Exploring the hidden curriculum: a qualitative analysis of clerks’ reflections on professionalism in surgical clerkship

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KEYWORDS:
Clerkship; Surgical education; Ethics; Professionalism; Reflective writing; Hidden curriculum

Abstract

BACKGROUND: Professionalism is an important part of the hidden curriculum that is gaining attention in surgical education. McMaster University, Hamilton, Ontario, Canada, has introduced a small group discussion model using critical incident reports (CIRs) to elicit students’ reflections on ethical, communication, and professionalism challenges during surgical clerkship. We described the themes identified by surgical clerks in their CIRs.

METHODS: Using thematic analysis, 4 investigators coded 64 CIRs iteratively until conceptual saturation. Rigor and validity were ensured throughout the process. Data were further explored to compare the CIRs of junior and senior clerks.

RESULTS: Twenty-seven themes and 4 relationship domains emerged: the clerk’s relationship to patients, the health care team, the health care system, and self. Challenges with communication, the consent process, and breaking bad news were most commonly cited. Theme frequencies differed between junior and senior clerks.

CONCLUSIONS: Small group discussions of critical incident reports allow surgical clerks to reflect on their developing professional relationships. The themes that have been identified can be used to guide professionalism education and uncover the hidden curriculum.

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Professional competencies are critically important for medical trainees to master in order to become good physicians, and much care is required to ensure this moral commitment is passed on to each new generation.1–3 One definition of medical professionalism is “the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served.”4 As medical students enter clerkship, they begin to participate progressively in the care of patients with mentors and other health professionals. In doing so, they encounter the hidden curriculum, which is “a set of influences that functions at the level of organizational structure and culture.”5 This occurs as they receive

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on-the-job instruction and compare and contrast the behaviors of their teachers and peers with the professional ideals they have been taught.9

The hidden curriculum is an unspoken code of conduct that pervades the learning environment, is not necessarily congruent with moral codes of conduct published by professional organizations, and is often not easily recognizable yet still sends a strong signal to clerks in their habit-forming years. It has been implicated in the moral and attitude decline sometimes associated with medical training,7–10 and a number of recent publications have discussed methods of teaching professionalism during clerkship.11–16 Although the importance of professionalism has been recognized since the time of Hippocrates, the method of teaching professional competence has been changing. Increasingly, medical schools have formal instruction in professionalism, communication, and ethics to offset the concern that professional behaviors deteriorate during medical school.7–10 Recognizing that much of what students learn in clinical practice, both positive and negative, is outside the formal curriculum, the Association of Faculties of Medicine of Canada report on the future of medical education in Canada recommended that the hidden curriculum be made “explicit and relevant.”17

At McMaster University, Hamilton, Ontario, Canada, a professional competencies course has been incorporated into the formal curriculum during the first 18 months of medical school.18 Recognizing the need to address the hidden curriculum and extend the preclerkship professional competencies course into the clinical clerkship training, we developed an educational model using critical incident reports (CIRs) as a stimulus for reflective writing and small group discussion with fellow students and faculty facilitators. Critical incident reports are widely used in medical education to promote reflective learning and are based on an event chosen by the student that influenced his/her professional development.19,20 At McMaster University, medical students voiced a need to extend this learning into clerkship where they found ethical and professional issues had a new relevance to them as those values they had merely talked about theoretically came alive in their everyday experiences and unearthed some unexpected challenges. This led to the introduction of the CIR and group discussion into the McMaster surgery clerkship block in 2007. This is the first study to explore the unique challenges experienced by students during the surgical clerkship rotation by analyzing their CIRs.

Just as a student must reflect on his/her experiences in order to grow and improve, so must a surgeon, a department, and a medical school. This article explores the reflections of the clerk, who is the team member so freshly instructed in the arts of communication, professionalism, and ethics and who understands the team’s terminology yet may identify more with the patient culture than the hospital’s culture. Furthermore, this investigation focused on what clerks found challenging and the differences between junior and senior clerks’ experiences. This project’s underlying goal was to characterize what clerks saw as challenges in professionalism, ethics, and communication, thereby establishing the groundwork for a more explicit and relevant professional competencies curriculum in clerkship.

