

Hidden and informal curricula in medical schools: impact on the medical profession in Sri Lanka

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Three components have been described in a teaching-learning environment: what is planned by administrators for the students, what is really delivered to the students, and what is actually experienced by the students [1]. What is experienced by students is different from what is planned by administrators in the universities. Three main types of curricula were defined by Hafferty: formal curriculum, informal curriculum and hidden curriculum [2]. The formal curriculum is the stated, intended, and formally offered and endorsed curriculum. The informal curriculum is an unscripted, predominantly ad hoc, and highly interpersonal form of teaching and learning that takes place among and between faculty and students. The hidden curriculum is a set of influences that function at the level of organisational structure and culture. These three components are highly interrelated. Hence some authors described informal curriculum and hidden curriculum together. To acquire knowledge, skills and attitudes, medical students use a range of learning strategies that extend beyond the intended formal curriculum interacting with their teachers, colleagues and other people around them.

Considerable evidence can be found for the existence of formal and hidden curricula in previous research. Clinical students were more favourable towards receiving gifts from the pharmaceutical industry than were preclinical students, yet there was no difference in their knowledge of the industry [3,4]. Empathy among medical students decreases as they progress through medical school [5,6]. Medical students' knowledge of ethics is contrary to what is expected [7]. Medical education inhibits rather than facilitates the development of moral reasoning of medical students [8]. Many such changes of knowledge and attitude were reported when students progress through medical school. These aspects were contrary to the teaching of formal curricula. Therefore, these changes can be attributed to the influence of a hidden curriculum [9-11]. It is interesting that some students believe that certain components of their learning could only be achieved through the informal and hidden curriculum [12]. A previous study described that the science of medicine is associated mainly with the formal curriculum, and the art of medicine is associated mainly with the informal and hidden curricula [12]. Two previous studies conducted in medical faculties in Sri Lanka showed possible influence of the hidden curriculum. The perceptions of the educational

environment changed as the student progressed through the medical school [13]. There was poor concordance between the planned and the hidden curricula at the time of curriculum change in a medical faculty [14].

Deep social bonds among students were reported in Asian countries compared to Western countries. Cultural differences in medical students' learning in Western and Asian cultures have been described [15-17]. Therefore, higher influence of hidden and informal curricula on our students may be more than in the Western countries.

Medical students acquire soft skills such as listening skills, interpersonal skills and communication skills from colleagues, seniors, doctors, nurses and other professionals. Students develop qualities such as excellence, humanism, accountability, and altruism through these forms of learning. They learn from role models they encounter. Most of these skills are hardly addressed in traditional formal curricula. Simple things like how to address the patients, relatives and other professionals in the healthcare team is rarely taught in formal teaching. How to build professional relationships with other categories of people encountered in healthcare delivery process is not formally taught in Sri Lanka. Generations of doctors have learned these through the informal and hidden curricula.

When we compare medical undergraduates with other undergraduates in Sri Lankan universities, a clear difference can be seen in their dress even in pre-clinical years. Most medical students can be recognised even when they do not wear an overcoat. We rarely find medical students with a moustache or beard in Sri Lankan medical schools although there are no rules about it. Formal curricula in medical schools do not teach a dress code. They learn these 'informal things' from people around them.

A group of activities labeled as extracurricular activities influence medical students. Student organisations and societies provide them learning opportunities. Social, cultural and political activities associated with these organisations help students to learn many skills such as organisation skills, negotiation skills, managerial skills and entrepreneur skills.

Medical students in Sri Lankan medical schools organise a peer assisted learning (PAL) process called

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'kuppi' classes. This informal PAL process is very organised and established for years in medical schools. They organise this PAL as small group classes as well as mass 'lectures'. Influence of 'kuppi' classes for those students who prepare for 2nd MBBS repeat examination seems to be considerable. Students have their own MCQ, OSPE and OSCE lists, most of these have been taken from previous examinations. They organise mock examinations, viva sessions and case presentations as preparation to the formal examinations. They learn from these informal clandestine processes which run parallel to the formal teaching process. 'Tutors' in this PAL process get the opportunity of engaging in reflective knowledge-building processes. These peer tutors benefit during this PAL process by improving their communication skills, teaching skills and leadership skills.

The impact of hidden and informal curriculum on the medical professional is huge. As mentioned by students in a previous study, they learn the art of medicine mainly from the informal and hidden curriculum while the science of medicine is mainly with the formal curriculum [12]. Students shape their confidence, attitude, motivation, empathy and many soft skills through the informal learning [11,18].

I am trying neither to evaluate the informal and hidden curricula nor to compare it with the formal curriculum. I think we should be informed about the existence and influence of the informal and hidden curriculum. There is an ongoing conflict between the formal curriculum and the informal/hidden curriculum with criticism and resistance against 'kuppi' classes. Some attribute 'kuppi' classes to the decreasing professional qualities in the graduate and students' affiliation to political activities. Therefore a constructive dialogue should be initiated among academics who are involved in training medical students on how the hidden and informal curricula can be manipulated to influence student learning positively. This understanding may help to avoid the visible conflict between formal curriculum and informal/hidden curriculum and extract the advantages of the informal/hidden curriculum to produce 'better' doctors.

Academics in medical schools, extended teaching staff in teaching hospitals, senior and junior doctors and even other healthcare workers are role models who influence medical students' learning. Professionalism demonstrated by these people is important not only for patients but for medical students. Hence we have to keep in mind that our professionalism, fairness, transparency and other qualities are observed by medical students who are trained to be doctors.

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