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Exploring the hidden curriculum of professionalism and medical ethics in a psychiatry emergency department

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ABSTRACT

Purpose: To investigate the hidden curriculum of professionalism in the emergency department.
Design and methods: This is a qualitative study that consisted of six in-depth semi-structured interviews and a focus group with psychiatry residents of a teaching hospital program about their perception of professionalism in emergency department. A simple content analysis method has been conducted for the extraction of findings.
Findings: Common themes that were detected in the hidden curriculum were "Disregarding the priority of the patients"; "Overriding patient autonomy"; "Non-empathetic care"; "Breaching Confidentiality"; "Injustice in providing care"; and "Dishonesty"
Practice implications: Professional behaviors are mostly learned through the hidden curriculum. The hidden and formal curricula of professionalism are different in several domains. Paying attention to organizational culture and social environment is critical for promoting professionalism.

1. Introduction

1.1. Background

Many attempts have been made to define the complex concept of medical professionalism. In the literature various definition of professionalism can be found, from general ones such as "Upholding professional values, exhibiting professional behaviors or demonstrating professional attitudes" (Aguilar et al., 2011) to very detailed ones. In a systematic review, Aylott et al. examined over 70 empirical and non-empirical records and deal with different definitions of professionalism in mental health services. They classified professionalism's dimensions into two levels: *societal level* ("a dynamics social contract between professions and society", incorporating; "power and purpose", "bidirectional expectations", and "change and variability") and *individual level* (having intrapersonal, interpersonal, and working professionalism). Authors concluded that within mental health services, emphasis is placed on the interpersonal aspects of the practice such as communication skills, maintaining boundaries, and humanity (Aylott et al., 2019).

In practice, to achieve professionalism, texts are usually compiled in any medical institute to train and monitor the professional behavior of staff, which usually includes study courses, planned content, training, assessment methods, curricula, and other materials used in any learning environment. This could be called the formal curriculum of professionalism (Wear and Skillicorn, 2009). But people's behavior is not always in accordance with formal curricula. Individuals' behavior is often influenced by instructions that are not clearly articulated and are implicitly learned by observing the behavior of others, the cultural climate, and social norms and values. We call these unwritten, unarticulated, and unexplored guidelines hidden curriculum that may be distant from the formal curriculum (Bandini et al., 2017; Hafferty, 1998; Lempp and Seale, 2004; Safari et al., 2020a).

The hidden curriculum comprises subliminal messages that transmit to individuals in the implementation of formal curricula. These messages are transmitted through human behaviors and the structures and practices of institutions. These unwritten codes are called "curricula" because of implicit and informal learning that lies within them (Wear and Skillicorn, 2009). In other words, the social environment and organizational culture that shapes people's behaviors is the hidden curriculum. Hence, discovering and expressing hidden curriculum (what is in one's mind and not talked about but shapes their behavior) is one of the effective ways to bring it closer to the formal curriculum (Hafferty and O'Donnell, 2015; Reisman, 2006).

With the revelation of the hidden curriculum, the barriers to the implementation of the formal curriculum were better known and ideas

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for removing obstacles were introduced. Hidden curriculum analysis can be done in three levels of formation, description, and impact, but usually, the first step is to explore the hidden discretion curriculum. For the analysis of hidden curriculum, three issues must be defined: content (what is it about?), context (in what context is this exploration? For example, is it at the level of a department or an institute), and from which lenz be explored? (for example, is it from the patients' or the residents' lenz) (Hafferty and O'Donnell, 2015).

In emergency departments, due to the critical nature of medical care, the ethical quality of patient care might be compromised. Several studies presented the challenges of professionalism in emergency care and also indicated the importance of medical students' and residents' ethical training in these settings (Aacharya et al., 2011; House et al., 2015). Delay in providing care, compromise in privacy and confidentiality, poor communication, failing to provide the necessary care, absence of compassion, and dishonesty are few examples of unprofessional behaviors that are reported in the literature of medical ethics in emergency services (Aacharya et al., 2011; Santen and Hemphill, 2011). The hidden curriculum can undermine the culture of patient safety. In a medical setting that structure, processes, and role models are not committed to safe health care, formal teaching of patient safety would not guarantee delivery of safe care (Wong and Ginsburg, 2017). On the other hand, patients with mental illness are a vulnerable group and a great ethical responsibility is attributed to mental health professionals (Bipeta, 2019).

