graduate versus post graduate entry and whether students were from overseas was obtained, no other identifying information was requested to encourage the students to answer openly. Students were free to choose not to participate.

The questionnaire aimed to:

- quantify the frequency that medical students were exposed to either positive or negative examples of the hidden/ informal curriculum
- establish a hidden/ informal curriculum impact rating by asking the students to rank their three most influential experiences during the clinical rotation
- examine whether the student respondents’ demographic influences (gender, undergraduate entry, international entry) influenced their exposure to or impact with the hidden/ informal curriculum

In order to optimise response rates and protect confidentiality, the survey was sent to the medical students by e-mail using a link with SurveyMonkey TM. Students completed the survey during the final week of their ten week clinical rotation. A separate part of this study used a qualitative approach to examine the impact of student self-nominated experiences; this part of the study is discussed in a separate paper.

Results

In total, 165 medical students had obstetrics and gynaecology clinical rotations in metro Perth during 2012. Ninety nine students participated in the survey (response rate 60%), of which 87 students completed the entire

survey (88% completion). As not all respondents completed all questions, the data discussed has variable denominators. Statistical analysis was performed using the Chi-square test for association.

To assess for any survey responder bias, the demographic information provided by the respondents (gender, type of entry to the course, domestic versus international) was compared with the known demographics of the 5th year medical students in metro Perth rotations. Although there were significantly less male responders to the survey (37% compared to 58%, $p=0.011$), there were no other differences for the other demographic variables (Table 1).

The survey asked the medical students to estimate the frequencies that they were exposed to or experienced either positive or negative examples of the hidden/ informal curriculum. To assist with data analysis the frequencies were then grouped into “Never/ occasionally”, “Half the time” and “Often/Always”. Tables 2 and 3 illustrate the relative frequencies for both positive (Table 2) and negative (Table 3) aspects of the hidden/ informal curriculum.

Table 4 illustrates the effects of medical student demographic variables (gender, level of entry and student origin) on the frequency of their experience with and exposure to the hidden/ informal curriculum.

Males more often felt disadvantaged by their gender ($p<0.001$) and felt disadvantaged by their ethnic background ($p=0.007$) than females. Females were more often troubled by the experiences they encountered ($p=0.048$) than males.

International students more often felt disadvantaged by their ethnic background than domestic students ($p<0.001$), and had non-statistically significant trends towards feeling less supported during clinical rotations ($p=0.059$), but they were less likely to describe feeling humiliated by supervisors ($p=0.069$) compared to domestic students.

All other hidden/informal curriculum scenario frequency of exposure or experiences did not differ between the demographic groups.

Students were asked to rank their three most influential experiences during the clinical rotation. This could be either positive or negative and was not based on the frequency that the students had experienced it, rather how much the experience had impacted on them. This data was used to develop an “Impact rating” for hidden/ informal curriculum experiences (Figure 1).

The experiences stated by the students as being most influential in their clinical rotation were mostly all positive examples of the hidden/ informal curriculum (Figure 1- encountering positive role models, feeling supported, and observing health professionals dealing with complex cases in a positive manner). The commonest example of a negative experience which had a significant influence on the students was the experience of being disadvantaged due to gender (joint 5th position at 19%).

The “Impact rating” for various student respondent demographics are tabulated for comparison (Tables 5, 6 and 7). Notably male students reported that the experience of being disadvantaged by their gender had a major impact on their experience of the obstetrics and gynaecology rotation. Similar to the experiences of the student group as a whole, the undergraduate entry students’ most influential experiences were all positive examples of the hidden/ informal curriculum.

Although only a relatively small number of the respondents were overseas students ($n=15$), they were extremely positive in terms of feeling supported during the clinical rotation. In spite of overseas students being more likely to perceive being disadvantaged by their ethnic background than domestic students ($p<0.001$), none of the overseas students rated being disadvantaged due to their ethnic background in their three most influential experiences of the hidden/ informal curriculum.

