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Confronting the Hidden Curriculum: A Four-Year Integrated Course in Ethics and Professionalism Grounded in Virtue Ethics

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Abstract
We describe a virtue ethics approach and its application in a four-year, integrated, longitudinal, and required undergraduate medical education course that attempts to address some of the challenges of the hidden curriculum and minimize some of its adverse effects on learners. We discuss how a curriculum grounded in virtue ethics strives to have the practical effect of allowing students to focus on their professional identity as physicians in training rather than merely on knowledge and skills acquisition. This orientation, combined with a student-generated curriculum, is designed to prepare students to identify and face challenges during their clinical years, further nurturing their professional growth. In short, a four-year integrated ethics and professionalism curriculum intentionally centered on cultivating virtuous physicians may alleviate, and even counteract, the effects of the hidden curriculum in the clinical years of medical training.

Keywords Ethics · Professionalism · Hidden curriculum · Medical education

Introduction

Academic discussions of the hidden curriculum in medical education have expanded significantly since 2012 (Lawrence et al. 2018). When discussing the hidden curriculum, we are referring to the basic problem of the entrenched medical culture in which the clinical years instill in learners the practices, habits, and understandings that undermine the formal objectives of medical education of the preclinical years (Hafferty and Franks 1994; Christakis and Feudtner 1993; Bloom 1988). One area of particular concern for us is how the hidden curriculum may neutralize an ethics and professionalism curriculum (Joynt et al. 2018;

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Silveira et al. 2019). Mitigation approaches may need to be institution-specific since ethics and professional curricula including learning objectives, pedagogical methods, and assessment strategies vary dramatically from institution to institution (Carrese et al. 2015).

In this paper, we will describe a virtue ethics approach in medical education and its application in a four-year, integrated, longitudinal, and required undergraduate course, entitled "Health, Care, and Society" (HCS). We discuss how a curriculum grounded in virtue ethics has the potential of allowing students to focus on their professional identity as physicians in training, rather than merely on knowledge and skills acquisition. This orientation, combined with a student-generated curriculum during the clinical years, is designed to help students identify and face challenges during their clinical years and beyond, which may further nurture their professional growth. In short, a four-year integrated ethics and professionalism curriculum intentionally centered on cultivating virtuous physicians may alleviate, and even counteract, the negative effects of the hidden curriculum in the clinical years of medical training.

Virtue ethics approach

Of the various pedagogical approaches to ethics and professionalism education in medicine, virtue ethics is the oldest and remains popular today (Irby and Hamstra 2016; Pellegrino 2007). In employing a "virtue ethics" approach, HCS draws from the original meaning of "virtue" in Greek philosophy, which means a rational and balanced approach for bringing out the most essential character traits of excellence in persons as they live, function, and assume roles with specific responsibilities (Daaleman et al. 2011). In fact, medical education as a practical activity operates implicitly as a system of virtue in which learners are expected to demonstrate professional standards of excellence at their respective level of development, reflecting what it means to be a good doctor in training and a competent physician (Brody and Doukas 2014)**.**

The most prominent proponent of virtue ethics in medicine over the past five decades has been Edmund Pellegrino, a physician-pioneer in medical ethics. Working within the Catholic, Aristotelian moral tradition, he crafted a virtue ethics approach, which we briefly summarize here, that provides a moral framework for understanding physicians' obligations to patients. For Pellegrino, it is not enough for good physicians to focus only on ethical and professional problems as abstract, conceptual quandaries in their education and training. Equally important is the kind of human beings they should aspire to become in order to fulfill those obligations. To do so requires an overarching virtue ethics framework emphasizing the character of the moral agent in moral life and ensuring that right action will be embodied in individual action and undertaken for each patient (Pellegrino 2002). As Pellegrino writes:

> Any ethical theory is shaped by the mind through which it passes. In its interpretation and application any theory can be converted from benevolence to malevolence. That is why virtue is an unavoidable element in any system of medical ethics. (Pellegrino 2012, 24)

