A Qualitative Exploration of How the Conflict Between the Formal and Informal Curriculum Influences Student Values and Behaviors

Casey B. White, PhD, Arno K. Kumagai, MD, Paula T. Ross, MA, and Joseph C. Fantone, MD

Abstract

Purpose

The third-year students at one medical school told the authors that values core to patient-centered care were impossible to practice in clerkships, in a culture where supervisors role modeled behaviors in direct conflict with patient-centered care. As they developed a new medical student curriculum, the authors designed the Family Centered Experience (FCE) to help students achieve developmental goals and understand the importance of and provide a foundation for patient-centered care.

Method

The authors solicited members of the first cohort to complete the FCE (the class of 2007) to participate in this focus-group-based study halfway through the third year. They explored the influence of the FCE on students' experiences in the third-year clerkships, and how conflicts between the two learning experiences shaped these students' values and behaviors.

Results

Students reported that during clerkships they experienced strong feelings of powerlessness and conflict between what they had learned about patient-centered care in the first two years and what they saw role modeled in the third year. Based on students' comments, the authors categorized students into one of three groups: those whose patient-centered values were maintained, compromised, or transformed.

Conclusions

Students revealed that their conflict was connected to feelings of powerlessness, along with exacerbating factors including limited time, concerns about expectations for their behavior, and pessimism about change. Role modeling had a significant influence on consequences related to students' patient-centered values.

Acad Med. 2009; 84:597–603.

The process by which medical students acquire the knowledge and develop the skills they will need and use as physicians requires a multidimensional learning environment with classroom, laboratory, and clinical training.[1] However, much of the professional socialization of medical students into the practice of medicine takes place outside of the formal instructional milieu, and some of what is learned in this "informal curriculum" might be in conflict with the explicit goals and content articulated by the school.[2] Research has shown that medical students often learn the values and ideology of the profession by observing the behavior of those in the positions to which they aspire.[2–4] Through this process of observing, students typically experience pressure to conform to and adopt values and behaviors not espoused by the formal curriculum as normative characteristics of the physician's role.[3,5,6]

In annual surveys and comments from our third-year students who returned from clerkships to participate in exercises with standardized patients, we frequently heard that many of the clinical skills they learned as first- and second-year medical students—particularly those core to patient-centered care—were idealistic and impossible to practice in the world of real medical care. In fact, they were not just impossible to practice because of productivity expectations and time pressures, they were impossible to practice in a culture in which supervisors often modeled behaviors in direct conflict with patient-centered care.

This conflict of values was not a local problem.[7] At least one medical school found a measurable decrease in students' empathy levels between entry into and graduation from medical school.[8] Others have reported student observation of actions that included deliberate lies and deception, breaches of confidentiality, discriminatory treatment, and noncompliance with informed consent policies.[9] In a survey of third- and fourth-year medical students in Pennsylvania medical schools, 98% reported hearing physicians refer to patients in a derogatory manner, and 61% reported seeing unethical behavior.[10] Researchers conducting that study found that seeing unethical behavior correlates with a greater likelihood of students behaving unethically themselves.[10] A smaller study concluded that the more senior the students, the more likely they believed that such behavior was appropriate.[11]

Despite the seeming pervasiveness of decreasing ethical and empathetic behavior, few have offered solutions, particularly feasible solutions. In response, we deepened our commitment to helping our students develop principles and values linked with patient-centered care, and we concerned ourselves with preparing them to preserve these in spite of what seemed to

Dr. White is assistant dean and assistant professor of medical education, University of Michigan Medical School, Ann Arbor, Michigan.

Dr. Kumagai is associate professor of internal medicine and director, Family Centered Experience Program, University of Michigan Medical School, Ann Arbor, Michigan.

Ms. Ross is research associate, University of Michigan Medical School, Ann Arbor, Michigan.

Dr. Fantone is professor of pathology and associate dean for medical education, University of Michigan Medical School, Ann Arbor, Michigan.

Correspondence should be addressed to: Dr. White, University of Michigan Medical School, 1135 E. Catherine St., 3960 TML, Ann Arbor, MI 48109-5726; telephone: 734-763-6770; e-mail: (bcwhite@umich.edu).

be overwhelming obstacles. Preservation of personally held values in the face of conflict requires fairly advanced cognitive and professional development. Medical educators cannot assume advanced levels of development for all medical students, and we had not previously designed learning activities to foster development nor integrated any into our curriculum, particularly in the first and second years.