Discussion

The hidden/ informal curriculum informs us that there is a major distinction between what medical students are taught and what they learn (Brainard, 2007; Hafler et al., 2011). Although by its very nature implicit (Assor & Gordon, 1987) this does not mean that we cannot or should not try to identify the characteristics (positive or negative) or measure the effect of the hidden/ informal curriculum. The Association of Professors of Gynecology and Obstetrics recommend that this can be initially at the personal level- but should develop to the institutional level by systematically collecting data including using surveys to assess the positive and negative aspects of the units hidden/ informal curriculum (Chuang et al., 2010).

The impetus for this study came from the belief that health professional and educational cultures can be modified; hence a medical student's experience with and exposure to the hidden/ informal curriculum should be able to be shaped to accentuate the positive. However in order to demonstrate this, we first need a tool for assessing the effect of the hidden curriculum on the students' experience. Based on our review of the literature in this area (Arnold, 2002; Billings et al., 2011; Blackall et al., 2007; Ginsburg, Regehr, & Lingard, 2003; Paul Haidet et al., 2002; Paul Haidet et al., 2005; Lynch, Surdyk, & Eiser, 2004; Thiedke et al., 2004; T. W. Wilkinson, Winnie; Knock, L Doug 2009; Zhang et al., 2011), no tool existed which measures *both* the frequency of exposure to and the impact on the medical students' experience with the positive and negative aspects of the hidden/ informal curricula.

We decided that measuring both the frequency of the student's experiences of hidden/informal curriculum scenarios and also the impact of the experiences on the student were important criteria to measure for the HICAT. The 20 hidden/ informal curriculum scenarios used in the HICAT are not yet a validated tool, but the data obtained in this study can be seen to be useful in determining the strengths and weaknesses within an educational and health care environment for medical students. For example in this study 8% of medical students often or always felt disadvantaged by their gender and 49% of male students ranked their experience of gender discrimination as one of the top three most influential experiences during their obstetrics and gynaecology rotation.

These figures are in contrast to New Zealand data published by Wilkinson (2006) which found that 24% of women and 17% of men in the whole medical course experienced gender discrimination. The disparity in terms of which gender experiences the discrimination fits with the expectation that male students are more likely ($p < 0.001$) to experience gender discrimination (perhaps the first time ever) during their obstetrics and gynaecology rotation. Whilst this gender discrimination might be anticipated, the HICAT was the first time that Faculty had a definite measure of the scale and impact this had on the students. The HICAT results have provided a stimulus for the department to address this gender discrimination and investigate patient's perceptions to medical students. Although we have not performed a follow up study to assess the effectiveness of these measures, this is a good example of the dictum "to change something, one must first be able to measure it" and illustrates the utility of HICAT as a means of measuring the informal/ hidden curriculum.

Weaknesses of the study are that the HICAT was developed from the perspective of Australian medical students, however the study population included 15% non-domestic student participants. Also the initial steps in validating HICAT are limited to one university medical school's clinical rotation over one academic year hence no claims can be made of its external validity. Likewise there is no longitudinal data using the HICAT survey by which face or content validity can be assessed (Sullivan, 2011). The authors intend these areas to be the focus of future research using HICAT.

The strengths of this study are its good response rate from students, minimal evidence of responder bias, and the anonymised survey format. The survey demonstrates satisfactory internal validity as students from certain demographics had differences in either their frequency of exposure or impact of exposure consistent with what could be anticipated based on these characteristics. For example, international students more often felt disadvantaged by their ethnic background than domestic students ($p < 0.001$), and male students experienced more gender discrimination than women ($p < 0.001$). Whilst these negative experiences from certain demographics merit analysis by Faculty to determine if these student experiences can be made more positive, they also demonstrate that the 20 question survey has good discrimination.

This study was part of a bigger research project which also evaluated the impact of the student's self-nominated experiences using a qualitative approach. Both studies had congruent findings in terms of the clear majority of students focussing on and being influenced by the positive aspects of the hidden/ informal curriculum.

The quantitative data was striking; more than 90% of student respondents had either "often" or "always" witnessed or experienced:

- high professional standards in their learning environments
- positive patient-doctor consultations
- health professionals who they considered were positive role models
- clinicians who inspired them to develop their doctor-patient skills
- health professionals dealing with complex cases in a positive manner

This reassuring finding is useful to feedback to staff in the educational and clinical environments to nurture and help sustain this positive culture.

