Through the Veil of Language: Exploring the Hidden Curriculum for the Care of Patients With Limited English Proficiency

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Abstract

Purpose

Patients with limited English proficiency (LEP) experience lower-quality health care and are at higher risk of experiencing adverse events than fluent English speakers. Despite some formal training for health professions students on caring for patients with LEP, the hidden curriculum may have a greater influence on learning. The authors designed this study to characterize the hidden curriculum that medical and nursing students experience regarding the care of patients with LEP.

Method

In 2014, the authors invited students from one medical school and one nursing school, who had completed an interprofessional pilot curriculum on caring for patients with LEP 6 to 10 months earlier, to participate in semistructured interviews about their clinical training experiences with LEP patients. The authors independently coded the interview transcripts, compared them for agreement, and performed content analysis to identify major themes.

Results

Thirteen students (7 medical and 6 nursing students) participated. Four major themes emerged: role modeling, systems factors, learning environment, and organizational culture. All 13 students described negative role modeling experiences, and most described role modeling that the authors coded as "indifferent." Students felt that the current system and learning environment did not support or emphasize high-quality care for patients with LEP.

Conclusions

The hidden curriculum that health professional students experience regarding the care of patients with LEP is influenced by systems limitations and a learning environment and organizational culture that value efficiency over effective communication. Role modeling seems strongly linked to these factors as supervisors struggle with these same challenges.

A high-quality health care experience involves trust and good communication with health care providers, as well as safe, timely, and effective care. However, the nearly 10% of U.S. residents who do not speak English well often do not receive such ideal care.[1] Compared with those who speak English proficiently, people with limited English proficiency (LEP) are more likely to misunderstand their diagnosis, treatment, and follow-up plans,[2–6] use medications incorrectly,[7] lack informed consent for surgical procedures,[8] suffer serious adverse events,[9–12] and report a lower-quality health care experience.[13–17] Being ill can be a dehumanizing experience for anyone, but a language barrier may make it harder for clinicians to provide high-quality care to patients with LEP.

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Unfortunately, health professions students do not receive effective training for ensuring clear communication with, and providing high-quality care for, patients with LEP. To illustrate, at Harvard Medical School (HMS), 70% (N = 58) of the fourth-year students we surveyed felt inadequately prepared to care for patients with LEP,[18] and one-third of residents nationally admitted to having used a child under the age of 12 as an interpreter.[19] Moreover, 60% of HMS students reported that a lack of role models for cross-cultural care was a problem, and more than half reported problems with dismissive attitudes about cross-cultural care among attending physicians and fellow students.[20] Anecdotal evidence suggests that nursing students are similarly unprepared. To help fill this gap in training, we developed an innovative interprofessional (IP) mini-course on providing high-quality, safe, humanistic care for patients with LEP (the Macy IP/LEP curriculum). We piloted the curriculum with eight medical students and eight advanced practice nursing students and reported our findings previously.[21]

While the Macy IP/LEP curriculum has filled an important gap in students' educational experience (the formal curriculum), we were particularly interested in these students' perspectives several months after the training. We wanted to understand their experiences with the care of LEP patients during their actual clinical training when the hidden curriculum could potentially challenge their ideals. The hidden curriculum has been defined as "the set of influences that function at the level of organizational structure and culture including, for example, implicit rules to survive the institution such as customs, rituals, and taken-for-granted aspects."[22] In addition, an aspect of the hidden curriculum, which has yet to be fully explored, is that of the null curriculum, or that which is taught through passivity or omission.[23] Although hidden and null curricula are not necessarily negative, educators often focus on their detrimental effects such as loss of idealism, emotional neutralization, degradation of ethical integrity, and acceptance of hierarchy[22]—all of which are particularly dangerous in the care of patients with LEP. We could find

nothing published in the literature that specifically explores the hidden curriculum for medical students or nursing students caring for patients with LEP; however, the literature on cross-cultural education describes negative elements of a hidden curriculum.[24] To explore and characterize the hidden curriculum that medical and nursing students experience regarding the care of patients with LEP and to understand the mechanisms of its transmission, we conducted interviews with students who were immersed in their clinical rotations and who had completed the Macy IP/LEP curriculum several months earlier.