To understand the basis of the virtues in medicine, Pellegrino continually turns our attention to the phenomenology of illness—how the patient during her illness experience can become vulnerable, anxious, and dependent causing her to seek help from a competent physician in a healing relationship (Pellegrino 1981). In a striking statement, Pellegrino makes clear that the healing relationship requires compassion, indeed empathy, by the good physician who is able to "feel what is like for *this* patient on the gurney" (Pellegrino 2012, 23). It is in the

very nature of a healing physician-patient relationship that Pellegrino finds the philosophical foundation for the internal moral norms of medical practice and the foundational virtues in medicine. (Pellegrino 2006). The good physician, acting out of beneficence, must be competent to help the patient but equally important, be dedicated to promoting the best interests of the patient, which invites the patient to trust the physician. To achieve those ends, the good physician should exhibit character traits, which allows a set of essential virtues in the physician-patient relationship to be articulated: fidelity to trust, benevolence, intellectual honesty, courage, compassion, and truthfulness (Pellegrino 2002).

Pellegrino's virtue ethics has its critics, including that it is based on a questionable tradition of philosophical essentialism and appeals to a nostalgic, even paternalistic, notion of medicine that fails to recognize that it is at least partly socially constructed. (Sulmasy 2014). Notwithstanding such broader philosophical critiques, we believe his practical value to medical education is undeniable. Medical education, whether or not directly embracing virtue ethics, as he says, prepares students to be safe and competent practicing physicians, which implies some conscious shaping of character to enable them to exhibit the virtues required of the profession (Pellegrino 2002). Moreover, Pellegrino reminds us that clinical role models bear a heavy responsibility for how students develop character traits associated with virtue; but students will need enough practical wisdom to distinguish between virtues and vices in their role models as they develop their own pattern of professional identity (ibid). However, a basic question remains: how much individual variability across a wide range of value laden issues should a virtue ethics framework, like Pellegrino's, allow? Can a virtue ethic accommodate diversity of values in medical education? How do we distinguish those essential, non-negotiable virtues that medical education should consciously shape in learners versus those that can be tailored to individual values?

Pellegrino realizes that we live in a pluralistic society in which we can expect a diversity of personal moral beliefs (ibid). At the same time, he believes that if the profession of medicine is to retain its essential character, the virtues related to healing based on beneficence toward the patient should have a central role and should be sharply distinguished from those that are external based on custom, sanctioned by professional associations, or reflective of social and cultural changes. Thomas Beauchamp claims that Pellegrino at times takes this view too far by assuming that beneficence represents the essential character of medicine focused exclusively on healing, which limits what might count as beneficence for patients and inhibit their rights to make autonomous decisions (Beauchamp 2001). For example, Pellegrino's view of beneficence would exclude a virtuous physician from honoring certain reproductive freedoms and terminally ill patients' control over the timing of death. We agree with Beauchamp that the limitation of beneficence to Pellegrino's concept of virtue is its principal vulnerability (Beauchamp 2001). If we understand beneficence as a broader moral principle, like Beauchamp does, physicians may provide, competently and safely, many services such as "cosmetic surgery, sleep therapies, assistance in reproduction, genetic counseling, hospice care, physician-assisted suicide, abortion, sterilization, and other actual or potential areas of medical practice as important benefits" – services that are typically viewed as beneficial by patients (Beauchamp 2001, 603). From a practical perspective, these services have become accepted as part of our healthcare system making it imperative that medical students become oriented to how they wish to approach them as good physicians, albeit with a broader notion of beneficence than Pellegrino is advocating.

Our perspective in HCS is that all students be expected to develop the core character traits of competence, empathy, and fidelity-in-trust and a more general notion of beneficence, essential to all physician-patient encounters; at the same time, students need to be supported in developing their individual approaches to what may often be controversial

issues that align with their personal and professional morality. Such a broader understanding of virtue ethics would also support other key character traits for optimal medical practice, such as being able to deal with the ambiguity and uncertainty, which are necessary to navigate the existing health care system in a democratic society (Shelton 1999). The faculty leaders of HCS have used such a basic virtue ethics framework to strategically create an integrated, longitudinal curriculum designed to orient students toward professional identity formation by which we mean the self-conscious and critical development of character traits compatible with one's own person and consistent with well-accepted standards of excellence of professional medical practice. Because medical practice is fundamentally about entering into and maintaining therapeutic professional relationships with those being served, a core theme of HCS is the patient-physician relationship.