When we examine the negative experiences or observations noted by students, albeit from a much smaller number of students, more than 5% of respondents had either "often or always" experienced or observed:

- hearing judgemental remarks about a patient in the clinical workplace
- needing to compete with other medical students
- feeling disadvantaged because of their gender

In a hidden / informal curriculum utopia there would be no negative experiences or observations made by medical students. However students work in the real clinical world of medicine- health professionals can suffer from compassion fatigue, there is competition for clinical experience and female patients tend to prefer female students (Carmody, Tregonning, Nathan, & Newnham, 2009; T. J. Wilkinson et al., 2006). As HICAT does not yet have longitudinal data or comparative data from other clinical rotations or educational institutions it is difficult to evaluate how much UWA Medical school should be concerned by the negative aspects of the student's experience.

The majority of students had positive experiences with the hidden/ informal curriculum (Figure 1), however 14% felt humiliated by a supervisor, 11% were troubled by their clinical experiences, and 5% had encountered health professionals who they considered were negative role models. Humiliation was the most common adverse experience described by medical students in the Wilkinson study (2006; 51% incidence), with 5% of students in their study saying that the experience would always be with them. In our study, 14% of students selected "Humiliated by a supervisor" to be one of their top three most influential experiences during the obstetrics and gynaecology rotation and it ranked as position 9/20 in terms of frequency of response (2% of respondents stating that they experienced this "often" or "always"). Humiliation was the 3rd most common negative experience ranked by students (disadvantage due to gender and hearing judgemental remarks about patients in the workplace ranked higher).

Although being reported by a relatively small number of respondents, other notable negative findings from the HICAT were that 3% of students felt that half the time they were asked to undertake tasks they felt under confident with performing (5% of students rated this in their top 3 hidden/ informal curriculum impacts). Eleven per cent of students heard judgemental remarks about patients in the clinical workplace and 21% of students felt that they needed to compete with other medical students half the time. The use of HICAT in a longitudinal setting (repeating it over time with different student cohorts) should provide an opportunity to identify and improve areas of concern identified by students based on their increased or persistently high reporting rates for the negative aspects of the hidden/ informal curriculum.

In summary, the Hidden Informal Curriculum Assessment Tool (HICAT) was developed to provide an instrument which could be used to quantify both the frequency of positive and negative aspects of the hidden /

informal curriculum and the “impact factor” of these experiences for medical students. In particular, we wanted to evaluate whether the instrument had internal validity by assessing whether the tool detected different exposures and experiences of the medical student cohorts based on the student’s gender and other demographics. Although HICAT has demonstrated some elements of internal validity, the data need to evaluate HICAT’s external validity is not yet available. Pending this, HICAT may prove to be a useful instrument for educational and health professional organisations to benchmark and identify the strengths and weaknesses of their hidden/ informal curricula.

Notes on contributors

Associate Professors Carmody, Tregonning and McGurgan all work and teach in the School of Women’s and Infants’ Health, The University of Western Australia, Perth. Their research interests include medical education with an emphasis on teaching and assessing professionalism.

Paul McGurgan designed and implemented the study with his co-authors, analysed the data and was the lead author of the manuscript.

Alexandra Tregonning designed and implemented the study, and contributed to the writing of the manuscript.

Diane Carmody designed and implemented the study, analysed the data and contributed to the writing of the manuscript.

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Declaration of interest:

The authors report no declarations of interest.

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Table 1. Demographic data for responders versus non-responders from the 5th year medical student group (N= number).

	Responders N=99 (%)	Non-responders N=66 (%)	p-value
Male	37 (37%)	38 (58%)	0.011
Undergraduate entry	75 (76%)	52 (79%)	0.651
Domestic students	84 (85%)	49 (74%)	0.091

Table 2. The frequency of responses for the medical students to the 10 positive hidden/ informal curriculum scenarios.