Method

We invited, through e-mail, 16 students (8 medical and 8 nursing students) from HMS and the Massachusetts General Hospital Institute of Health Professions to participate in interviews. These students had previously (6–10 months earlier) participated in an IP pilot curriculum focused on providing safe, effective, and humanistic care for patients with LEP called the Macy Curriculum on Safe, Effective, and Humanistic Care for Patients with LEP.[21] They were invited to participate in this curriculum semirandomly based on whether they happened to be on one of a few rotations with a relatively light workload. The pilot curriculum focused on three major themes and learning goals: (1) understanding disparities in care for patients with LEP and the need to address them, (2) developing skills to work effectively with interpreters, and (3) understanding how improving systems can lead to safer and more effective care for patients with LEP.[21]

Considering the implicit nature of the hidden curriculum, we theorized that these students would be primed, through their participation in this structured training, to think about the care that patients with LEP receive and to recognize and recall more aspects of the hidden curriculum pertaining to such patients. Between the time of the training (July 2013) and the interviews (January through May 2014), the students participated in both inpatient and outpatient clinical experiences in various settings from primary care to tertiary services.

We developed a structured interview guide, which was informed by an extensive literature review on the hidden curriculum, informal in-person and telephone-based meetings with several experts, and our own expertise in the field of language barriers in health care. Two of us (A.R.G. and T.C.K.) conducted test interviews with two students to determine the pace and effectiveness of the interview guide. We made no major substantive changes to the guide based on these two pilot interviews, and we included the data from these pilot interviews in our results.

After obtaining informed consent and guaranteeing anonymity and confidentiality, two of us (A.R.G. and T.C.K.) conducted semistructured interviews with the students about their clinical experiences caring for patients with LEP. Together, we (A.R.G. and T.C.K.) conducted all the interviews in person (n = 9) or via phone (n = 4). We began each interview by asking the participants to share an impactful personal story about the care delivered to a patient with LEP, how the incident affected them, and how it compared to an ideal interaction. We then asked about the direct messages (specifically stated) and the indirect messages (implied through attitude or nonverbal communication) that students received from their peers and their supervisors (generally residents, attending physicians, and practicing nurses) about patients with LEP. Additionally, we asked about students' overall experiences caring for patients with LEP in the clinical sites where they had worked, whether or not their initial story was broadly representative, and if/how their perspective on caring for patients with LEP had changed during their clinical experiences.

After each interview, two of us (A.R.G. and T.C.K.) discussed and documented key themes. One of the interviewers (T.C.K.) recorded and transcribed each interview verbatim and assigned a unique identifier. We applied qualitative content analysis by systematically coding and identifying categories and themes. The two interviewers (A.R.G. and T.C.K.) worked together to develop a set of themes while an independent investigator (L.T.) did the same. Then, the three of us used an iterative process to compare, compile, and consolidate the themes into a coding scheme. We coded the data from nursing and medical students together because of the similarity in themes.

Next, one of us (T.C.K., one of the interviewers) coded all of the interview transcripts, while another of us (A.R.G., the other interviewer) coded sample sections of the interviews and reviewed all the coded material. We discussed and reconciled our few initial disagreements.

We used ATLAS.ti 7.1.8 (Berlin, German) to code and analyze the data. We received approval for the study from both the Partners HealthCare and HMS institutional review boards. Students received no compensation for participation in this study.

Results

Study participants and interviews

Of the 13 students we interviewed, 7 were medical students and 6 were nursing students; 4 were men and 9 were women. On average, they were 27 years of age. Members of some race/ethnicity groups numbered too small to report.

Each interview lasted between 35 and 50 minutes. We identified no major new themes after 7 interviews, and no new subthemes after 10 interviews.

Content themes

We identified four overarching themes that represent the informal teaching mechanisms that help to define and characterize the hidden curriculum for the care of patients with LEP in medical and nursing education: (1) role modeling, (2) systems factors, (3) learning environment, and (4) organizational culture. We describe each of these overarching themes and several subthemes in detail below.

Role modeling. All of the interviewees readily discussed the role modeling of the care of patients with LEP that they experienced in the clinical setting (see Table 1). All 13 students described *indirect* negative experiences in their opening story. They described peers or supervisors who, when discussing patients with LEP, expressed an attitude of frustration. To illustrate, one student said, "I don't think this is unusual, per se, because I mean I've even taken my mom to the primary care clinic and I see it. I see the rolling of the eyes."