Methods

The McMaster surgical clerkship

McMaster medical students complete a mandatory 6-week surgical rotation that consists of 4 weeks of general surgery and 2 weeks of a specialty surgery. During this rotation, clerks attend formal teaching sessions as a group including 2 sessions on professional competencies led by a surgeon. Early in the rotation, medical students are given a mandatory 500-word reflective writing assignment. Students are to “identify a ‘critical incident’ involving an ethical, communication, or professionalism issue when (1) you personally had difficulty dealing with a difficult issue; or (2) you observed another physician dealing with a difficult issue in an exemplary way.”

Near the end of the 6-week rotation, students are assigned to small groups of 6 to 8 with 2 facilitators, typically a surgeon and a social worker. Confidentiality is ensured, and in order to promote a safe sharing environment, papers are not marked and students are matched to facilitators who work at different hospitals and who are not involved in their evaluations. Each student presents his/her CIR to the group for discussion.

Upon finishing the rotation, clerks complete a short exit survey. In 2008, 80% of the responders rated the professional competencies exercise as useful, and 85% indicated that they gained new insights. Facilitators of the discussion groups noted that the group members reinforced one another’s values and empowered each other in a reflective manner.

Data collection and analysis

Research ethics board approval was obtained for this study. The transcripts of the CIRs from 149 students in the McMaster class of 2009 were collected for analysis. To study differences between junior and senior clerks, CIRs that could not be traced to a rotation were excluded. This left 64 reports, with 39 written by clerks in the first half of clerkship (junior clerks) and 25 in the second half of clerkship (senior clerks).

Four independent reviewers (2 health research methodologists [J.P., J.H.], a junior surgical resident [T.K.], and a staff surgeon [B.C.]) read and coded each deidentified CIR. Group meetings were held to achieve consensus on the themes in each CIR by using thematic analysis involving open, axial, and selective coding. An iterative codebook of these themes was generated until conceptual saturation was achieved. Through data reduction, we finalized the themes and their respective major analytic domains. Using the finalized codebook, 2 independent reviewers (T.K., B.C.) then determined the frequencies of each theme including
a further frequency breakdown used to compare prevalent
themes among junior and senior clerks.

To increase validity, we solicited the input of the facilita-
tors, and each agreed that the themes were reflective of his/her
experiences in the surgical clerkship small groups. Member
checking was achieved via discussion with and surveys of the
current year’s general surgery clerks. We found that the clerks
did not consider any of the themes irrelevant based on their
experiences as surgical clerks nor did they think that any
themes were missing from our data. We also maintained an
audit trail and ensured investigator and data triangulation.

Results

The 27 themes that emerged from our analysis were
organized under 4 main analytic domains related to the
clerk’s relationships to his/her patients, the surgical team,
the health care system, and his/her evolving professional
self (Fig. 1). The clerks’ statements in the CIRs helped to
provide an understanding of each of these relationships.

The majority of CIRs described clerk-patient experiences,
which we subcategorized into communication and ethical
decision-making domains (Table 1). Clerks provided many
examples of how they witnessed different ways of obtaining
informed consent and delivering bad news, which ranged
from heartwarming to insensitive. Patient autonomy, patient-
vs staff-centered care, substitute decision makers, end-of-life
issues, and code status discussions were some of the many
themes that emerged under this relationship.

One clerk had witnessed an inappropriate discussion
between staff members in the operating room while the
patient was still fully conscious and being prepped for an
embarrassing procedure. Although the clerk did not speak
up at the time, he/she wrote very clearly about the effects of
these conversations on the patient’s dignity and well-being:
“Reacting to stressful situations by revealing your frustra-
tion can only contribute to the patient’s anxiety and
possible apprehension, and I believe in this case his
humiliation; if I had been in his position, I would have
felt like I was burdening the team with my unfortunate
problem.” The following quotes describe 2 additional
challenging ethical situations the clerks faced: “This was
a sad case of a terminal patient and many health care
providers seem to favor DNR [do not resuscitate], but we
shouldn’t let that affect our patient care when the patient
and family have not made a decision” and “Almost every
other consult I’m forced to do my history taking and even
physical exam in the hallway, where it is impossible to
protect the patient information.” In their CIRs, clerks
repeatedly reinforced the value of putting patients first.