After a review of evidence-based developmental schema that included Perry[12] and King and Kitchener,[13] we selected one created by Kegan[14] that described specific characteristics of advanced development, or "self-authorship"; these characteristics include autonomy, responsibility, and critical thinking. Kegan describes a development scale from the first "order" (infancy) to the fifth (middle to late middle age, if achieved at all), with transition stages between each order. The first order is impulse driven, and perception is reality; that is, if an infant sees a picture of a donkey flying, that means donkeys fly. In the second order, a person can coordinate impulses and establish a personal point of view; individuals now understand that different people have different perceptions. Individuals in the third order recognize that they exist within a broader context in which they play a role; the values and expectations of others influence them. Self-authorship characterizes the fourth order. Self-authors are able to self-initiate, self-correct, and self-assess, without necessarily having to depend on others to frame problems or articulate needed adjustments. Most people do not achieve the fifth order, in which individuals continuously explore and question their self-identity; connections with others enhance and sharpen this exploration.[14]

This schema complemented our intended learning outcomes as autonomy, responsibility, and critical thinking are characteristics demonstrated by high-functioning physicians. Pedagogical approaches that help students achieve self-authorship emphasize active learning methods, self-regulated learning, peer teaching and assessment, and problem solving/critical thinking.[13,15] Baxter Magolda's[16] research, for example, provides evidence of links between self-authorship and constructivist approaches to learning—that is, active approaches through which faculty and students work through problems and construct knowledge together, thereby learning from each other; through which faculty expect students to carry more than minimal responsibility for monitoring or self-regulating their own learning and achievement of their own goals; and through which students hold responsibility for teaching and assessing their peers. Thus, the role of educators is to guide students but also to place increasing responsibility on their shoulders. This transfer of responsibility helps students mature in terms of developing into professionals and lifelong learners, and it prepares them to construct their own values and standards rather than relying solely on others/experts to ensure that they achieve their educational and professional goals.

As we developed and implemented (in 2003) a new medical student curriculum, we designed the Family Centered Experience (FCE) to help students understand and achieve self-authorship goals and to help them understand the value of humanistic, patient-centered care.[17] Characteristics of patient-centered care include respect for and attention to the patient's preferences and values, emotional support, physical comfort, and recognition and involvement of family and friends.[18,19]

In the FCE, which is now a required course for all first- and second-year medical students, we match pairs of students with a patient with a chronic or serious illness; the students visit and talk with their patient and family at home and accompany them on at least one clinic visit.[20] In addition to the visits, the FCE incorporates patient narratives (the patient's description of his or her own illness journey), reading/writing (e.g., reflective essays on personal experiences related to illness, or books and articles that describe and address others' experiences with illness), and interpretive projects (multimedia representations of the students' relationship with their patient and family) into small-group discussions centered on specific themes (e.g., the nature of illness, the patient–physician relationship, stigma) preselected by the course directors based on learning outcomes. Discussions are based on a developmental framework (there are no didactic presentations). To foster cognitive and professional development concretely, we expect students to take active responsibility for their own learning and that of their peers, to bring and share relevant personal experiences to the discussion, to incorporate evidence into theme-based discussions, and to develop and demonstrate leadership, reflection, critical thinking, and self-assessment in moderating and participating in discussions. These are characteristics of adult learners as self-authors.[14]

In this study, we explored the influence of the FCE on students' experiences in the third-year clinical clerkships, and how conflicts between the two learning experiences shaped values and behaviors of third-year medical students. We hypothesized that those who had achieved higher levels of development (i.e., self-authorship) would demonstrate evidence of that development through maintaining patient-centered values in spite of conflicting role modeling and perceived expectations.

Method

All first- and second-year medical students (170 per class) participate actively in a longitudinal course, the FCE. The FCE espouses principles of patient-centered care through visits and conversations with patients and their families, and through student-moderated small-group discussions.[20] We recruit FCE patient volunteers through advertisements in the university clinics and by word of mouth. Interested patients/families complete application and consent forms, and the FCE course director (A.K.K.) or associate director (both physicians) interview each applicant before he or she is accepted into the program.