Three interviewees described more *direct* negative role modeling, including supervisors who clearly disregarded the

Table 1

Illustrative Quotations That Demonstrate Positive, Negative, Indifferent, and Mixed Role Modeling From a Qualitative Study on the Hidden Curriculum in the Care of Patients With LEP at HMS and MGH Institute for Health Professions School of Nursing, 2014

Theme	Illustrative quotations from medical and nursing students
Indirect negative role modeling	• I don't think this is unusual, per se, because I mean I've even taken my mom to the primary care clinic and I see it. I see the rolling of the eyes. • On the staff side, it just seemed to be an extra step or just take longer to use a phone or to call an interpreter up to the floor or something like that. It just seemed, "Oh, if we can get by with just speaking a little bit of the language or using some other form of communication, it would be easier than taking the time to make the phone calls and go through somebody else." • And that is there seems to be [*pause*] a sense that, you know, "Oh man, these visits are going to take longer," because they do. Sometimes they take twice as long because you have to wait for an interpreter to say anything between the patient and yourself…. There's kind of a dread, I think I'm trying to say, when beginning these visits of "Oh, this is going to take a while." • But I felt like sometimes people would just like be really kind of frustrated with having to call interpreter services but it didn't stop them from doing it because they knew that they had to do it. It was more like, "SIGH, now this visit is going to take twice as long and I'm already running behind." • I don't know if that's what you are getting at, but you can pick up nonverbally the frustration of the patient and the team's frustration by both the nonverbal clues that they are giving and through the actions that they are taking. Whether that's just not asking questions anymore or, sort of, changing the goal of their questions to, "I'm just going to tell you that this is what's happening and I'm going to do it regardless of how you respond." I think that in that conversation, it went almost immediately from trying to get a sense from the patient of whether he was oriented and whether he had any complaints, to [instead], "Ok, we are just going to examine you." Then the conversation was off the table and there wasn't any more interpreting happening.
Direct negative role modeling	• And he said, "Oh, you know we see this, a lot of this Haitian chest pain." And I said, "What do you mean by that?" And he said, "Well, they come in and the tests are negative, and they have a different perception of pain than other people." He kind of wrote it off that way. I felt a little weird that it was written off that quickly. To write off the chest pain on a patient who is having trouble communicating because she's using a phone interpreter. • I think that there are some ignorant comments that come with that as well: "Because he doesn't have insurance, he is here illegally. He doesn't speak the language." And a lot of the nurses kind of snubbed at it.
Positive role modeling	• I think that the ones who consistently do it, for them, it's something that you are supposed to do. But in a good way. They have a high standard for their patient care. And I think that it's also, not only them trying to do the best but also *show* the best. You see them doing that and you're like, "Oh shoot, I should definitely be doing that more often." • People are willing to call interpretation services in a timely fashion. Calling in advance, knowing that they will need them. I think that people have been good role models, particularly for Spanish languages…. But for pretty much every other language. I think I've learned enough and seen enough experiences to know how to use the services when I need them as well.
Indifferent role modeling	• I don't think anyone ever said make sure you are using a phone when you speak to him every morning. I think we are very impressionable as students and if someone had said, "This is how I always treat my patients," I would have said, "Great, I will do that." • It was mostly the way they acted. I don't think I ever heard, "Oh don't get the interpreter." It was more, "Let's just get this done. Everybody seems to be in a rush and there's a lot to do so let's just make this as quick as possible."
Mixed role modeling	• He definitely was someone who had really good relationships with all of his patients…. So I was a little surprised that he would've just said, "Okay. Well this is the best that we can do," like we've got to get this patient taken care of and just moved out the door because in the context of this visit, we can't do anything. He was just kind of giving up on things. It was a little frustrating and just surprising that we weren't trying a little bit harder to provide the same standard of care that we would provide to any other patient.

Abbreviations: LEP indicates limited English proficiency; HMS, Harvard Medical School; MGH, Massachusetts General Hospital.

needs of patients with LEP during clinical encounters. For example, supervisors communicated with patients with LEP without an interpreter when it was obviously necessary or they made assumptions based on stereotypes. One student commented, "I think that there are some ignorant comments that come with that as well: 'Because he doesn't have insurance, he is here illegally.'"

No student identified a specific positive role model for the care of patients with LEP even when prompted; however, six interviewees described some generally positive practices. One student reported: "People are willing to call interpretation services in a timely fashion. Calling in advance, knowing that they will need them."

Seven students described role modeling that we labeled as either "indifferent" or "mixed." *Indifferent* role models gave no special attention to ensuring optimal communication for patients with LEP, but would involve interpreters when convenient or obviously necessary. These supervisors appeared to tacitly accept limited communication with LEP patients but never directly or indirectly expressed negative attitudes towards them. To illustrate, one student remarked, "It was mostly the way they acted. I don't think I ever heard, 'Oh, don't get the interpreter.' It was more, 'Let's just get this done.'" Indifferent role models appeared to contribute directly to the null curriculum by not demonstrating

a commitment to optimizing care for patients with LEP.

Mixed role modeling occurred when supervisors demonstrated good patient communication skills and a dedication to high-quality care in general, but seemed frustrated and less effective when providing care to patients with LEP. An interviewee commented: "He definitely was someone who had really good relationships with all of his patients.… So I was a little surprised that he would've just said, 'Okay. Well, this is the best that we can do.'"