Students enter medical school with ample, raw potential as human beings and as future healthcare professionals. To tap into that potential, a type of applied ethical education is required to nurture learners over time with the simultaneous acquisition of knowledge, skills, and professional habit formation. HCS provides a normative framework for this approach based on well-established ethical and professional virtues such as being altruistic, knowledgeable, skillful, and dutiful (Association of American Medical Colleges 1998). While these ethical and professional standards typically are not presented in the explicit language of virtues, this is in fact what these standards demand: that physicians in training embody them as virtues and not that they treat the standards as mere rules that need to be followed separate from the kinds of professionals they are becoming (Madani et al. 2017). Unlike modern ethical theories, virtue ethics does not seek universal rules for "right" action in a particular ethical or professional dilemma but rather starts with what it means to be a good human being and physician. By grounding the curriculum in an understanding of medicine as a social practice and ultimately a humanistic endeavor, HCS avoids excessive abstraction and reduction of ethics to a series of competing theoretical principles and analyses. Furthermore, HCS contextualizes medical practice within our lived reality which recognizes that the practice of medicine is socially situated and demonstrates how patients can be affected both positively and negatively by nonmedical factors, such as health disparities and financial considerations.

The mission for HCS in all four years is to challenge students to consider how course topics reflect essential competencies for excellence in the professional practice of medicine. The learning objectives are geared toward the growth and development of learners' professional identity and in preparation for residency and professional practice (Holden et al. 2012). As such, classes are structured to enhance students' reflective and moral sensitivities to and critical awareness of their learning environment (Branch and George 2017) rather than an exclusive focus on knowledge and skills transfer. Experienced faculty members facilitate small group discussion sections to achieve the goal of nurturing medical virtues and to "encourage an embodied and sophisticated understanding of professionalism" (Monrouxe, Rees, and Hu 2011). While small group discussions are a key component in the preclinical years of HCS, they are an essential, and the only, modality for the clinical years of the course.

Brief historical background

HCS was implemented in 1993 around the time of calls for "more virtue based medicine" and the "placement of character at the hub of physicians' identity and practice orientation" (Hafferty and Franks 1994, 870). Following a major curricular reform initiative at

our institution, HCS was created with forty hours in each of the preclinical years as well as small-group class time in all 3rd and 4th year clerkships and rotations. Attendance in all classes throughout the four years is required. Each year uses a pass/fail, competency-based grading system. Administratively, the course is divided into HCS 1 and 2 and HCS 3 and 4, each with its own course director who reports to the Dean of Medical Education for those respective years. The two HCS course directors collaborate to integrate topics and learning objectives across the four-year curriculum.

In the next two sections we describe the preclinical and clinical curricula for HCS.

HCS curriculum

One important feature of HCS is its integration into the curriculum throughout all four years of education and training. Topics during the first two years are often correlated with the ongoing basic science themes such as end of life issues during the oncology theme and reproductive topics during the obstetrics-gynecology theme; most of these topics are then revisited during the third and fourth years in the respective clerkships and rotations. Medical ethics and professionalism education during the preclinical years alone cannot have the practical impact on the professional education and development of learners that we hope to achieve (O'Sullivan et al. 2012) since training during the clinical years occurs in the context of a system in which clinical mentors are overstretched with responsibilities (Sturman, Régo, and Dick 2011). While in clinical settings, based on the knowledge students gain from their preclinical studies and orientation to become critical learners, they notice and are affected by many types of ethical and professional issues that arise. Much of the purpose of HCS is to make the implicit, emotionally laden process of medical education more explicit to learners, which we recognize may be difficult to measure (Lewis et al. 2005) but nevertheless is important to pursue. Without a formal ethics and professionalism curriculum as part of students` education, there is often not an adequate opportunity for them to explore and process their observations and experiences with clinical mentors.