Students contact their patient and family directly within a specified time frame that is linked to small-group discussions in order to arrange each of the five visits (across two years); visits are usually two to three hours long and almost always in the patient's home. We also require a sixth meeting, a visit to the clinic with the patient. Once or twice a year, a patient is no longer willing or able to continue in the program. In this circumstance, the course director assigns the student pair to another patient (we maintain a waiting list of patients wanting to participate). Even more rarely, one or both of the

students sense that the patient has an agenda not focused on education or that the patient is just not really interested in participating. In this circumstance, the course director (A.K.K.) calls the patient and determines whether assignment of a new patient is necessary.

A few weeks after each scheduled visit, students engage in a small-group discussion on the theme of that particular visit as it related to their meetings with patients and families. The students bring in written essays and other assignments to trigger personal connections to the discussion. Group size is 11 or 12 students; the pairs of students assigned to a particular patient/family are separated, and each student is assigned to a different small group, so there is representation of 11 or 12 different patients in each group. Clinical faculty facilitators guide the discussions, but students lead and moderate. Each group maintains the same composition, including the same faculty facilitator, throughout the course. Groups reconvene for reunion sessions in the third year; faculty do not assess students at these third-year sessions, which we designed to help them explore similar issues (the nature of illness, etc.), now that they have had concrete clinical experiences.

Using a checklist with specific anchors, faculty facilitators assess each student's development (quantitatively and qualitatively) five times throughout the first two years, based on characteristics of self-authorship as noted above (e.g., leadership, reflection, critical thinking) and also on the quality of moderating and participation. Students receive one-to-one feedback from their facilitator at each grading period. Peer assessment is done but is more informal, and a checklist is not used.

The purpose of this study was to understand how the knowledge, attitudes, behaviors, and skills learned in the FCE influenced students' clinical clerkship experiences. We solicited members of the first cohort to complete the FCE (the graduating class of 2007) to participate in this study at the conclusion of their first six months of clinical clerkships. A semistructured protocol that included open-ended questions guided focus-group discussions; we designed the questions to capture the diversity of unique experiences and opinions and to allow students to use their own words (List 1).[21] We limited the size of each group to 10 students to allow each of them the opportunity to become engaged in the dialogue. The FCE administrator selected students randomly and contacted them by electronic mail. We purposefully included two students (one man and one woman) from each of the 15 FCE groups to achieve a stratified sample; the selection process continued until a total of 10 participants had been selected for each of the three focus groups. Three groups of 10 students were sufficiently reflective of the study population.

Each of the three sessions lasted 60 to 90 minutes. A final sample of 27 students, consisting of 13 men and 14 women, participated in the study (three of the students did not attend the groups in the end because of clinical responsibilities). One of us (P.R.) and another staff member facilitated the focus groups in November 2005. In the groups, we asked the students to discuss how the FCE influenced their experiences on the clerkship (List 1).

At the beginning of each focus group, student volunteers received a full description of the study and provided written informed consent for participation, including permission to videotape. Our institutional research board reviewed and approved this study. The audiotapes from each focus group were transcribed verbatim, and to maintain the participants' anonymity from those of us with teaching responsibilities, all identifiable information was removed from the transcripts.

Using grounded theory analysis methodology,[22] three of us (C.B.W., A.K.K., P.T.R.) read through the transcripts several times in an open coding process, through which we identified specific codes that emerged from the transcripts (e.g., Powerlessness, Time, Compassion, System/Culture). We met and, through continuous discussion and comparison of individually developed codes, devised mutually agreed-on codes. One of us (C.B.W.) consolidated the codes into themes, which another (J.C.F.) validated against the transcripts to ensure appropriateness. When this was complete, we performed axial coding[22] to understand the connections between general thematic categories and the variations of responses (subcategories) comprising the general themes. Close analysis of the transcripts revealed saturation of the themes derived from the analysis; that is, open and axial codes appeared repeatedly in the transcripts. We agreed that additional focus groups would garner no new information.

Results

Two major themes emerged from the transcripts: (1) conflict exists between values adopted in the first two years and values observed in the third year and (2) third-year students feel a sense of powerlessness in general, but especially in the context of addressing (or not addressing) the conflict. The majority of students who participated in this study reported that, on the clinical clerkships, they experienced a constantly reinforced feeling of powerlessness, which they attributed to being the "lowest of the low" in the chain of health care providers. Over the years, many of our medical students transitioning from classroom to clerkship have described these feelings of powerlessness. In fact, many consider such feelings to be a rite of passage into the world of clinical care.