1.2. Objective

The purpose of this study is to investigate the hidden curriculum of professionalism from the perspective of psychiatry residents in the emergency department (ED) of Roozbeh hospital which is affiliated to Tehran University of Medical Sciences (TUMS). At the time of the study, the hospital had approximately 7800 emergency presentations and 2400 admissions per year. Previous research on the ED working condition and the staff experiences in Roozbeh hospital showed several problems in the process of care and staff preparedness for working in such a high-demand environment(Motamed et al., 2019). Therefore, compliance to the professionalism guide is of great concern to the hospital and education authorities.

2. Materials and methods

2.1. Context

This study was conducted between January 2019 to December 2019 in Roozbeh Hospital in downtown Tehran, Iran. The hospital is a referral psychiatric center and runs one of the main psychiatry training programs in Iran. On average, 20 physicians start their four-year residency in the hospital each year. At the time of the study, 80% of the residents were female physicians. All wards of Roozbeh hospital are closed and they are all used for short-stay. Psychiatry residents are an integral part of daily work in the ED, and they range from PGY 1 to PGY 4, however, PGY 2 residents have the main responsibility for clinical decision making.

2.2. Study design and data collection

Due to the complexity of the subject of the hidden curriculum and informed by prior research on professionalism, we adopted an exploratory approach and a cross-sectional qualitative methodology using both individual interviews and focus groups. The individual and group interviews were used sequentially as the questions framed to conduct the focus group were developed using data obtained from the individual interviews.

2.3. Individual interview

We designed an in-depth semi-structured interview. The interview guide and outlines were prepared using the major pillars of professionalism of Tehran University of medical sciences booklet guide ("Guide to Medical Professional Behavior in Tehran University of medical sciences", 2013) (Altruism, Honesty and integrity, Justice, Respect, Responsibility, and Excellence) and through the research team discussion. The interview began with a broad, general question about their daily experiences in the emergency department, followed by exploratory questions to collect more in-depth information. The interviews were conducted by a senior psychiatry resident (SH) trained and supervised by two qualified faculty members (STY, MT). The goal was to reduce the hierarchy between participants and researchers and facilitate sharing of sensitive information. The participants were six PGY 2 and PGY 3 residents including five females and one male. We excluded PGY 1 residents because of their lack of experience in ED and PGY 4 residents due to less involvement in the daily routine of the ED. The participants were selected based on purposeful sampling. To maximize the richness of the data, we conducted some interviews, performed preliminary analyses, and then selecting more participants to discuss emerging questions.

2.4. Focus group

We invited all PGY 2 residents to participate in the focus group and 8 out of X joined the group interview. The focus group was conducted by an experienced facilitator (STY). Through the process of coding the individual interview data, 12 question themes emerged that all were used in focus group discussion.

2.5. Data analysis

Individual interviews and the focus group discussion were recorded and transcribed. Content analysis was performed by simple thematic classification method with the help of MAXQDA 10 software and by discussion among the authors. The data were coded using an iterative process, concurrently with data collection, and the final classification was argued and agreed upon by authors.

2.6. Ethical considerations

To consider ethical issues, participants were informed about the goals and importance of the research and consented to participate and recording the interviews. They were assured confidentiality of their responses. The research was approved by the ethics committee of Tehran University of medical sciences with the code: IR.TUMS.MEDICINE.REC.1398.165.

3. Results

In total, 127 initial codes and 6 categories were extracted from the individual and group interviews. These six categories are the points where there are serious differences between the official curriculum (Guide to Professional Behavior of Tehran University of medical sciences) and the hidden curriculum. These 6 categories include: disregarding the priority of the patients, overriding patient autonomy, non-empathetic care, breaching confidentiality, injustice, and partial honesty. Each category consists of several codes that together help to better draw the professional atmosphere of the emergency department.

3.1. Disregarding the priority of the patients

According to the formal curriculum and professionalism guide, the patients' welfare is the priority, however, our findings show in some cases, priority is not given to the patient. The main codes obtained, and the sentences of the participants help to explain this situation.

3.1.1. The priority is to keep the ED calm

A calm emergency means a situation where staff feels in complete control of the situation and there is no excitement or agitation. The staff is more concerned about an orderly ED than patients' needs. For example, sometimes patients with aggressive behaviors are transferred to the general wards sooner than it must be or restrained physically or chemically more than it needed.

P6:. The staff comes and asks quickly: "Should I inject the patient with a sedative to calm him down?" And constantly insists. We may also say "yes" to calm the ED. But have we completed the assessment? No! We just want to calm down the patient and of course the staff.

