The Informal and Hidden Curriculum in Physical Therapist Education

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The Informal and Hidden Curriculum in Physical Therapist Education
Lisa L. Dutton, PT, PhD, and Debra Ough Sellheim, PT, PhD

Background and Purpose. The learning environment in medicine has been described as encompassing 3 areas of influence: (1) the formal curriculum or that which is explicitly stated; (2) the informal curriculum which reflects teaching and learning that occurs through informal faculty and student interactions; and (3) the hidden curriculum through which organizational structure and culture exert influence. While the formal curriculum is explicit and its influence more easily identified, the informal and hidden curricula can also have significant impact on student outcomes relative to attitudes, knowledge, and behavior. Although work has been done in medicine to identify the informal and hidden curriculum, no literature exploring these influences in physical therapist education could be identified. The purpose of this study was to examine the informal and hidden curriculum in professional physical therapist (PT) education as perceived by PT students. The research questions were: (1) Do PT students believe there are informal and hidden curricula in their educational program? (2) If so, how would they describe the informal and hidden curriculum in both the didactic and clinical portion of their program?

Subjects. Twenty-eight third-year PT students from 3 Midwestern physical therapist educational programs (2 public, 1 private) participated in this study.

Methods. Qualitative data were gathered using focus group interviews. Audiotapes were transcribed and data were coded utilizing a framework, linking student learning associated with the informal and hidden curriculum to the physical therapist profession's core values.

Results. PT students believe that informal and hidden curricula are present in the didactic and clinical aspects of their program. Three major influences related to the informal curriculum (faculty, clinical education, peers) and 2 major influences (physical environment, policy) related to the hidden curriculum were identified. Themes illustrating what students were learning from the implicit curriculum were linked to the core values of compassion/caring, excellence, integrity, and professional duty. Student learning related to compassion/caring was associated with attributes of successful relationships. For the core value of excellence, faculty influence was related to standards of excellence and habits supporting excellence. For both excellence and integrity, areas of dissonance between the academic and clinical setting emerged in relation to patient/client examination, documentation, practice standards, reimbursement, and productivity. Professional duty associated with involvement with the American Physical Therapy Association was influenced by faculty and policy. Faculty-student relationships, as well as perceptions of educational quality, were associated with the physical environment influences.

Discussion and Conclusion. Student learning and professional development are impacted through the informal and hidden curriculum. By gaining an increased understanding of the informal and hidden curriculum, physical therapy educators will be able to better address potential negative influences and support those influences that may be positive.

Key Words: Hidden curriculum, Informal curriculum, Physical therapist education.

INTRODUCTION
"What students are taught in class is not necessarily what they learn.” Rather, it is probable that it is through a combination of formal teaching along with informal and inadvertent influences that physical therapist (PT) students learn the knowledge, skills, and professional behaviors of a PT. Hafferty described the learning environment in medicine as encompassing 3 areas of influence: (1) the formal curriculum, which includes "stated, intended, and formally offered and endorsed" elements; (2) the informal curriculum, which reflects the teaching and learning that occurs through informal faculty and student interactions; and (3) the hidden curriculum, through which organizational structure and culture exert influence. While the formal curriculum is explicit and its influence more easily identified, the implicit curriculum, which includes informal and hidden curricula, can also have a significant impact on student outcomes relative to attitudes, knowledge, and professional behavior. In particular, the development of attitudes, values, and beliefs, such as those exemplified by the profession's core values, is of particular interest to physical therapy educators. The American Physical Therapy Association (APTA) Education Strategic Plan (2006-2020) identified "strategies to effect behavioral change in PTs and student PTs...to integrate professional core values into physical therapy practice" as a key goal supporting the realization of Vision 2020. Efforts to foster and assess professional development among PTs have

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incorporated a variety of approaches including the use of 360 assessment,10 advisory sessions,12 reflection,12 the facilitation process,13 and standardized patients.14 The impact of these approaches is unclear, with Jette and Portney15 showing no change in professionalism in association with increasing participation in clinical education, and Hayward and Blackmer16 reporting a decline in Professionalism in Physical Therapy Core Values scores after clinical education experiences. In addition to explicit strategies designed to foster the development of affective behavior, some researchers have suggested that “core professional abilities...often remain part of the implicit curriculum.”5(p67) These implicit curricular influences may be particularly important because of the prolonged periods of exposure students have to the learning environment and physical therapy professional culture during their education.16 Although research has been conducted in medicine and other health professions to identify and address the informal and hidden curriculum, no literature exploring these influences in physical therapy could be identified. As such, the purpose of this study was to examine the informal and hidden curricula in professional physical therapist education as they are perceived and experienced by PT students. By gaining an increased understanding of these curricular influences, educators of PT students will be able to better address potential negative influences and strengthen and support those influences that may be positive.