A common theme in HCS discussions is how critical awareness of the learning environment enables students to recognize and keenly observe the hidden curriculum. The preclinical years of HCS lay the foundation of basic knowledge and skills of medical professionalism and ethics. Coursework during the clinical years builds upon the first two years by encouraging students to identify elements of the hidden curriculum in their clerkship rotations and to reflect on their views on what it means to be a virtuous physician in the everyday reality of medical practice in a complex healthcare system.

Preclinical years

HCS 1 and 2 learning objectives, incorporated in a mixture of didactic sessions, small group discussions, and short written assignments, lay the foundation for the clinical years by building a knowledge-based orientation to applied competencies related to the ethical, social, and humanistic aspects of the practice of medicine (see Table 1). For instance, we expect students to gain the basic vocabulary of medical professionalism and clinical bioethics as well as demonstrate skills in applying ethical principles and discerning relevant tensions in cases in an ethics consultation assignment. Such knowledge and skills are prerequisites for orienting students to their learning environment and developing their ability to

Table 1 HCS Learning Objectives

Knowledge	Skills	Professional and Personal Development
To describe the ethical foundation of the practice of medicine	To explain how non-medical factors may be associated with the illness	To recognize the humanistic and ethical aspects of practice of medicine
	To explain the relationship between clinical and ethical reasoning	To reflect on and clarify personal values, beliefs and attitudes
To define core ethical principles and values of the medical profession	To demonstrate how ethical values impact clinical decision making	To examine professional values and behaviors toward peers, colleagues, staff and faculty
To define terms, concepts and ideas relevant to medical ethics	To perform a systematic analysis of ethical dilemmas and value conflicts	To continue the process of life-long learning
To identify elements of patient-centered care	To apply ethical principles to analyzing ethical conflicts/dilemmas	
To identify non-medical factors impacting the patient and his/her access to care	To construct recommendations for solving ethical conflicts/dilemmas	
To describe the interplay between ethical dilemmas and clinical problems	To assess communication strategies regarding end of life care	
To consider the ethics of social ills	To apply ethical principles to key social problems	

analyze critically ethics and professionalism dilemmas and issues they likely will confront during their clinical rotations. In this process, students are being introduced early in their education to the characteristics of professionalism, what it means to be a good doctor, and to the competencies of an ethics consultant who 1) gathers facts systematically, 2) grapples with understanding the patient's values and preferences and the contextual features of a case, and 3) can apply and analyze the principles of medical ethics.

As noted earlier, the preclinical years of HCS are not limited to imparting knowledge and skills; we also attempt to begin cultivating medical virtues via a variety of modalities (see Fig. 1). For example, the first HCS written assignment follows on the heels of the white coat ceremony and asks students to develop and discuss their own personal medical oath that will guide them through their four years of medical school. The assignment also requires the students to describe the type of physician they aspire to be with most of them discussing various virtues, such as life-long learning and commitment to justice, respect, and beneficence. Continuing this thread, in the fourth year, students revisit their oath to reflect on their professional growth through their years of education and training.

In order to support students as they evolve as professionals we discuss how practice habits may be unreflectively assumed and the importance of the virtue of self-reflection as preparation to counteract the elements of their clinical experience that will be contrary to normative professional standards and/or to their own expressed oaths (Coverdale, Balon, and Roberts 2011). For example, HCS 2 provides students the occasion to think critically and compassionately as they grapple in small groups with persistent problems of inequalities among diverse patient populations. The first part of the class presents a diverse panel of physicians based on gender, race, religion, sexual orientation, specialty and years of practice who discuss practicing medicine in a nonideal world, including situations that may run counter to what they are being taught in the classroom. We bring in other speakers who tackle head on specific aspects of potentially powerful negative influences of the medical culture in order to foster the virtues and standards of medical professionals, such as the physician who almost lost her license due to a conflict of interest, the physician who practiced while impaired due to a substance use disorder, and a clinical psychologist who