Student reactions to indifferent and mixed role modeling varied, but they were not critical of their supervisors in general. Instead, they tended to attribute their supervisors' behavior to limitations imposed by the system and lack of structural support for working with patients with LEP (described below). This made it difficult for students to make value judgments on the quality of the care delivered. The mixed messages from otherwise-respected role models seemed to conflict with students' ideals and with explicit teaching in their preclinical years. To illustrate, one student commented:

> Part of it is, if this can happen to someone that I see as such a model.… I'm sure it happens across the board, regardless of how cognizant you are of all of these limitations. You know part of it is, he does such a great job on a typical case but part of it is that he did the best that he could. Part of it … some of the problems leading to this are basically a systemic issue of why did no one give him a heads-up about this is what's going to be happening, this patient is going to be coming to your clinic.

Systems factors. All 13 students identified examples of substandard care for patients with LEP that resulted from inefficient and/or ineffective systems in the clinical environments where they trained (see Table 2). Many of the inefficiencies and ineffective practices were actually part of the systems in place for addressing language barriers. These included inadequate interpreter services, lack of staff training or knowledge of how to access and work with interpreter services, and inadequate identification of patients requiring language assistance.

Inadequate interpreter services. According to our data, the most common structural barrier was inadequate interpreter services. Students recalled long wait times for interpreters, limited on-site interpreters for some languages, too few

Table 2

Illustrative Quotations That Demonstrate Some of the Systems Barriers Described by Participants in a Qualitative Study on the Hidden Curriculum in the Care of Patients With LEP at HMS and MGH Institute for Health Professions School of Nursing, 2014

Theme	Illustrative quotations from medical and nursing students
Inadequate or poor interpreter services	• I think one thing that I found frustrating was arranging for an in-person interpreter to come to the floor. We made sure for certain procedures that someone was there. It was always difficult and that was very frustrating. The interpreter also speaks Spanish and was very overworked in the hospital. So we'd have to call days before to make sure.… That was always frustrating because when we felt like it was important for someone to be there, it was hard to get or it took a lot of preplanning which is not always possible given a busy schedule and sort of diagnostic tests moving around. • I think in a lot of institutions it's not something that is highly invested in unfortunately. So there is a shortage of interpreters in places, so because of that shortage, there are sometimes long wait times. So when people have one bad experience with interpreter services, so they have to wait 20 or 30 minutes to have an interpreter present, they don't want to deal with that again. And they are worried that it's something that's going to keep happening. So they would rather circumvent that if they can.
Lack of staff training or knowledge of how to use or access interpreter services	• Sometimes the phone services are hidden. The nurses don't know how to put them together. I should know how to put them together too, but just because the nurses are that floor person who often helps you with [details such as] how do I move this thing here or do this … so that was an issue for me in the past. • But I felt like this resident wasn't making the best use of the available interpreter services. I guess I just found that a little disappointing.… I can't remember if as third years, if we got training using interpreters, but I know we did during second year and I was at CHA during our second year as well. We had a session about how to work with interpreters, which I don't know if other sites had. But yeah, it just struck me that it should be a part of orientation at least. • So I asked one of the nurses at the nursing station, and she said that we do have interpreter phones that we can use. So they showed me where to go in the storage closet to get a phone, and I rolled it down to the room. It was two handsets, and I listened on one end and the patient listens on the other, and we called the interpreter with it. And the resident was really surprised because he was a PGY 2, and at the end of his PGY 2 year, and he had never seen that phone ever. And I found that striking that no one on the floor, none of the physicians on the floor, actually knew that those phones were available.
Lack of identification of patients requiring language assistance	• But structurally, I think that it's true that the patients' charts are often not flagged to say that this person is Russian speaking. I remember calling consultants on him and not mentioning that and realizing, "Wow, that's really important," and calling them back to say, "By the way, he doesn't speak English." Things like that. But had it been flagged in his chart that would have been something that would've been caught. • Learning how to use interpreters and there I learned the biggest difference between inpatient and outpatient work. Outpatient was actually a lot easier to use an interpreter because you knew when patients were going to come in and need an interpreter, so people were better about scheduling interpreters to come at those times versus like inpatient [where] you didn't know if an interpreter was going to be available, so you wouldn't feel like waiting, so you'd go in and do what you could. But even then, I felt like the residents, if an interpreter arrived, knew what to do and knew how to make the best use of them. But I felt like this resident wasn't making the best use of the available interpreter services. I guess I just found that a little disappointing.

Abbreviations: LEP indicates limited English proficiency; HMS, Harvard Medical School; MGH, Massachusetts General Hospital; CHA, Cambridge Health Alliance; PGY, postgraduate year.

interpreters in the outpatient setting, and no on-site or phone interpreters at all.