Scenario	N	Never-occasionally	Half the time	Often-always
I have observed high professional standards in my learning environments	96	1%	5%	94%
I have observed positive patient-doctor consultations	96	1%	6%	93%
I have encountered health professionals I consider were positive role models	97	4%	4%	92%
I was inspired to develop my doctor-patient skills	97	4%	5%	91%
I have observed health professionals dealing with complex cases in a positive manner	97	5%	4%	91%
I felt supported during my placements	97	2%	10%	88%
I have observed patients being treated as unique individuals	97	3%	9%	87%
I have observed health professionals educating patients about their condition	95	2%	15%	83%
I have witnessed health professionals going out of their way to assist colleagues	96	11%	24%	65%
I have witnessed staff acknowledging their limitations	97	55%	16%	29%

Table 3. The frequency of responses for the medical students to the 10 negative hidden/ informal curriculum scenarios

Scenario	N	Never-occasionally	Half the time	Often-always
I heard judgemental remarks about a patient in the clinical workplace	97	72%	11%	16%
I needed to compete with other medical students	96	69%	21%	10%
I felt disadvantaged because of my gender	97	82%	9%	8%
I have witnessed discriminatory attitudes in learning environments	96	95%	2%	3%
I have encountered health professionals I consider were negative role models	97	96%	1%	3%
I have felt humiliated by a supervisor	97	97%	1%	2%
I felt disadvantaged because of my ethnic background	95	98%	1%	1%
I have observed poor interprofessional team work	97	94%	6%	0
I was asked to undertake a task I was not confident to perform unsupervised	97	97%	3%	0
I was troubled with the experiences I encountered during my placements	97	99%	1%	0

Table 4. Demographic variables and the effect on frequency of responses to hidden/ informal curriculum scenarios

Scenario	Frequency of response*		p-value
	Data represents the median score (25 th -75 th percentile; minimum-maximum)		
	Male N=37	Female N=60	
I felt disadvantaged because of my gender	2 (2-2;1-3)	1 (1-1;1-3)	<0.001
I felt disadvantaged because of my ethnic background	1 (1-2;1-3)	1 (1-1;1-2)	0.007
I was troubled with the experiences I encountered during my placements	1 (1-2;1-3)	2 (1-2;1-2)	0.048
	Domestic N=82	International N=15	
I felt disadvantaged because of my ethnic background	1 (1-1;1-2)	1 (1-2;1-3)	<0.001
I felt supported during my placements	4 (4-5;2-5)	4 (3-4;2-5)	0.059

I have felt humiliated by a supervisor	1 (1-2;1-3)	1 (1-1;1-2)	0.069
	Undergraduate N=73	Postgraduate N=24	
I felt disadvantaged because of my gender	1 (1-2;1-3)	1 (1-1;1-2)	0.062

*Scores obtained using Likert scale: 1=never, 2=occasionally, 3=half the time, 4=usually, 5=always.

Table 5. The hidden/ informal curriculum impact rating determined by asking the male students (n= 36) to rank their three most influential experiences during the clinical rotation

Hidden/Informal Curriculum Scenario	% Response
I have encountered health professionals I consider were positive role models	49
I felt disadvantaged because of my gender	49
I felt supported during my placements	40