What we heard from students that was new and that could be attributed to goals and experiences specifically integrated into the 2003 curriculum was that they were also experiencing strong internal

List 1
Sample Focus Group Questions

Please comment on whether you were able to extend the skills you acquired in the Family Centered Experience (FCE) to your clerkships in these areas, and whether you observed these role modeled on your clerkships.

1. Taking a thorough patient history
2. Developing good communication skills (e.g., rapport, trust, respect, listening)
3. Using effective nonverbal skills
4. Assisting the patient with social services

Please comment on whether you were able to extend the attitudes and behaviors you acquired in the FCE to your clerkships in these areas, and whether you observed these role modeled on your clerkships.

1. Awareness of patient's beliefs, values, culture(s), age, and gender
2. Accountability and commitment to patients and families
3. Compassion toward the patient
4. Respect for confidentiality related to patient
5. Effective trust and rapport with family

conflict with what they had learned about patient-centered care in the first two years and what they saw role modeled in the third-year clerkships. They said that they felt as if they were expected to behave in the same manner as that role modeled, which exacerbated the conflict. The powerlessness they all felt, combined with the conflict, created an interaction leading to three potential outcomes: (1) Values Maintained, putting patient-centered values into practice in spite of entry into a conflicting culture in which they had no authority or power, (2) Values Compromised, struggling to fit in with the culture, the sense of powerlessness overwhelming personal values, or hopeful that—if not now, then at least in the longer term—they would be able to behave based on these values, and (3) Values Transformed, rejecting patient-centered values as irrelevant and unrealistic in the real-world clinical milieu. Their reaction to the powerlessness and conflict slotted them into one of the three categories.

Values maintained

Some students felt able to take specific action that demonstrated they were holding firmly to the patient-centered values they had adopted. These very acts could be interpreted as evidence that the students in this group had become self-authors. Despite role modeling and expectations for their behavior that conflicted directly with patient-centered values discussed in the first two years, these students found ways to maintain espoused values:

> Usually I end up going back into my patient's room and, because there are a lot of times we make a plan and no one tells the patient what that plan is—we're just outside of the room talking about it—if I have extra time I usually go back and say "This is what the plan is today."

> It doesn't take too much extra time, [particularly] if someone's crying. Just take a moment and validate that; recognize it instead of ignoring it. That's not too much to ask.

> This year, I've watched attendings go in a [patient's] room and go like "You have this" and walk out. So when I go in, in the mornings, if they [my patients] have questions, I explain to them as best I can because they're probably not going to hear that from anyone else. Nobody really cares if a patient doesn't understand what's going on.

Many students described their reactions, as opposed to actions, in the face of the conflict they were experiencing:

> It's when the physician runs through a whole list of "you have to remember to take this medicine here and this medicine there and go do this and that" and then just walks out of the room without writing a list or asking if [the patient] remembers those things—you just feel really uncomfortable being associated with that physician.

Some comments demonstrated that students were not only maintaining the values they adopted from principles espoused in the FCE but also that they were using their own judgment as to what fit them best, given their own personal beliefs and values:

> Sometimes when I'm working now I remember things I learned [in the FCE] and I emulate the things they [FCE faculty] said that made sense for me.

Positive role modeling allowed students to cut through the conflict and to connect FCE goals with patient-centered care:

> The best I've seen so far is Peds outpatient. The point of the well child visits is to go in and find out what's going on at home and what's going on in school and touch on the things we kind of got drilled into our head in the FCE, which is good and I think that's why I love it so much.

> Right now one of my attendings is fairly good about trying to see the patient as a whole, even though he's a specialist, and I find that inspiring. I feel like he does a good job of taking into account how the illness is affecting the person.

Values compromised

Time was a driving factor in student values that were compromised. Most of the students worried about slowing down the team, and they also believed that the behaviors they observed in the negative role modeling they saw were the product of time pressure. Several students, when confronted with conflicts between patient-centered values and behaviors inconsistent with these values, reacted emotionally to the conflict (i.e., they said they felt "sad," "frustrated," "upset"). We could interpret these reactions as evidence that these students were transitioning developmentally to the fourth order, self-authorship. That is, they felt strongly that what they observed was not consistent with what they had learned in the FCE, even though they felt powerless to do anything about it:

> It's kind of sad but if you actually try to apply some of [the FCE principles] and try to spend extra time with them [patients], you're just holding someone else up. So a lot of time you just go in there and do what you're supposed to do and quite possibly you won't ever see that person again.