Lack of staff knowledge regarding interpreter services. Eleven students also identified lack of staff knowledge as a major barrier. They reported knowledge gaps in how to access on-site interpreters, poor ability to find and use interpreter phones, and poor technique when using interpreter services. Interestingly, students did note that interpreter services were involved more appropriately in the outpatient setting, particularly when patients with LEP were preidentified appropriately. Students reported that in the inpatient setting, the patient's primary team was more likely than specialists to routinely involve an interpreter. Overall, students observed that supervisors were not knowledgeable on when to involve interpreter services; some supervisors used such services only for eliciting consent for procedures or discussing important diagnoses. Students noted that interpreter services were often absent during resident and student prerounding, day-to-day nursing interactions, and when patients had a prolonged inpatient stay. Five students also noted that some of their supervisors, impatient with the timing of interpreter services, were unwilling to wait for the interpreter services to be arranged.

The students noted a difference in knowledge between nurses and doctors when using interpreter phones. They observed that attending physicians and residents may not always work in the same setting, so floor nurses or a secretary may know more about accessing interpreter services or how to use the phone than the physicians. Nursing students also reported that they observed nurses coordinating interpreter phones or video systems in patients' rooms if the resources were available. Notably, medical students did not report their supervisors—attending physicians or residents—arranging interpreter phones or videos, which sent a message that such tasks are not important to the way a physician might address a language barrier—an example of the null curriculum at work.

Identification of patients with LEP. Students noted that providers in the most language-supportive environments successfully identified patients with LEP ahead of time and arranged interpreters in advance. Although this practice happened most in the outpatient setting, even there, according to students, it was not the norm.

Overall, students recognized that lack of effective systems for caring for patients with LEP led to delays, frustration, and difficulties in providing high-quality care. They highlighted a strong link between these structural barriers and "indifferent" or "mixed" (our terms) role modeling.

Learning environment. Students described a learning environment that emphasizes an implicit hierarchy of values in the clinical setting (see Table 3). This hierarchy places much higher value on efficient completion of defined clinical tasks than on ensuring either effective communication or excellent care. Working with interpreter services adds another layer of complexity that could prevent health care providers from completing more highly valued tasks (e.g., checking blood test results). Students observed that during less-critical interactions with patients with LEP, supervisors would not involve interpreter services. The hierarchy extended to roles as well. One student noted that when a supervisor asked her to do even mundane tasks (e.g., finding a pair of socks), these took precedence over tasks that the student considered more clinically relevant (e.g., finding an interpreter).

The students perceived the hierarchy and the conflicts it created in different ways. Six students felt that competing priorities were inevitable and that the practical limitations justified different standards of care for patients who required more effort, such as patients with LEP, lower socioeconomic status, or with less education. Students noted that tending to patients with LEP had lower value on the hierarchy of tasks, comparable to tending to patients who frequently complained. Other students did not believe that patients with LEP received a significantly different level of care.

Another aspect of the learning environment that 12 students described was their limited role and low status in the clinical setting. When they observed behaviors that conflicted with their values, such as providing lower quality of care to patients with LEP, they did not feel empowered to express their views or change the situation—even if it impacted clinical care. Both nursing and medical students expressed this conflict; however, a medical student noted that the role of medical students is focused much more on data collection than on skillful communication. Although no students noted receiving negative feedback for spending time or effort on patients with LEP, they *did* note that they received no *positive* feedback either. This lack of positive feedback for providing good care for patients with LEP is another example of the null curriculum.

Students described a learning environment in which poor communication is considered appropriate and acceptable—the norm. Even when students had received more training in the use of interpreters than their supervisors had, they did not feel that they could intervene or advocate for patients.

Peer interactions did not seem to have much influence on the care of patients with LEP. Only four interviewees mentioned any peer interactions. Two noted peers expressing frustration about working with patients with LEP, and two reported negative comments from peers about participating in curricula related to cross-cultural care.