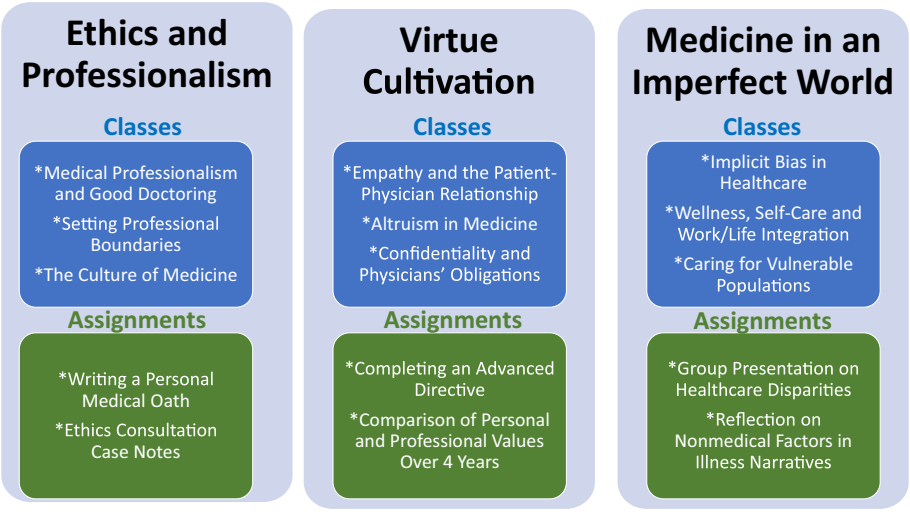

Fig. 1 HCS Sample Class and Assignment Topics

provides an overview of how implicit bias plays out in medicine. Additionally, we invite speakers from a variety of specialties to discuss ethics and professionalism issues commonly encountered in their particular fields. The goal of these classes is not only to provide exposure to relevant topics that may ameliorate the negative impact of the hidden curriculum but also to aid students' growth as professionals through reflection on their learning environments, including positive role models, and what it means to be a virtuous physician in conflicting situations and, more broadly, in an imperfect and, often, inequitable healthcare system. The virtues that are being highlighted at this stage of the students' education include the ability to accept ambiguity, cope with a flawed healthcare system, respect patients' varied values, and to make the commitment to promote social justice.

Clinical years

HCS in the clinical years consist of small group discussion sessions in six of the required third-year clerkships and four of the required fourth-year rotations, usually ten to fifteen students led by an experienced faculty preceptor. One of the unique features of HCS in years three and four is that rather than the course directors pre-determining the course content in terms of specific topics and cases, the content for most of the sessions is generated by the students from their own clinical encounters. For example, in the third year HCS Medicine clerkship, prior to each small group meeting, students are required to post a case they viewed as problematic, value laden, and worthy of class discussion, drawn from their clinical experience during that rotation. This assignment asks students to identify issues and concerns that drew their attention derived from four broad categories—ethical, professional, quality of care, and medical—with many subcategories under each one (see Table 2). Students also respond to a few questions about the circumstances of the situation surrounding their case to further spur reflection in preparation for class. Then, in the small group meetings, lasting one and a half hours, each student presents a case. The issues and concerns in their individual cases are wide-ranging and often emotionally charged—including common issues in clinical ethics, professional role modeling, and medical decision-making (See Table 2)—prompting the students to pursue reflections as a group on how their observations and reactions made them feel about being part of the profession of medicine. Furthermore, they are asked to consider whether the mentor, who is always deidentified, is someone they wish to emulate or not and how they will use the lessons learned from sharing their case for their own professional identity formation. Group discussions probably focus more on negative than positive observations made by students, since this class is their only formal educational opportunity to express them. This process reflects the practical application of knowledge (competence) and analytical skills (discernment) learned in the first two years to the clinical and professional development process of the learners.

Creating a safe space for small group discussions in which students can share and reflect on their own and their peers' experiences serves multiple purposes (Wasson et al. 2015). First, having students present their perceptions and observations of clinical encounters gives them buy-in for the small group sessions (Williams, Saizow, and Ryan 1999). Indeed, based on years of observations by our small group faculty preceptors, students are personally invested in the importance of these HCS sessions because of their mutual support, which fosters strong bonds of collegiality. Secondly, for these reasons and because students have already had experience with the meaning of virtue cultivation and sustained reflection from HCS in the preclinical years, they take the course

Table 2 Students' Reports of Primary and Secondary Concerns with Taxonomy of Subcategories for 2018-19 and half of 2019-20. *N*= 1210*