> There's no time for compassion. You just need to be in with the patient for four minutes and get done and get your [paperwork] done. We're all really upset and maybe it's because we've seen a little bit of the light.

> I feel like I thought I was always [going to] be able to be really nice to people and give them my full attention. There have occasionally been breakdowns just when I'm really tired and I know I have to be somewhere or someone's going to yell at me or I'll lose the team and have to page them and they'll be mad, and you cut someone off in the middle of something or just do something that would be really out of character for me if I was in control of my own time.

One student described a particular moment of conflict:

> This was a surgery clinic and this woman was like "I'm depressed, I don't want to leave my house, I don't want to live anymore." The surgeon was like "You need to get up and walk around and get some circulation." Then he left and I'm sitting there and I know I need to go but I also need to do something but I'm only a med student. What I needed to do was get out of there and move on to the next patient so we wouldn't get backed up. You are caught between what you are told to do and what you really should do.

Some of the students' comments indicated that they were holding onto their values for later, when they had more authority or power, but for now they gave in to pressure to behave in ways that conflicted with FCE principles:

> It's hard to change the entire system and instead what I can do is recognize every time I'm frustrated that … I'm going to put up with two more years of being quiet so that hopefully there's enough frustration in me that for the next 40 years as a practicing physician I don't do that.

> When you only spend five minutes talking to somebody about what's going on you feel guilty … but there's nothing you can do about it so you just kind of accept it and move on. Maybe one day when we're out of med school, maybe

> some of [us] will remember something we learned in the FCE and we'll have the time and make the decision to apply it.

Many students linked their struggle to mixed messages between the preclinical curriculum and the hospital-based clinical experiences:

> What are the goals here? Because it's tough. We have one set of faculty telling us X [one way] and the med school faculty telling us the other way. They need to be on the same team.

Some also linked their struggle to role modeling:

> It's hard for "third-years" [students] now that we're in this time warp. Maybe the FCE would be beneficial for our attendings—that might shape the way we interact with patients. Because right now we're just focused on the system and how it sucks.

Values transformed

Some of the comments described a mix of the powerlessness and the loss (in some cases, pending loss) of the patient-centered values. Their comments provided evidence that these students had surrendered patient-centered values to survive within the clinical environment, allowing those around them to dictate values and behaviors. In doing so, these students were demonstrating behaviors consistent with a lower developmental level (i.e., the third order). We also observed evidence of a distinct shift in attitude with regard to patient-centered values:

> It's nice to be taught all this "touchy feely" medicine but if you're looking at realistic medicine … the fact of the matter is you have 15 minutes to talk to patients.

> This year has made even [those of us] who cared the most become so cynical. We are on the bottom of everything. We simply have to do what we are told and we don't have any say in anything. They don't care what we have to say.

Some showed a transformation that was—surprisingly—almost complete halfway through the third-year clerkships:

> It's really hard to apply how we feel now as opposed to how we felt back then (in the first and second years). I feel a lot more cynical—my mind is so different now.

Sometimes, along with evidence of transformed values was a sense of pessimism and a feeling that the system attributed to and reinforced the feeling of powerlessness:

> You're not going to make changes by doing something like the FCE. All the incentive is to be less caring.

> You need to do what you're told and nothing else.

Also underlying these students' transformation was a recognition that the house officers and the attendings they were working with would be evaluating their clinical performance and that they might have to ask these attendings for letters of recommendation. Their strongest motivation was to fit in and do whatever was expected of them:

> Most of what you're graded on is all the paperwork you do. [You do that] if you want to be looked on favorably. I spent way more time on paperwork than I ever did caring for patients.

Again, many of the students linked their transformation with negative role modeling, or a system that rewarded physician-centered behavior:

> Our role model is supposed to be the attending, but we never see the attending, we see the residents who are so stressed for time they don't have time to practice [patient-centered] skills.

> We don't sit and talk about [the patient's] spiritual means of dealing with their illness. It's not important to them (attendings and residents), so it's not important to us.