Scenarios that clerks discussed in the patient communica-
tion arena were also diverse, covering cultural nuances,
health literacy, breaking bad news, disclosure, and the
difficult patient. Clerks had a keen eye for the effects of
medical jargon on patients and their families. One clerk wrote
the following: “When the words ‘lymph nodes’ were spoken,
I saw on the faces of the family members that they did not
understand.” Another clerk described a difficult scenario
involving breaking bad news: “When we saw him in clinic,
I was shocked to hear him ask me whether the lesion on his
arm was ‘normal’...he reported having surgery on it for
cosmetic reasons but nobody ever told him he had
cancer...I found it difficult to answer him when he asked
me whether or not he was going to die.” The CIRs that dealt
with the clerk-patient relationship clearly displayed some of
the struggles clerks encounter on a regular basis as they learn
to work with their patients and highlighted their keen desire
to understand the patients’ perspective and needs despite
barriers of culture, literacy, and strong emotions.

The clerk/health care team (Table 2) was also identified as
a significant relationship domain. Although some clerks were
given too much responsibility, such as obtaining surgical
consents from patients or rounding on ward patients unsuper-
vised, others simply were not clear on what their role was to
be in certain situations. The surgical hierarchy was fre-
cently cited as a barrier to team communication and patient
safety. One student was directly told by a chief resident that
a clerk is meant to be seen and not heard, a sentiment we saw
more than once during our analysis. After reflecting on why
he/she remained silent after a breach of sterile technique by
a staff member, a clerk shared a newfound resolve to act dif-
cently next time springing from this quote from Caldicott
and Faber-Langendoen,21 “moral courage is within the realm
of professional expectations for medical students.”

Self-advocacy came out in the CIRs as clerks wrote about
barriers to their learning and also about bullying: “Verbal
abuse also interferes with our ability to learn...I have over-
heard several clerks state that they simply don’t want to be in
the OR [operating room] anymore as it isn’t worth the abuse.”
Clerks’ stories highlighted how the surgical culture shaped
their interactions with members of the health care team,
including both hierarchy and patient handover. “Being relatively junior, I didn’t feel appropriate interrupting the ER physician who was presenting the case very quickly. After he was finished, I said I would go talk to my residents (not knowing that this had somehow meant that I had accepted the consult and therefore accepted the patient).”

Another important relationship identified in the CIRs was the clerks’ interaction with the health care system (Table 2), including issues related to patient safety and advocacy, medical errors, and resource management. One clerk reflected on the physical hospital environment after noticing the difficulty in ensuring privacy and confidentiality in the hospital setting, “I believe that our patients (especially in surgery) suffer enough from their diseases. They came to us looking for help and relief. And it is our job to make the hospital environment safe for our patients.” One clerk critiqued the on-call scheduling practices as follows: “It is well established that fatigue and a lack of sleep are correlated with poorer cognitive function, which begs one to ask why a truck driver must be limited to 10 or 12 hours on the road without sleeping but working 30+ hours in surgery is acceptable.”

The clerk-self domain (Table 2) captured themes that expressed clerks’ introspection and humanity. Clerks wrote of fatigue and uncertainty, fears and failures, uncomfortable situations, and coping mechanisms. One clerk reflected on many feelings during a rough night on call by writing the following: “Frustration, exhaustion, helplessness were only some of the emotions present in the room as we went through

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<th>Table 1</th>
<th>Clerk-patient relationship themes</th>
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<td>Theme</td>
<td>Key concepts</td>
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<td>Clerk-patient communication</td>
<td>Cultural competency</td>
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<td>Health literacy</td>
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<td>Disclosure of adverse event</td>
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<td>The difficult patient</td>
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<td>Clerk-patient ethical decision making</td>
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<td>Informed consent</td>
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<td>Substitute decision makers</td>
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ER = emergency room; OR = operating room; SDM = substitute decision maker.
a six-hour procedure, our last chance to make a difference, but considered by all to be most likely a futile endeavor to save the patient’s life.” Clerks were often quite sensitive to patient suffering and at times suffered moral distress and were at a loss as to how to respond. Only a few wrote about coping mechanisms. One clerk reflected on an exemplary staff member sitting down with the team and sharing about the burdens and stress on health care providers after explaining to a family that no surgery could save their loved one. “He took the resident and me out for coffee. There, we talked about anything and everything. It was an ideal way to release the burden of the situation we had just experienced.”