3.1.2. The less responsibility, the better

There seems to be little willingness to accept responsibility. For example, patients with multiple medical problems are often considered as trouble to a psychiatric ED because they need a lot of medical follow-ups, which is not the routine of psychiatric services. Thus, such patients are managed.

P6: when a complicated patient with medical comorbidities comes to the ED, everyone wants him to leave the ED, by referring him to other hospitals or discharging the patient. They [staff] do not have enough motive for a patient who needs a lot of work such as counseling, VBG, serum therapy, etc.

3.1.3. Quantity is more important than quality

Based on the residents' perceptions, the "system" prioritizes the quantity of patient care (for example, the number of patients visited per 24 h) and not its quality, and the staff act accordingly.

P6: The goal is just to visit more patients. Quantity is important, not quality. The important issue is that every patient who has suffered from any condition should be visited. The more, the better. But the fact is when you visit a lot of patients, you will miss some emergent cases.

3.1.4. Patients' families have more priority than patients themselves

Most patients who are referred to the hospital accompanied by their families and family members are often the main caregivers. It is noteworthy that in the current laws of Iran if the family requests the patient's hospitalization and the doctor determines that hospitalization is necessary, there is no need for a judge's order.

P4: Most of our patients do not want to be hospitalized. We are often faced with the fact that the family wants the hospitalization …and we admit the patient against his will.

3.2. Overriding patient autonomy

One of the main principles of the formal curriculum is "respect for patient autonomy". The autonomy of patients with severe mental illness might be limited in some conditions, however, it seems that the ED staff generally underestimate patient capacity and competency. For example, patients' choices regarding therapeutic interventions, admission, time of discharge, and access to facilities are limited.

P1: Prescribing the medicine depends on the doctor's opinion, and most often the medicine is prescribed without asking the patient's preference, and the patient does not have any idea about what he is receiving….

FG: The patient is not given any choice about bedtime. The patient is lying on the bed, he is told to sleep! "If you do not fall asleep, we will give you sleeping pills!" People are different in the time of sleeping and this fact is not respected in our setting.

P6:. *the admitted patients are not allowed to use telephones freely, we put several limitations on them, and they need the staff permission to call someone. The reasons for that are protecting families from unsolicited calls, protecting other patients' rights…we think all patients have impaired judgment.*

3.3. Non-empathetic care

Dealing professionally with patient violence requires skill, knowledge, conscientiousness, responsibility, empathy, and efforts to avoid harm. In fact, several important ethical principles must be followed to manage the violence well. According to our participants, the ED "System" (set of environment, people, and relationships), does not provide empathetic care and sometimes it makes the patients more aggressive. Furthermore, in some cases physical or chemical restraint is used for punishment of disobeying patients.

3.3.1. Staff behavior as an aggravating factor of aggression

The staffs' behavior sometimes increases the patient's violence and aggression. The reason might be inadequate skills, ineffective teamwork, or lack of staff morale.

P6: The ED staff should be competent in not getting angry after patient verbal aggression. Unfortunately, some of us do not have the appropriate attitude or skills. Staff sometimes agitates the patient because they can not tolerate or manage the patient's aggression which leads to the escalation of anger. Perhaps, physical restraint is not assumed as a therapeutic technique.

3.3.2. Physical restraint for punishment

Physical restraint is a therapeutic intervention to control patients' aggression towards others or themselves, but it seems that sometimes the intervention is used to maintain discipline. Here, the therapeutic perspective changes to the disciplinary perspective, and the goal is for the patient to understand that no violence is tolerated here.

FG: Sometimes a senior staff comes and says that in my experience, if this patient is restrained now, he will be calm by the end of his hospitalization and he will not have any more problems. So, you feel that you will be responsible for all things that happen if you don't accept the staff's suggestion.

P5: It is a priority that the patient is not harmed in the process of physical restraint, but we do not take it very seriously, and rarely we do monitor this process and we often know what is going on, but we do not do anything.

The point that is emphasized in the above phrase is "we often know what is going on, but we do not do anything". In fact, it is as if sometimes doctors prefer that someone else manage the situation as he wants, although this may increase the chance of harm to the patient. Perhaps there is a hidden connection between the components of the system that the patient is punished respectfully and with a justified and therapeutic appearance.

3.4. Breaching confidentiality

Confidentiality is one of the formal curriculum principles that is violated to some extent. Staffs tell the stories of some patients to each other unnecessarily, and sometimes some of the patient's issues are leaked onto the family.