Ethics		
Issues that pertain to determining physician obligation to respect patient autonomy, do good, prevent harm, and promote justice.		• Unnecessary harm to patient/surrogate • Patient decision making capacity • Surrogate decision maker(s) • Patient non-adherence • Difficult patient • Drug seeking patient (suspected or real)/ weighing risks and benefits of administering drugs and determining obligation to patient • Pain Management • Informed consent/disclosure • Confidentiality/privacy • Goals of care • Futility • End of life/comfort care • Justice/fairness • Respect for patient autonomy • Other (student must specify)
Primary Concern Prevalence N (%)	*Secondary Concern Prevalence N (%)*	
441 (36%)	193 (16%)	
Professionalism		
Issues that pertain to physicians modeling appropriate professional standards and demonstrating respect for patients, families, and colleagues.		• Physician-patient/surrogate relationship • Clinical mentor demeanor/communication • Clinical mentor not showing proper respect for patient/surrogate • Clinical mentor not showing proper respect for learners • Clinical mentor not showing proper respect for other members of the care team • Clinical mentor bias • Provider other than clinical mentor not demonstrating adequate professionalism • Drug seeking patient (suspected or real)/unprofessional response of provider or student to drug seeking patient or patient's family • Other (student must specify)
Primary Concern Prevalence N (%)	*Secondary Concern Prevalence N (%)*	
271 (22%)	176 (15%)	

Table 2 (continued)

Quality of Care		
Issues that pertain to the coordination and communication between care teams and systems, not individual care providers.		• Unnecessary tests and procedures • Overtreatment • Medical error • Continuity of care/Care teams not communicating • No one taking ownership of the case • Trying to solve the medical riddle without additional benefit to the patient • Other (student must specify)
Primary Concern Prevalence N (%)	*Secondary Concern Prevalence N (%)*	
418 (35%)	205 (17%)	
Medical		
Issues that pertain to missed opportunities to learn about medical decision making, often due to lack of transparency or communication about the medical decisions made.		• Uncertain why certain tests and/or procedures were or were not done • Uncertain why this care plan was pursued vs. another (If this is selected, designate whether the issue pertains to a question of why aggressive treatment was pursued vs. comfort care) • Other (student must specify)
Primary Concern Prevalence N (%)	*Secondary Concern Prevalence N (%)*	
80 (7%)	122 (10%)	

*N= 1210 reflects the total number of student submissions over the academic year 2018-19 and half of 2019-20

in the clinical years seriously, as demonstrated in their consistently thoughtful and penetrating case write ups, lively discussions, and positive evaluations. Evaluation data of the 3rd year HCS medicine clerkships show majorities of students reporting the benefits of their group discussions (See Table 3).

As HCS course directors, we have found that allowing students in the clinical years to identify salient examples of noteworthy—and to them often concerning—patient cases creates the content for class discussion that largely overlaps with what the most medical ethics educators would want them to learn about, as evidenced by other researchers in the field (Kaldjian et al. 2012). In other words, the issues raised by the students generally match what we, as educators, would like them to learn if we were setting the agenda—only now, students are learning with personal investment and engagement validating their own observations and concerns from their direct clinical experiences. In doing so, students are becoming acutely aware of their perceptions of unethical/unprofessional behavior and injustice, as well as examples of models of good doctoring, all of which they can continue to contemplate in relation to their future practice as physicians. The hope is that this enhanced awareness instills in students a sense of the kind of physician they wish to become, which is essential for the right habit formations necessary for virtue.