Organizational culture. We asked students to describe aspects of organizational culture with respect to care of patients with LEP and how this culture was established, but the students often paused and seemed to struggle to describe the culture (see Table 4). They recognized that the culture changed from setting to setting (e.g., floor to floor and hospital to hospital). They also recognized that attending physicians and nursing faculty were not necessarily around enough to establish the local culture, so culture depended more on the residents and floor nurses. One student stated that it took only a few staff members to create a negative culture around providing care for patients with LEP; such staff members seemed to communicate that actions like procuring an interpreter went above and beyond the normal standard of care. Students clearly indicated that the prevailing practices of the staff present at the time seemed to determine culture—more than any regulations established in the hospital by higher-level administration. Students did not identify any institutional measures reinforcing a high standard of care for patients with LEP. This notable

Table 3

Illustrative Quotations That Demonstrate Aspects of the Learning Environment Described by Participants in a Qualitative Study on the Hidden Curriculum in the Care of Patients With LEP at HMS and MGH Institute for Health Professions School of Nursing, 2014

Theme	Illustrative quotations from medical and nursing students
Competing priorities in the clinical setting	• I don't think that anybody wants to not communicate, or I think if we had unlimited time, it would happen so much more often. I think that's the main thing and as you said, the institutional thing: "This [other task] is priority for us and I'm going to pass this down the ranks so that this gets back up…." So I would say the barriers are time and not considering it to be a priority by the supervisors. • It's just really hard to figure out where in that list of unaccomplishable tasks to put getting this broken interpreter phone that's going to take 20 minutes to work and it's a weekend, so you can't get an in-person interpreter, and even if you did, they'll like roll their eyes at you because it's a busy day. • So no matter what, when you're asked something, you're trained to think if this is a specific request, that's up there too. "Go get this person some socks," and I'm like, "Okay. That has to be now?"
Low value assigned to patients with LEP	• I think the example of the negative perception of this person with low SES and the implicit perception that we won't spend as much time with the patient who doesn't speak English, it just shows that treatment of all patients is not equal…. I think it's difficult to watch patients receive different treatment. But there are all sorts of reasons why patients receive different treatment. Even wearing the yellow gowns and entering a room of a patient who has MRSA, we are less willing to go into those rooms or hop in and say something because there's a barrier. I feel like language is a similar barrier that's even more extreme because it requires extra resources and extra brain power as well. • I'd almost liken it to … the level of empathy lost for a patient who is LEP might be kind of similar to the empathy you lose towards the patient who complains a lot or something, and it's through no fault of that patient themselves. • This thought just came into mind: This is terrible, but there are a lot of similarities when you see an LEP patient on rounds or a contact patient or airborne-precautions or droplet-precautions patient on rounds. Now, everybody sees the patient who is on precautions and it takes a bit of extra time, but everyone does it and goes through the motions and there's some grumbling and stuff, but for the most part, it happens.
Limited role of the student	• To me I know, when you get on the floor and you're just a student, it's sort of hard to find your place. And if I say, "Oh, we need an interpreter for this patient," how is that going to be received? I know that can influence students not to do anything because it's a weird situation because you are dealing with the staff who are there all the time and saying we need to do things differently. • It bothers me, but then, you know, it's like your role. Who am I to correct a veteran nurse like, "You know you just said a really ignorant comment." How can I teach her like, "You shouldn't be saying that out loud." I don't know. I was just kind of like in this [*pause*] kind of dilemma: Do I say something or do I not? • You have no power as a medical student on general surgery rounds in the morning to be like, "Hey everybody, let's slow down and make sure we hear this patient out."
Poor communication is the norm	• So typically people are using one-word questions like "Dolor?" and then like mimicking or pantomiming where the patient should point if it hurts. Very kind of barbaric. Primitive communication techniques.

Abbreviations: LEP indicates limited English proficiency; HMS, Harvard Medical School; MGH, Massachusetts General Hospital; SES, socioeconomic status; MRSA, methicillin-resistant *Staphylococcus aureus*.

want of institutional policies further demonstrates the strength of omission and pervasiveness of the null curriculum even on an organizational level. One student explicitly mentioned that he felt that hospitals could strengthen the organizational culture by instituting a campaign, similar to the focus on hand washing, to provide consistent high-quality care for patients with LEP.

Discussion

On the basis of our interviews with medical and nursing students, we have described four domains that influence the powerful hidden curriculum regarding care for patients with LEP in the clinical setting: role modeling, systems factors, learning environment, and organizational culture. We found each of these domains to be highly intertwined with the others such that they were sometimes difficult to separate. Most notably, systems factors had a huge impact on all of the other domains. Even the best of role models, for example, could be quickly frustrated in caring for patients with LEP if the systems were not adequate to allow for efficient access to interpreter services.

Overall, students perceived this hidden curriculum negatively; their responses ranged from neutral to highly disturbed. The students that were most negatively affected seemed to be disillusioned by the dissonance between their ideals and the realities of clinical care (at least in these settings). For example, the hidden curriculum they experienced in clinical settings with LEP patients often taught them that working with interpreters to ensure effective communication was not important and could be overlooked whenever time was limited, while the formal teaching in their patient–doctor course emphasized the importance of effective communication with all patients in all settings. This dissonance is not unlike other descriptions of hidden curricula regarding ethics, patient centeredness, and other aspects of clinical practice.[25–28] Although students made little reference to any positive elements of the hidden curriculum, five described some generally positive behaviors around working with interpreter services, and some indicated that certain rotations provided better care to patients with LEP than others.