Discussion

We can conclude from research-based evidence on developmental progression that individuals mature at different rates; that is, some students enter medical school having achieved an advanced developmental level, whereas others have not.[13,23] On the basis of his research, Kegan[14] advises that, through pedagogy, educators can intentionally help learners to advance developmentally. Research also provides evidence that, in ages ranging generally from the early to mid 20s, peers and mentors can still shape or influence an individual's values.[16]

We designed a curriculum intended to achieve developmental progression as well as development of and commitment to patient-centered values. This study constituted an investigation into students' descriptions of their experiences to determine whether they had adopted personal values related to patient-centered care and whether they maintained these values in the face of conflicts they encountered on the clinical clerkships.

The students' comments revealed that the conflict we had anticipated was closely connected with feelings of significant powerlessness, along with interacting and exacerbating factors that included limited time, concerns about how they were expected to behave that were linked to concerns about assessment (of their performance), and pessimism about change. Especially given their sense of powerlessness, role modeling—both positive and negative—had a significant influence on consequences related to students' patient-centered values. From these findings, we were able to construct a grounded theory model (Figure 1).

Medical schools rely on physician role modeling as an important component of clinical education, and its influence on medical students as they try to fit into a new, frightening, and evaluative environment cannot be overstated.[24] In part, as studied and described in the literature on social learning theory,[25] students learn how to be clinicians by observing and interacting with them. Students are eager to fit in and earn favor; in this sense, the values and actions of those in positions of authority impress them extraordinarily. Thus, we were not surprised to find a strong connection between students' values and the role modeling of others.

The experiences described by the medical students in this study are not new in medical education. In the 1980s, Conrad[26] described "sleep-deprived and stressed medical students who spend more energy on preserving face than on absorbing knowledge." As they begin and progress through the clerkships, they have already learned that their time is no longer something they control,[27] and they suffer with an overwhelming need to be accepted in the clinical milieu. This need to survive the rough transition from one culture to another, completely different culture is at the very root of the values conflict related to patient-centered care. Konner[28] and others[29,30] described doctors who role modeled controlling and demeaning exchanges with their

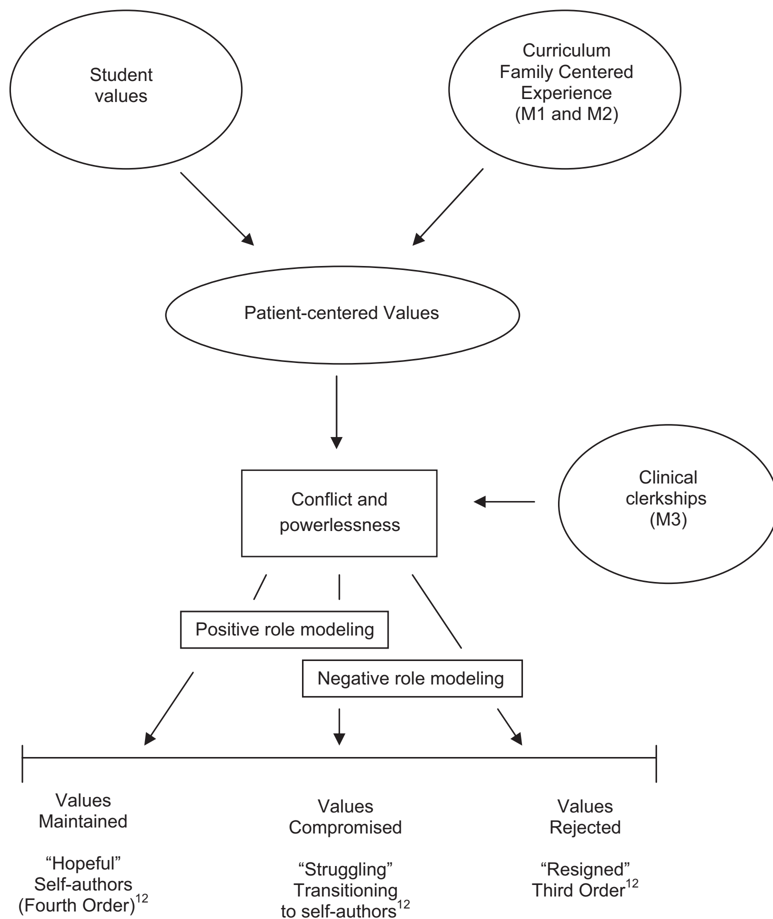

Figure 1 Grounded theory: Students' experiences with value conflicts on the clinical clerkships. M1, M2, and M3 = first-, second-, and third-year medical students, respectively.

patients, who focused on disease rather than individuals ("The lymphoma in Room 304"), and who discussed patients with their team as if the patients were not in the room. Twenty years ago, Conrad[26] concluded that medical education does "precious little" to facilitate patient-centered care.