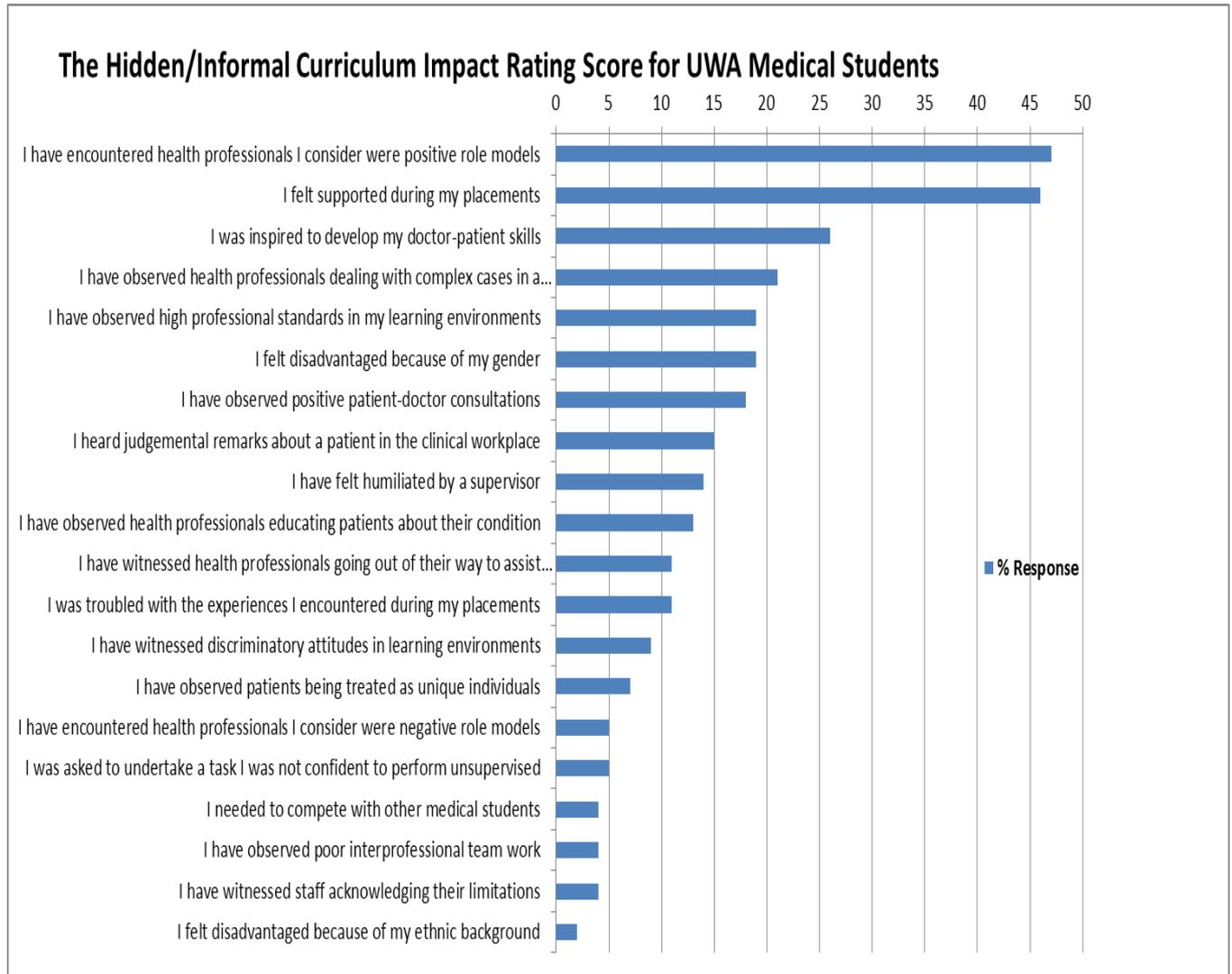
Table 6. The hidden/ informal curriculum impact rating determined by asking the undergraduate students (n= 75) to rank their three most influential experiences during the clinical rotation

Hidden/Informal Curriculum Scenario	% Response
I felt supported during my placements	49
I have encountered health professionals I consider were positive role models	46
I have observed health professionals dealing with complex cases in a positive manner	23

Table 7. The hidden/ informal curriculum impact rating determined by asking the overseas students (n=15) to rank their three most influential experiences during the clinical rotation

Hidden/Informal Curriculum Scenario	% Response
I felt supported during my placements	62
I have encountered health professionals I consider were positive role models	39
I felt disadvantaged because of my gender	39

Figure 1. Graph representing the hidden/ informal curriculum impact ratings determined by asking the students to rank their three most influential experiences during the clinical rotation



Appendix 1. Hidden Informal Curriculum Assessment Tool (HICAT)

Dianne Carmody, Lexie Tregonning and Paul McGurgan, teaching coordinators, at the School of Women's and Infants' Health (SWIH) invite you to participate in an educational study. Please read the following information to ensure you understand the study and what is expected of you should you choose to participate.