Another described a situation in which a patient chose to undergo a surgery despite the high likelihood of postoperative complications, and the patient did not survive: “Our goal as health care professionals is to do no harm, but we cannot prevent all negative events from occurring despite our best intentions. We may not always agree with the personal decisions of our patients.” Clerks were quite expressive as they reflected on themselves as individuals.

Based on frequency counts, the most highly cited theme by clerks was team communication, which was closely followed by stress and emotions, level of responsibility, and hierarchy (Table 3). Differences were observed between junior and senior clerks. Junior clerks were more likely to discuss themes directly related to patients, including patient autonomy, patient-centered care, patient advocacy, patient safety, informed consent, and code status. On the other
hand, senior clerks more often reported on themes related to bullying and barriers to learning. None of the senior clerks cited code status or cultural competency in their CIRs.

**Comments**

Medical students are taught about professionalism, but what do they learn and how do they learn it? We found that asking clerks to identify and reflect on critical incidents served as a valuable tool to gain rich insight into surgical clerks’ perceptions of professionalism and its attributes. We were impressed by the keen observations and depth of responses to the visceral experiences of being a surgical clerk. Students were thoughtful and reflective, still possessing the idealism that more than likely led them into medicine in the first place. Clerks not only proved to be acutely aware of their interactions with patients and their colleagues but also of their own selves as learners and the bigger picture of the health care system. During clerkship, when theory meets reality, the concerns of eroding values are valid, and this issue is deserving of attention in the realms of curriculum development and evaluation. Allowing reflection, sharing with peers, and hearing interpretations by faculty helps to reinforce a positive, supportive response to challenging experiences, to allay moral distress, and to lead students to realize they can modify their own professional behaviors as they continue on into practice.

Reflective writing of short narratives has been shown to be an effective method of teaching professionalism in emergency medicine, internal medicine, and obstetrics/gynecology, particularly when combined with supportive, transformative feedback. It has been reported that written reflection is associated with a more positive learning experience, allowing students to revisit and assess their experiences and to use this exercise as a change agent for future practice.

In 2005, Branch wrote about the effectiveness and impact of reflection using CIRs, outlining the importance of a supportive, validating discussion environment and the benefits of transformative learning. We chose to use this type of written report and subsequent small group discussion as the basis for our surgical clerkship professional competencies education. In speaking with the participants in our curriculum, the small group component of the assignment was deemed an invaluable opportunity for students to receive immediate, tangible feedback from peers and facilitators in a comfortable environment that further extended the learning process of the exercise. Indeed, our facilitators shared that on multiple occasions, groups have opted to extend the length of the session out of a strong desire to continue discussions or share more of their experiences.

At McMaster, students were purposely asked to reflect broadly about ethics, professionalism, and communication to allow for a variety of different written reflections. The assignment question in our study was somewhat biased toward negative experiences by asking students to reflect on “challenges” rather than on learning experiences. This contrasts with the Karnieli-Miller et al study, which had a predominance of positive stories when 3rd-year clerks were asked to write about an event that “taught them something about professionalism or professional values.” In future assignments, we may find it helpful to rephrase our instructions for writing CIRs to see if we elicit more positive experiences from the clerks.

The 4 relationship domains that emerged during our analysis were not what we initially expected but became very evident as we examined the themes. It was clear to us that the clerk was central to all of the themes, and the relationship domains served as a model from which to draw our conclusions. Communication-related themes, team dynamics, and self-care were frequently chosen CIR themes, which is not surprising considering the complexity of those topics and skills and their traditionally limited representation in the formal curriculum. These may be useful areas to target in future curriculum development.