As we expected, the students experienced negative role modeling—both during direct patient care and through indirect discussions about patients with LEP. Although students clearly disapproved

Table 4

Illustrative Quotations That Highlight the Organizational Culture Described by Participants in a Qualitative Study on the Hidden Curriculum in the Care of Patients With LEP at HMS and MGH Institute for Health Professions School of Nursing, 2014

Theme	Illustrative quotations from medical and nursing students
Limited number of people can determine culture	• It's hard because the culture of the floor is so dependent on who is on it and if you have just three people who are like, "I don't care," and make [displaying that attitude], kind of, the cool way to be.… I think that the idea is that if you somehow go above and beyond and want to do a good job that you're just sort of, I don't know, I can't think of another word for goody two-shoes. But you just get a bad rap on the floor. • Also, when you train people … instead of rolling your eyes when a patient rings a call bell or saying, "This is a pain. Oh, this is a pain," you can say, "Oh, this is really important."… If you can set a certain tone, you can really affect the culture of the floor.
Institutional culture	• I think that the culture is very inviting of all different walks of life, languages, races, sexuality—at least from the way that it is advertised on the floor. Again with the pictures and the magazines in the waiting room. Even our staff is very diverse. Not so much the clinicians, they are all pretty much white but, you know the medical assistants and the secretaries. There's a good mix there. • I don't remember ever having a formal session about working with patients who have LEP.… But even without it, if you were training in the hospitals where they have a good culture for this setup, then you will see that and kind of pick up on it. But there are limitations to that of, okay well, if the people that you are working with somehow set a bad model, then you are out of luck.

Abbreviations: LEP indicates limited English proficiency; HMS, Harvard Medical School; MGH, Massachusetts General Hospital.

of negative role modeling, what struck us was the power of passive indifference and the null curriculum. Many students described supervisors who simply did not pay much attention to ensuring effective communication with patients with LEP and supervisors who often did nothing to explicitly address any communication gaps. We thought that this passivity sent a very strong message to students that not involving professional interpreters, struggling through interactions with patients with LEP, or using family members to interpret was considered acceptable and unavoidable. Although faculty would not be likely to directly advocate any of these actions, they endorsed all of them through their actual behavior. This observation is consistent not only with the literature on the null curriculum[23] but also with literature on implicit (and unconscious) bias, which has been shown to be prevalent in health care, and more likely to impact care than conscious discrimination.[29–31] The prevalence of passive inaction stood in contrast to the fewer examples of direct and blatant negative role modeling, which students easily wrote off as aberrant behavior to be avoided. Although the concepts of passive indifference and the null curriculum appear in the hidden curriculum literature,[23] they deserve deeper exploration as to their impact on students.

What we referred to as "mixed role modeling"—the mismatch between supervisors' previously demonstrated dedication to high-quality care and their apparent unwillingness or inability to deliver this same level of care to patients with LEP—was particularly disturbing for students. Students often attributed inconsistent care to factors outside the supervisor's control, thereby protecting their image of these role models, and perhaps accepting that high-quality care for patients with LEP is not possible in the "real" world. The prevalence of such seeming unwillingness or inability among supervisors to deliver consistent high-quality care to patients with LEP, along with the apparent absence of positive role models, indicates a need for extensive faculty development in caring for such populations. We have developed and piloted an IP training curriculum involving medical students, nursing students, and professional interpreters that is adaptable for clinical faculty and staff and is freely available.[21] We also previously collaborated with the Agency for Health Care Research and Quality to develop a TeamSTEPPS training module on caring for patients with LEP that has been used in several institutions nationally.[32]

The systems issues that students continually cited align with those described in other reports on hidden curricula but have not been emphasized regarding patient–provider communication in particular. These systems issues related to the care of patients with LEP are somewhat unique given that effective communication is closely linked to the coordination of an ancillary clinical service (professional interpretation). One possible parallel is the teaching of patient safety, which also relies heavily on effective systems. When systems do not work well, they prevent effective role modeling, negatively impact the learning environment and organizational culture, and encourage the omission of important actions, thereby reinforcing a negative null curriculum. Training in a system wherein dysfunction eclipses individual clinicians' values can lead to disillusionment, frustration, a belief that substandard care is inevitable for patients with LEP, and ultimately, an erosion of values.