What *is* new in medical education is that society is pushing back on medical practice—and medical practice is pushing back on medical schools—to fix communication problems between physicians and patients, some of which are attributed to disparities in medical outcomes, now considered to be a significant, national health care dilemma.[31] Underlying the communication problems are physician attitudes and values that pervade the culture of medical practice. Third-year medical students begin clinical training in the midst of this entrenched culture, with no power or authority to change it and little insight into how to hold onto patient-centered beliefs and behaviors that, in many cases, do not seem to be important or valued.

Students who participated in this study were members of the first class to complete a new curriculum with elements intentionally designed both to foster cognitive and professional development and to help students develop and maintain values that are core to patient-centered care. We hypothesized that if we could help students become self-authors *before* entry into the clerkships, they might be better equipped to maintain patient-centered values despite conflicting role models and expectations for third-year students to conform to the clinical culture.

In the third month of the clerkship year, all students in this class (2007) met once with their small group and their faculty facilitator from the first- and second-year FCE experience. The purpose of this reunion was to provide students with a safe and comfortable environment within which to discuss links and conflicts between the values they developed in the first two years and the behaviors they encountered in the third year. In their groups, students passionately shared the many conflicts they experienced, along with their feelings of powerlessness and frustration, and the influence of these on their own values and behaviors.

The reunion gave the facilitators an opportunity to listen reflectively, to validate the students' accounts of their experiences, to build on positive role modeling, and to reinforce that conflict was natural when values clashed. As positive role models themselves with strong connections to the students in their groups, faculty facilitators were in a position to provide powerful reinforcement of patient-centered values and to share their own techniques for maintaining patient-centered values and behaviors in the face of productivity and time demands. In fact, in a recent, related study the faculty facilitators reported to us that the discussions with their student groups had fostered reflective approaches to their own patient care and teaching, had enhanced interpersonal relationships between them and their students, colleagues, and patients, and had been a source of fulfillment and renewal for them.[32]

After that first reunion meeting in 2005, we invited students to participate in this study, aimed at understanding and documenting their clinical experiences in the context of the FCE goal to foster patient-centered care. We decided, on the basis of student feedback, to expand the number of reunion meetings in the future. Students now reunite with their FCE group and facilitator four different times during the third year. So far, anecdotal feedback on these sessions indicates that they are critical to helping students understand and handle the conflicts they experience in the third-year clerkships, giving them an opportunity to share positive and negative feelings and providing a safe haven within which to reinforce values that are foundational to patient-centered care.

Conclusions

We undertook this study to explore the influence of the FCE on students' experiences in the clerkships, in the context of patient-centered values. We hypothesized that we would find conflict, and we did. We also found that the combination of conflict and powerlessness, supported or mitigated by the influences of negative and positive role modeling, led to

three possible consequences: Students' patient-centered values were maintained, compromised, or rejected. This study sheds light on how students' specific clerkship experiences influenced their patient-centered values. As educators, our short-term goal is for students to be able to maintain patient-centered values through the clerkships. Our long-term goal is that they, as practicing physicians, will become agents of change through their own behaviors and, ultimately, will dismantle the negative influences of the "hidden curriculum" and reinforce values associated with patient-centered care. We are currently studying whether continuous support through the clerkships—in the form of FCE reunion sessions with familiar and influential clinical role models—moderates negative and unintended consequences.