3.4.1. Telling the story of patients together

Confidentiality sometimes is violated in dealing with patients who have "exciting" history or unusual life events such as sexual issues, extramarital affairs, or patients who are kind of celebrity or public

figure. In these cases, the staff probably disclose confidential issues among themselves.

FG: I remember one of the patients who was hospitalized, his father was one of the famous doctors who had a position in the university, and the news had reached all the staff in the hospital. If a famous person like an actor referred to ED,. or a patient with gender dysphoria, staff may talk about patients' private matters.

P5: I recently had a patient who was a resident in one of the medical fields, and very soon, almost everyone in the ED finds out that a resident referred, she is suicidal and should be hospitalized. News will be broadcast very soon, especially if we emphasize that it should not be disclosed!

3.4.2. Telling the patients' secrets to their families

Sometimes, justifying the necessity of family education and perhaps related to the priority of the patient's family over the patient himself, some patient information such as drug use is provided to the family.

F.G: Sometimes we tell patient information to patients' families. For example, they ask if he has used drugs. We comprehensively explain and finally says it's because of the substance.

3.5. Injustice/ discrimination in providing care

Justice as one of the principles of medical ethics and professionalism says all people of any class, age, gender, and race should use the services equally with no bias. Our findings show patient favoritism in the ED, as well as discrimination against patients with particular problems. Some clients receive better services (Including patients who are recommended by facultys), and on the other hand, some people (like patients with a personality problem or have a comorbid medical condition) receive less service at the same time.

3.5.1. Patient favoritism

Special patients include patients recommended by faculties, other authorities, physicians, or paramedics.

P1: The professors' referral letter makes us more attentive to what we do, maybe this is a kind of discrimination. We are more careful not to make mistakes, even if our behavior is excellent. The patient should not be dissatisfied if he returns to the professor's private office again…

P4: Well, for example, two people are exactly the same regarding their medical condition, but one with a recommendation letter from a professor… As far as I know, we give priority to the patient who has the recommendation letter.

P5: The most challenging situation that I have faced was related to one of the medical students who was admitted in a manic episode, and I did not want to order the physical restraint. He was really aggressive. I tried to calm him down, so he only received medication orally and became calm. If the patient was not a medical student, I would not spend one-fifth of that time and I would quickly order the physical restraint.

3.5.2. Discrimination

Patients with "personality problems" who provoke negative emotions in the medical team are often treat unfairly. Moreover, the staff are relatively intorant towards "frequent fliers", or patients with multiple admissions that are usually noncomliant, self-destructive, or manipulative. These groups of patients who make the medical team feel frustrated are prone to discrimination.

P5: we differentiate between a repeater patient [a patient who are frequently hospitalized]) and a non-repeater patient. We will visit them again and again… and they are demanding… some negative feelings arise, and it is possible to treat them differently [in a negative way].

P4: We prefer not to hospitalize patients with comorbid medical conditions, and we give priority to the physically healthy.

3.6. Partial Honesty/ dishonesty

We found our patients are not always treated with complete honesty in the ED. The most common themes to justify partial honesty is "protecting patient against a painful truth", and "protecting a colleague against consequences of a minimal error".

3.6.1. Expedient "dishonesty"!

A Persian proverb says: "a white lie is better than a truth that makes trouble". It seems that this cultural background influences our professional behavior. Considering patient benefit is a common reason to justify dishonesty.

P1: We usually consider how beneficial it is for the patient to be honest with him. I mean, our dishonesty is for his interest [the patient]. For example, patients often ask about their duration of stay, if we honestly tell them that they need to be hospitalized for a few weeks, they will become agitated and aggressive, and it will be difficult to control them. So, we tell them: "You should be hospitalized for now, and we can discharge you in a few days", which of course is not so honest.

3.6.2. Covering up a colleague's error

The ED staff tends to cover up each other's errors and sometimes it is not in the best interest of the patient.

P1:. The patient says she has received extra pills and injections, but it is not recorded in medical notes. Few cases are like this. But it happens… when you ask the staff about it, they may try to cover up the error.

4. Discussion

Describing a hidden curriculum is the basic step of understanding a learning environment and introducing change in a healthcare setting. As expected, our study shows that the hidden and formal curricula of professionalism in the ED are different in several domains (Joynt et al., 2018). The qualitative interviews provided examples of ethical issues which residents faced in a psychiatry emergency setting. Patient autonomy (consent for admission, coercive treatments) and ethical problems that arise during the management of difficult patient populations (medically ills, substance users, and frequent fliers) were the most common themes. Our findings appear to be similar to other studies that investigated medical ethics and professionalism in emergency departments (House et al., 2015; Santen and Hemphill, 2011).

