Collection III. Episode 17: 'Being on Both Sides': Canadian Medical Students' Experiences With Disability, the Hidden Curriculum, and Professional Identity Construction."

[Introduction]

Lisa Meeks: Hello! And welcome to the Research and Resource Rounds Podcast, an offshoot of our Docs With Disabilities Podcast.

Peter Poullos: Every month we will bring you two episodes of our new mini-cast. Each mini-cast reviews a research article or commentary about disability in medical education.

Zoey Martin-Lockhart: We bring you, the listener, an easily digestible way to become familiar with this growing body of literature.

Research outcomes and calls to action within the literature are then paired with parallel resources for improving the inclusion of healthcare learners, trainees, and professionals with disabilities.

We also explore publications that address the status of, need for, and benefits of disability representation among the medical education curricula.

Lisa Meeks: In the process we hope that you, our listeners, learn more about the research and resources in this area

Peter Poullos: and find some new ways to conceptualize disability and why it belongs in medicine.

Lisa Meeks: I'm Lisa Meeks,

Peter Poullos: I'm Peter Poullos, and

Zoey Martin-Lockhart (ZML): I'm Zoey Martin-Lockhart, the curator and co-host of research and resource rounds and we are thrilled to bring you this important and impactful information.

[Narration]

ZML: Today on research and resource rounds we're discussing "'Being on Both Sides': Canadian Medical Students' Experiences With Disability, the Hidden Curriculum, and Professional Identity Construction." Erene Stergiopoulos, Oshan Fernando, and Maria Athina Martimianakis published this piece in 2018 in Academic Medicine.

Their research article investigates how medical discourses shape the conceptualizations of the prototypical "good medical student" and "good patient" roles as featuring mutually exclusive characteristics. They explore how disabled medical students' experiences during training and professional identity construction are shaped and hold complexity as students navigate positions in both these roles—as both patients and medical trainees.

Methodologically, the authors drew on critical discourse analysis to analyze text and interviews, developing codes informed by academic work on the Hidden Curriculum and professional identity construction. They drew on textual materials from 13 universities in Canada that discussed medical student wellness and carried out 10 interviews with University of Toronto medical students who identified as having a disability. At publishing, the authors were unaware of research covering medical students' professional identity construction. The article appendix contains the interview question guide.

The authors describe the Hidden Curriculum as "a theoretical concept describing the learning that takes place outside of course syllabi and lecture slides, and instead emerges implicitly from institutional policies, practices, resource allocation, evaluation, and institutional nomenclature" (p. 1551). They cite Hafferty, who helped coin the term, to explain that the Hidden Curriculum is created by, and partially comprised of micro-components of medical pedagogy and practice that are so familiar they become invisible and their powerful contributions to the collective vector of medical culture is overlooked. Hafferty, in his 1998 piece "Beyond curriculum reform: confronting medicine's hidden curriculum," includes amongst these unnoticed components [quote]: "commonly held 'understandings' customs, rituals, and taken for granted aspects" [close quote].

Disjuncture and contradictions between signals sent by the formal and hidden curricula are common.

I'll note that folks use "the hidden curriculum" in a variety of related senses. Some scholars use the phrase to broadly reference various messages and learning absorbed during medical training that are *not* official or that occur outside a classroom or training session. Others seek to parse the concept into component constructs—the shadow, the informal, and the invisible curriculums are among these. Check out the resources recommended at the end of this mini-cast for a few pieces that theorize the Hidden Curriculum.

The article begins by highlighting the concerningly small prevalence of disabled medical trainees and practitioners, particularly highlighting the substantial discrepancy between the prevalence of medical trainees who indicate disability identification and the prevalence who disclose to and seek accommodations from their institution. The authors point out that their article offers a key reframing: they regard experiences of patienthood and disability as a type of expertise, a knowledge that's particularly valuable for providers to have or learn from rather than one that is somehow contrary to medical competence or professionalism. Literature reviewed in the article's introduction documents ableist bias and assumptions that manifest both implicitly and explicitly across spheres of the medical ecosystem, including in: institutional policies, doctors' social exchanges with colleagues, language and tone used in training, and more.

[Short musical interlude]

While the authors sought methods for increasing wellness and decreasing disability stigma, they were also interested in determining how trainees' compassion and success were affected by distinct aspects of medical training, both social and curricular.

It is worth focusing momentarily on the research team's methods and philosophy, as these are intwined with the focus of their work. Thoughtfully, the authors piloted the interview questions on their team, a creative way to drew on their own experience and positions in order to test and become personally familiar with the discomfort potentially aroused by the sensitive, personal questions about disability and discrimination.