### Table 3Junior and senior clerks’ theme frequencies by relationship and domain

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<th>Themes by relationship domain</th>
<th>Frequencies</th>
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<tr>
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<td>Breaking bad news</td>
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<td>Disclosure of adverse event</td>
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<td>The difficult patient</td>
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<td>Confidentiality</td>
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<td>End-of-life issues</td>
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<td>Substitute decision makers</td>
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<td>Interprofessional communication</td>
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<td>Responding to suffering</td>
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<td>Resolving ambiguity</td>
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We are not aware of any literature that has examined the differences between junior and senior clerks’ experiences learning about professionalism. Junior and senior clerks wrestled with many of the same topics; however, junior clerks tended to describe more incidents about informed consent and code status, which could be because of the fact that the senior clerks had struggled with them in previous rotations and were more comfortable with those discussions as they neared the end of medical school. Senior clerks seemed to be stronger self-advocates; they were more likely to speak up for themselves in this setting when it came to issues of bullying or needing better conditions for their learning. Many of them described the following barriers to taking action: fear of losing opportunities in the operating room or getting a negative evaluation, seeing more senior staff also witnessing incidents and remaining silent, and believing that they were too junior to have an influence. It is possible that senior clerk burnout may have played a role with their increased self-advocacy, or the fear of a negative evaluation may be less of a factor because their residency applications have been completed. This speaks to the transition from junior to senior clerkship during which the roles and responsibilities change. During this period, there is a shift toward the application of knowledge and skills in problem solving, and students learn to think and act like clinicians and also learn to apply in patient care the abstract knowledge they acquired earlier in clerkship.27,28

This work opens up exciting new avenues for further research. Given the positive feedback from clerks, what might be the impact of implementing a similar reflective small group model in a surgical residency training program? Some themes involving interprofessional conflict arose in these sessions including how interprofessional small group discussions might assist in achieving a higher level of collaboration and teamwork in health care.

One of the limitations to this study is that more sensitive topics may have been underrepresented because the written CIRs had to be discussed in small groups. For example, some students were concerned that faculty involved in the incident might be facilitating the group. For this reason, we subsequently tried to ensure that the small group surgeon-facilitators were not the same surgeons who had clinically supervised any of the clerks in the group. Because our analysis did not involve coding the small group discussions, additional important incidents and stories may have been shared. However, the subsequent member checking with preceptors and clerks who had been in the small group discussions supported our findings from the written CIR analysis because they did not identify any missed themes. Also, because our sampling was limited to a single class year at a single institution, it is difficult to generalize the findings to other centers and programs.

Another potential limitation is the personal bias of the coders. We sought to minimize bias by having 4 independent coders and by using consensus to establish rigor in the coding process. Two of the 4 coders were involved in the professional competencies course (1 was a medical student in the year before the study and 1 was an organizer and facilitator of the course), and all of the coders have been patients. This brought a range of perspectives and allowed us to capture more themes and define them better.

Conclusions

In conclusion, CIRs are a rich source of information, and the learning format is well received by learners. Clerks face diverse challenges in relating to themselves, their patients, the health care team, and the health care system. Junior and senior clerks may have different educational needs, as suggested by some of the topics about which they wrote more frequently. Clerks are sensitive to the examples of professionalism they see every day. They are a wonderful resource to established professionals, and their fresh perspectives and lack of desensitization can teach residents and faculty how to be better physicians.

This work is timely because one of the Future of Medical Education in Canada project’s recommendations is to address the hidden curriculum.17 One of the ways in which we started to do this was by sharing these medical student stories with staff surgeons, residents, and curriculum planners so that they would know what clerks struggle with most and what we could do better. This and other feedback from students have stimulated a working group to design a professional competencies curriculum for all core clerkship rotations, which was modeled in part after the surgical clerkship format. It is expected to launch in the near future, with the ultimate goal of enhancing the way we teach our trainees to become collaborators, communicators, professionals, and health advocates.

References