Our findings about the learning environment and the hidden curriculum related to patients with LEP are very consistent with those from other studies about the hidden curriculum for topics like patient centeredness and ethics.[25,27,28,33] Namely, supervisors place lower value on the humanistic aspects of care in favor of medical knowledge and efficiently accomplishing clinical tasks, and they reinforce this hierarchy when they fail to provide positive feedback for students who do offer or advocate higher quality of care. Students have internalized this hierarchy of values and feel disempowered and unable to advocate for patients with LEP. Even suggesting something as basic as involving a professional interpreter would be difficult for a student because doing so could slow down the team. This tension is parallel to that in the field of patient safety in which hierarchical structures lead to inhibition among lower-ranked team members who do not feel free to speak, ultimately allowing errors to occur.

Students had less to say about the broader organizational culture and what influence it had on them compared with the other three domains—perhaps

as a result of their stronger link to the educational environment as established by their supervisors. Their weaker connection to the organization as a whole may reflect their transient roles. In general, hidden curriculum studies are challenging in that students can identify some of the more obvious influences but have more difficulty recognizing subtle aspects such as organizational culture. Similarly, students have difficulty recognizing the influence that even the more obvious aspects of the hidden curriculum have on their own developing values and behaviors. Most students in our study recognized a waning of idealism in general, but not specifically for the care of patients with LEP. In fact, 10 students stated that they felt a personal commitment to providing high-quality care to all patients and to effecting positive system-level change, and 11 students said they were willing to advocate for patients and system improvements in their future careers. Nonetheless, we were not able to define what unconscious impact this hidden curriculum had on students' values and behaviors.

Comparing medical and nursing students

We found few differences between the experiences of medical and nursing students. Nursing students identified more structural changes that could be made in each setting and seemed to have a stronger role in how to access interpreter services (e.g., locating interpreter phone and relocating them to patient rooms). Nursing students seemed more hesitant to imply any lack of empathy on the part of their supervisors toward patients with LEP (regardless of the supervisor's actions)—perhaps because empathy may be more highly emphasized as an integral part of nursing training than it is in medical training. As such, implicating supervisors as lacking in empathy may imply that they are not capable of doing their job. Otherwise, nursing and medical students had very similar experiences and observations across all four domains.

Limitations

This study has several limitations. Although we are able to generate hypotheses about the hidden curriculum for the care of patients with LEP, our findings—the results of a qualitative study—cannot be taken as representative of the views of other medical and nursing students at HMS or Massachusetts General Hospital Institute of Health Professions more broadly. Students seemed to choose their words carefully at times when critiquing their supervisors (especially if the students respected them otherwise), so our findings may show a more positive view of these role models than what the students truly felt at the time. Their hesitation to criticize may have also led students to implicate structural factors more strongly as a way of protecting their image of their supervisors. Because the nature of the topic we are exploring is "hidden," we are unable to know for sure whether we were able to delve deeply into the hidden curriculum regarding the care of patients with LEP or if we have just gained a preliminary view. The student interviewees had participated in a mini-curriculum on the care of patients with LEP, so although they were perhaps better prepared to recognize the hidden curriculum they were experiencing clinically, this exposure could also be a source of bias. Ultimately, we felt that 6 to 10 months between the interviews and the curriculum would limit this potential bias, and that it was more important for our study not to miss elements of the hidden curriculum that are particularly subtle.

Conclusions

To our knowledge, our study is the first to explore the topic of the hidden curriculum for the care of patients with LEP in medical and nursing education. The conceptual model proposed by Haidet and Teal[34] to explore hidden curricula posits that educators should move beyond describing one general hidden curriculum and instead focus on hidden curricula that are specific to the content (e.g., care for patients with LEP), context (e.g., a specific clinical setting), and lens (e.g., medical and/or nursing students). We have used this approach to better understand an aspect of medical and nursing education, for which a powerful hidden curriculum is a likely driver—especially because it is underemphasized in the formal educational curriculum (and in health professions research). Although some limitations mitigate the application of our specific findings to other contexts, our study and discussion clearly uncovered three domains (role modeling, systems issues, and learning environment) in which the hidden curriculum, particularly the null curriculum, had a strong impact on how students learn about caring for patients with LEP in the clinical environment. We believe that the hidden curriculum within these domains—and in organizational culture—can be improved through trainee education and faculty development. Further, we think such training programs would likely be applicable to other contexts, trainees, and patient populations.

Ensuring safe, effective, and humanistic care for patients with LEP will require new educational approaches and a reinvigorated commitment to humanistic medical education. Such a commitment goes beyond simply teaching students how to work with an interpreter. It involves raising expectations for the level of care that is possible, speaking up when others accept (and even contribute to) suboptimal care, and seeing beyond the veil of language to understand the individual patient in the context of his or her culture.

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