Moreover, allowing students the time to share their experiences in a confidential and supportive small group setting may give them a much-needed outlet, which can reduce burnout, enhance wellness, and promote professional growth (Benbassat 2019) and a deeper sense of gratitude and dedication to becoming a healthcare professional. The evaluation data referred to above indicate that students find the small group discussions helpful in reducing their stress (See Table 3). This is important since the transition to the third year of medical school, during a time when students often are impressionable and vulnerable emotionally, can be a challenging time (Robinson 2015). Venturing out of the academic classroom for the first time as physicians-in-training and becoming part of a professional care team, they rapidly come under strong pressure to conform and please their clinical mentors. The fast pace of clinical medical care in academic medical centers at times relegates medical education to an afterthought which can have a serious impact on students (Rosenthal et al. 2011). Every day, students witness their mentors managing patients in ways that can make significant impressions upon them though they may often not share those reactions—negative or positive—with clinical mentors and peers. It is safe to assume that for most of modern medical education, such experiences were absorbed internally and processed without much critical reflection, which was perhaps emotionally easier for learners without extensive background knowledge of the normative standards of medical professionalism and ethics and without having been formally sensitized to their ethical environment. But for learners with considerable knowledge of such standards and developed sensitivities to decisions and actions that they perceive to be contrary to, as well as those that exemplify, normative standards, the opportunity to critically reflect on these experiences is an essential component of quality medical education. This is particularly the case for nurturing the importance of virtues like empathy (Baker, Wrubel, and Rabow 2011). Giving students a voice and allowing their experiences to be validated is the essential task of HCS, thus providing on-going support of students' development as professionals until they graduate.

In sum, HCS during the clinical years provides the occasion for students to critically examine and assess their clinical experiences, role-models, and other elements of the hidden curriculum and use these as learning opportunities to guide them during their professional training and growth (Holmes et al. 2015; Atherley et al. 2019). As learners, they become able to anticipate and reflect together how they would manage problematic

Table 3 HCS Evaluation Data for 2018-19 half of 2019-20

Please rate your level of agreement with the following statements (N=204):					
	1 Strongly Disagree	2 Disagree	3 Neither Agree nor Disagree	4 Agree	5 Strongly Agree
	n (%)	n (%)	n (%)	n (%)	n (%)
The discussions we had in HCS III allowed me to reflect on cases and topics in my clinical experiences that I may not have had a chance to explore with my clinical mentors.	0 (0)	3 (2)	1 (1)	51 (25)	149 (73)
Because of these discussions, I realized at times there were ethical issues in my clinical experiences that were not addressed by my mentors in a manner I felt they should have been.	0 (0)	2 (1)	26 (13)	73 (36)	103 (50)
Overall, I gained important insights and knowledge that will be helpful in my career as a physician.	0 (0)	2 (1)	11 (5)	79 (39)	112 (55)
HCS III sessions have helped reduce my stress.*	2 (1)	12 (7)	42 (24)	45 (26)	71 (41)

*N=182 reflects the fact that the question was added half-way into 2018-2019 academic year.

situations and what traits and qualities of good doctoring will be most important in their future roles as physicians (Wald et al. 2015; Cruess, Cruess, and Steinert 2016). The class discussions are guided by a critical perspective whose purpose is for students to gain insight into their experiences, without assuming necessarily that their interpretations are authoritative. In short, the small group discussions enable students to illuminate and critically analyze the hidden curriculum giving them a greater degree of mastery over how they choose to develop as professionals and virtuous physicians in training.

Conclusion

This paper describes a longitudinal virtue ethics course in medical education as an approach to address and offset the adverse effects of the hidden curriculum while also strengthening students' awareness of the positive elements on their learning environment. This course has evolved over time providing students many occasions over the four years to consider the traits and qualities, indeed the virtues, of doctoring that they hope to embody for themselves as aspiring healthcare professionals. The essence of HCS is to foster a critical, but respectful, attitude in students toward their learning environment and to be able to assess their clinical role models, both positively and negatively, in terms of what they are being taught and how they intend to manage similar situations as future physicians. This critical attitude, we maintain, is the only viable antidote, short of having uniformly ideal role models, to the negative aspects of the hidden curriculum.

HCS was implemented during a time of medical curriculum reform nationally, suggesting that a similarly sweeping change today may be difficult for many medical schools. Regardless of how an ethics and professionalism approach is implemented, care needs to be taken in selecting faculty preceptors who can create supportive environments in which students can honestly and openly discuss their experiences without fear of negative repercussions. We have been fortunate to receive solid support for HCS at our institution because of strong clinical faculty and administrative leadership who recognize that this four-year integrated ethics and professionalism curriculum is essential to students' preparation to become virtuous physicians.

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