In many residency and undergraduate programs, ethics training is not integrated into clinical training (House et al., 2015). Furthermore, formal curricula often provide residents with minimum structured and practical training in professionalism. Consequently, these virtues are taught through the hidden curriculum (House et al., 2015). Likewise, little or no real-world training regarding medical ethics is offered to healthcare providers in the ED of our hospital. The only exception is the hospital monthly sessions of professionalism that provide the residents with the opportunity to discuss their challenging cases with the faculty.

House et al. (2015) indicated that role models are major sources of learning professional behavior (House et al., 2015). In a study by Wear and Skillicorn (2009) in a psychiatry department, students and residents believe that the hidden curriculum is strongly related to the performance of role models and does not uniformly present a consistent set of values, beliefs, behaviors across the department (Wear and Skillicorn, 2009). There is also another study that shows medical students may model or reject faculty's behavior in the emergency departments (Santen and Hemphill, 2011). In our ED, the role of attendings as role models was not prominent, because the faculties only have a passive

supervisory role and higher-level residents guide lower-level residents.

Maintaining the ethical quality of patient care in emergency settings is a complex topic in healthcare. The clinical complexity of patients, limited resources like space and trained personnel, overcrowding, and constraint of time could burden the staff (Aacharya et al., 2011). These factors usually lead to compromised quality of care, and low staff morale (Aacharya et al., 2011; Moskop et al., 2009). Webster et al. (2015) investigated the hidden curriculum of an ED and its implication for training. They suggested that efficiency is a major concern for ED staff and trainees. During interviews, we frequently encountered scenarios and examples that mention these factors as the reasons for unethical behavior or attitude. However, exploring the causes of the hidden curriculum is beyond the scope of our research and needs further research with appropriate design (Azmand et al., 2018; Safari et al., 2020b; Yazdani et al., 2019).

Considerable attention must be paid when reading the results concerning the frequency of non-professional behaviors. The design of this study requested residents to focus on examples of non-professional behaviors even if it is not frequent. Thus, the positive behaviors of the staff were not explored in this study. As reported by other researchers, there is considerable diversity in enacting the hidden curriculum, and several factors such as the behavior of role models shape trainees and staff behavior (Aacharya et al., 2011; Wear and Skillicorn, 2009). It can be assumed that the formal curriculum is like a solid object that does not change shape, but the hidden curriculum is like liquids that take the shape of a container. This metaphor highlights the contextual nuances embedded in THE hidden curriculum (Poola et al., 2021). Moreover, the present study has only investigated the hidden curriculum of professionalism from the perspective of psychiatry residents. To obtain a comprehensive picture of professionalism in the ED, we need to investigate the subject from the point of view of other groups of staff, patients and their families, and other groups of trainees like medical students.

Several interventions and strategies are recommended to improve the training of professionalism in emergency settings and reduce the effect of the hidden curriculum including; 1) regular guided sessions to discuss the ethics behind clinical decision-making with the ED staff; 2) direct involvement of faculties in the ED daily practice and their active approach to mentoring ethical challenges; 3) revising formal curriculum to be more compatible with ethical challenges of real-world settings; 4) promoting a culture that values the staff and teamwork, and improves staff morale; 5) considering professional behavior lapses as medical errors to create a “just culture” and promoting a culture of patient safety. (House et al., 2015; Person et al., 2013; Varjoshani et al., 2015; Wasserman et al., 2020; Wong and Ginsburg, 2017).

Our study shows that the hidden and formal curricula of professionalism in the ED are different in several domains. Patient autonomy and ethical problems that arise during the management of difficult patient populations were the most common themes. The hidden curriculum is an invisible reality in clinical settings, and trying to identify and reveal it is the first step to change it (Gardeshi et al., 2018; Maynard et al., 2018; Neve and Collett, 2018). Paying attention to the importance of role modeling, creating a “ just culture”, and empowering trainees to address unprofessional behavior might be critical to change the hidden curriculum (Aeder et al., 2018; Bandini et al., 2017; Joynt et al., 2018; Wasserman et al., 2020).

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Ethical consideration

The research was approved by the ethics committee of TUMS with the code: IR.TUMS.MEDICINE.REC.1398.165.

Declaration of Competing Interest

The authors report no actual or potential conflicts of interest.

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