The interviews sought to engage participants as both patients and medical students with disabilities. As medical students, interviewees were—of course—immersed in the many social, societal, policy, and bureaucratic discourses around these positions. The authors' methods allowed them to analyze these discourses *and* to study how they impact medical trainees' experiences and their perspectives on themselves, their patienthood, and their medical professionalism.

The collection of textual materials that the authors analyzed capture a set of sociocultural and institutional scripts and expectations that the authors term "medical school discourses" (1553). Together, these produce the milieu that shapes interviewees' experiences as both patients and medical students.

The team's results and cogent analysis are fascinating.

A key finding by these authors is that the robust, vivid roles of "good student" and "good patient" constructed by medical discourse were juxtaposing and mutually exclusive.

The archetypal "good student" was, the authors write, "one who juggled rigorous academic demands with active social commitments while maintaining excellent evaluations" (1553). Thus, they embody the hyper-ability and individualism traditionally valued in doctors.

In the shadow of the "good student" ideal, interviewee participants worried about not being able to measure up to it. Not only are students subject to unfair, exclusionary standards, they contend with discourses *from institutions* that frame wellness as a requisite component of model studenthood rather than an important individual practice. Wellness was not framed as valuable in and of itself in content from student affairs offices in particular. Rather, it was a means to the end of [quote-unquote] "peak performance." The authors call out that "wellness, therefore, was mobilized as a means to perform the ideal student role" (1553).

As a high-endurance, efficient, hard worker, the ideal med student sits in distinct contrast to the prototypical "good patient." "Good patients" were cooperative, maintained a positive outlook, and followed directions while taking responsibility for and prioritizing their health and medical care. The latter, especially, clashes plainly with the uncompromising prioritization of school expected of the "good student."

[Short musical interlude]

Interviewees' discussions of stigma also reveal important patterns.

Participants with mental health conditions mentioned stigma more than others. Stigma came up more when participants described being patients. And, patienthood itself was more commonly mentioned by those with chronologically earlier diagnoses.

Some medical students interviewed recalled moments in training when their own condition or diagnosis was described during their *schooling*, in abstract and apersonal terms. Interviewees reported a sense of outsiderness in these moments and that a range of powerful feelings arose as such stimuli simultaneously invoked their patient role as they were focused on occupying their student position.

Other aspects of training also evoked what the authors label "challenges to identity compartmentalization" (1556). Such provocations include vivid memories of patienthood experiences being triggered during clerkships and in other scenarios.

Particularly interesting and perhaps telling are the authors' findings about how medical student interviewees' proximity to diagnosis correlated with the language they used when discussing the teams of providers treating them. Those diagnosed during medical school employed the pronoun "we"; those diagnosed before more often used pronouns them and I. The latter pronouns distinguish the interviewee from their providers rather than identifying the student as themselves a medical professional and part of the team. Consistent with this pattern, the researchers found that the students they interviewed with diagnoses prior to medical school seemed to identify as

patients and to identify with the patient role more than did those diagnosed during medical school.

Interviewees also reported that their patient experience augmented their clinical skills in ways that echo benefits highlighted by articles we've covered in earlier episodes. Expertise and skills gained through patienthood enumerated in *this* article include: knowledgeability navigating medical care, communication and advocacy skills, and familiarity with the difficult emotions many patients contend with. The authors label the students' synergetic integration of their patient and professional identities or roles "identity intersection" (p. 1556).

As the authors point out in their conclusion, the culture, discourses, and policies of medicine and medical education all mutually and iteratively impact and produce each other. Thus—for example—admissions and pedagogical standards are influenced by prevailing notions about the characteristics of good doctors, students, and patients. These expectations, in turn, shape and are shaped by norms of behavior and professionalism among physicians. Shifting norms, expectations, and mores take time and persistence. But, when it comes to changing ideas about if—and how—disability belongs in medicine, the change *is* happening.

At the end of each episode we like to recommend additional articles and resources.

First, Hafferty and Franks' 1994 article introducing the term "hidden curriculum," is a pivotal work. They published "The Hidden Curriculum, Ethics Teaching, and the Structure of Medical Education" in *Academic Medicine*.

A more recent 2014 anthology edited by Hafferty and O'Donnell contains a plethora of excellent chapters offering diverse engagement with the Hidden Curriculum. *The Hidden Curriculum in Health Professional Education* is published by Dartmouth College Press.

Finally, the fraught issue of wellness and its adoption as a core competency is explored by Stergiopoulos, Hodges, and Martimianakis in their 2020 article "Should Wellness Be a Core Competency for Physicians?" also published in *Academic Medicine.*

We welcome your ideas and feedback. You can find us on Twitter @DocsWith or email us at docwithdisabilitiespodcast@gmail.com, Subject line: Research and Resource Rounds Podcast. And, don't forget to subscribe to this podcast and tell a friend about us!

Outro:

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Thank you for listening!