We would like to assess the hidden and informal curriculum in the unit of obstetrics, gynaecology and newborn medicine at the University of Western Australia. The terms hidden and informal curriculum describe the interpersonal processes, organisational structures and culture that influence both students learning and socialisation to professional behaviours and attitudes. These influences, often instrumental in student development, occur outside of the formally stated and endorsed syllabus. Examples of some of these processes and structures are: interactions with patients, health professionals and teachers; norms and implicit rules learnt to survive in the system; and immersion in the clinical culture. Students may be exposed to both positive and negative experiences in their encounter with the hidden and informal curriculum. Day-to-day examples of these experiences may include: witnessing a staff member behave in a discriminatory fashion to a patient; feeling unwelcome in a clinical placement; watching a skilled clinician work with a distressed patient or being a member of a well-functioning multidisciplinary team.

The study will utilize both qualitative and quantitative methods to collect data. Towards the end of term you will be asked to complete an on-line questionnaire on Survey Monkey. The questionnaire involves rating your response by a tick-box method to 20 questions and answering questions about your experience of the hidden and informal curriculum.

Information about the study will be given to you by a member of the study team and / or via this information sheet. All students will be sent an on-line request to participate in the final weeks of the term. If you choose to participate in the study your results will be collated in Survey Monkey and analysed when results are finalized.

It is not compulsory to participate in this study and your teaching and learning program in obstetrics and gynecology will not be affected in any way by your participation. Data will be stored at SWIH and no information identifying individuals will be incorporated in any publication. The overall results are expected to be used to review future delivery of obstetrics and gynaecology teaching programs.

If you choose to participate in this study we will acknowledge your participation as consent.

If you would like further information please contact Dianne Carmody, Lexie Tregonning or Paul McGurgan at SWIH on 9340 1330.

Please use the tick box to describe how often you relate to the statements about your experience in the hidden and informal curriculum in obstetrics, gynaecology and newborn medicine:

1. I have encountered health professionals I consider were positive role models

Never Occasionally Half the time Usually Always Not applicable

2. I have observed patients being treated as unique individuals

Never Occasionally Half the time Usually Always Not applicable

3. I needed to compete with other medical students

Never Occasionally Half the time Usually Always Not applicable

4. I was asked to undertake a task I was not confident to perform unsupervised

Never Occasionally Half the time Usually Always Not applicable

5. I have observed poor interprofessional team work

Never Occasionally Half the time Usually Always Not applicable

6. I was inspired to develop my doctor-patient skills

Never Occasionally Half the time Usually Always Not applicable

7. I heard judgemental remarks about a patient in the clinical workplace

Never Occasionally Half the time Usually Always Not applicable

8. I have witnessed staff acknowledging their limitations

Never Occasionally Half the time Usually Always Not applicable

9. I have observed positive patient-doctor consultations

Never Occasionally Half the time Usually Always Not applicable

10. I have witnessed discriminatory attitudes in learning environments

Never Occasionally Half the time Usually Always Not applicable

11. I have felt humiliated by a supervisor

Never Occasionally Half the time Usually Always Not applicable

12. I have encountered health professionals I consider were negative role models

Never Occasionally Half the time Usually Always Not applicable

13. I felt disadvantaged because of my gender

Never Occasionally Half the time Usually Always Not applicable

14. I felt disadvantaged because of my ethnic background

Never Occasionally Half the time Usually Always Not applicable

15. I was troubled with the experiences I encountered during my placements

Never Occasionally Half the time Usually Always Not applicable

16. I have observed health professionals educating patients about their condition

Never Occasionally Half the time Usually Always Not applicable

17. I have observed high professional standards in my learning environments

Never Occasionally Half the time Usually Always Not applicable

18. I have witnessed health professionals going out of their way to assist colleagues

Never Occasionally Half the time Usually Always Not applicable

19. I have observed health professionals dealing with complex cases in a positive manner

Never Occasionally Half the time Usually Always Not applicable

20. I felt supported during my placements

Never Occasionally Half the time Usually Always Not applicable

Impact rating

List which of the three experiences from above list (1-20) that had the most impact for you during clinical rotation (these do not necessarily need to be those which you experienced most frequently).