References

1. Merton RK, Reader G, Kendall PL, eds. The Student–Physician: Introductory Studies in the Sociology of Medical Education. Cambridge, Mass: Harvard University Press; 1957.
2. Hafferty FW, Franks R. The hidden curriculum, ethics teaching, and the structure of medical education. Acad Med. 1994;69: 861–871.
3. Gofton W, Regehr G. What we don't know we are teaching. Unveiling the hidden curriculum. Clin Orthop Relat Res. 2006;449: 20–27.
4. Thiedke C, Blue AV, Chessman AW, Keller AH, Mallin R. Student observations and rating of preceptor's interactions with patients: The hidden curriculum. Teach Learn Med. 2004;16:312–316.
5. Reisman AB. Outing the hidden curriculum. Hastings Cent Rep. 2006;36:9.
6. Shuval JT, Adler I. The role of models in professional socialization. Soc Sci Med. 1980; 14A:5–14.
7. Goldberg JL. Humanism or professionalism? The white coat ceremony and medical education. Acad Med. 2008;83:715–722.
8. Newton BW, Barber L, Clardy J, Cleveland E, O'Sullivan P. Is there hardening of the heart during medical school? Acad Med. 2008;83: 244–249.
9. Caldicott CV, Faber-Langendoen K. Deception, discrimination, and fear of reprisal: Lessons in ethics from third-year medical students. Acad Med. 2005;80:866–873.
10. Feudtner C, Christakis D, Christakis NA. Do clinical clerks suffer ethical erosion? Students' perceptions of their clinical environment and personal development. Acad Med. 1994;69: 670–679.
11. Satterwhite WM 3rd, Satterwhite RC, Enarson CE. Medical students' perceptions of unethical conduct at one medical school. Acad Med. 1998;73:529–531.
12. Perry WG. Forms of Intellectual and Ethical Development in the College Years: A Scheme. New York, NY: Holt, Rinehart and Winston; 1970.
13. King P, Kitchener KS. Developing Reflective Judgment: Understanding and Promoting Intellectual Growth and Critical Thinking in Adolescents and Adults. San Francisco, Calif: Jossey-Bass; 1994.
14. Kegan R. In Over Our Heads: The Mental Demands of Modern Life. Cambridge, Mass: Harvard University Press; 1994.
15. Belenky MF, Clinchy BM, Goldberger NR, Tarule JM. Women's Ways of Knowing: The Development of Self, Voice and Mind. New York, NY: Basic Books; 1986.
16. Baxter Magolda MB. Creating Contexts for Learning and Self-Authorship: Constructive-Developmental Pedagogy. Nashville, Tenn: Vanderbilt University Press; 1999.
17. Kumagai AK. A conceptual framework for use of illness narratives in medical education. Acad Med. 2008;83:653–658.
18. Committee on Quality of Health Care in America, Institute of Medicine. Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, DC: National Academy Press; 2001.
19. Gerteis M, Edgman-Levitan S, Daley J, Delbanco TL. Through the Patient's Eyes: Understanding and Promoting Patient Care. San Francisco, Calif: Jossey-Bass; 1993.
20. Kumagai AK, White CB, Schigelone A. The family centered experience: Using patient narratives, student reflections, and discussions to teach about illness and care. Ann Behav Sci Med Educ. 2005;11:73–78.
21. Morgan D. Focus groups. In: Hesse-Biber SN, Leavy P, eds. Approaches to Qualitative Research: A Reader on Theory and Practice. New York, NY: Oxford University Press; 2004.
22. Glaser BG, Strauss AL. The Discovery of Grounded Theory: Strategies for Qualitative Research. Chicago, Ill: Aldine; 1967.
23. Tennant M, Pogson P. Learning and Change in the Adult Years: A Developmental Perspective. San Francisco, Calif: Jossey-Bass; 1995.
24. Wright S, Wong A, Newill C. The impact of role models on medical students. J Gen Intern Med. 1997;12:53–56.
25. Regehr G, Rajaratanam K. Models of learning: Implications for teaching students and residents. In: Distlehorst L, Dunnington G, Folse JR, eds. Teaching and Learning in Medical and Surgical Education: Lessons Learned for the 21st Century. Mahwah, NJ: Lawrence Erlbaum Associates; 2000.
26. Conrad P. Learning to doctor: Reflections about recent accounts of the medical school years. J Health Soc Behav. 1988;29:323–332.
27. LeBaron C. Gentle Vengeance: An Account of the First Year at Harvard Medical School. New York, NY: Penguin; 1982.
28. Konner M. Becoming a Doctor: A Journey of Initiation Into Medical School. New York, NY: Viking; 1987.
29. Klass P. A Not Entirely Benign Procedure: Four Years as a Medical Student. New York, NY: Putnam; 1987.
30. Reilly P. To Do No Harm: A Journey Through Medical School. Dover, Mass: Auburn House; 1987.
31. Smedly BD, Stith AY, Nelson AR, eds. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington, DC: National Academies Press; 2003.
32. Kumagai AK, White CB, Ross PT, Perlman RL, Fantone JC. Impact of facilitation of small group discussions of psychosocial topics in medicine on faculty growth and development. Acad Med. 2008;83:976–981.