REVIEW OF LITERATURE

The idea that educational curricula contain both explicit and implicit components is not new. In the early 20th century, John Dewey17 noted that “collateral learning” has a more lasting effect on students than the formal curriculum. During the 1970s and 1980s, Kohlberg,18-19 Giroux, and Penna20 published on the role of the hidden curriculum in conveying norms and values. As described above, Hafferty2 further defined the explicit and implicit curricula in medical education as encompassing 3 areas of influence: the formal, informal, and hidden curriculum. In addition, he proposed that examination of the hidden curriculum should include consideration of program and institutional policy development, evaluation methods and processes, resource allocation, and institutional slang or nomenclature.

A number of authors have attempted to identify aspects of the informal and hidden curriculum in medicine and other health professions. Ho21 described examples of the hidden curriculum in nursing midwifery clinical education. She noted that in some cases, student nurse midwives adopt an attitude of subservience to the physician based on their observation of midwives in clinical practice. Others have illustrated the importance of spatial arrangements and physical facilities in the hidden curriculum of nursing education.22-23 For example, locating schools of nursing in standard buildings provides a statement to students about the view taken of their education by the institution's decision makers.24 Physicians having separate facilities in hospitals and faculty having staff rooms and separate eating areas in academic settings tell nursing students about their relationships with their teachers and other disciplines.22 The significance of language and metaphor in the hidden curriculum of nursing education has also been discussed.22-24 Much of the language of health care is dehumanizing and detached, and students learn this language as they become health professionals.22,24

The amount of time allocated to academic subjects and the type of required clinical rotations can also imply a hierarchy in the importance of knowledge that a practicing nurse requires.21 Several nursing authors discuss the powerful influence of the practice setting in transmitting the practice of nursing and nursing values to students.25-28 Difficulties arose when students experienced situations where what they learned in school did not match what they experienced in clinical practice. Students’ desire to fit in can lead to the adoption of practices that may differ from those taught in school as they seek to avoid rejection by the nursing staff associated with questioning standards or practices.25-27,28

In dentistry education, Masella29 describes the contributions to the professional development of students made by the elements of extracurricular learning that comprise the hidden curriculum. Several categories of the hidden curriculum in dentistry education are described, including faculty-student interaction, student-student interaction, extra-institutional clinical and research experiences, organized dentistry (ie, the professional association), faculty and student diversity, and an active alumni/alumnae network.29

A recent qualitative study of the hidden curriculum related to teaching pharmacy students about patient safety found that informal learning from teaching practitioners was given a high level of credibility by students, indicating the importance of role models in practice.30 In a commentary on the hidden curriculum in pharmacy education, Gardner31 discussed the hidden influences of messages sent by institutional policies and resource allocation, educator silences, and inconsistent formal versus informal messages students receive from role models.

The informal and hidden curriculum has been explored to the greatest extent in medical education. Haidet and Stein32 reviewed research on the assumptions, messages, and underlying premises as communicated through the informal curriculum in medicine. Identified premises included the following: doctors must be perfect; uncertainty and complexity are to be avoided; outcome is more important than process; medicine takes priority over everything else; and hierarchy is necessary. Illustrating how these premises are expressed, the authors stated, "in a medical school environment, one often encounters a demand for ‘right’ answers (avoidance of uncertainty); intimidation, public shaming, and humiliation (doctors must be perfect); the treatment of students as objects to be ‘filled up’ with knowledge and facts (outcome is more important than process); unhealthy competition (medicine takes priority over everything else); and deference to experts, regardless of teaching abilities (hierarchy is necessary)."32(p517) In a qualitative study utilizing semi-structured interviews with 36 medical students, Lempp and Seale16 examined student perceptions of teaching and the student-teacher relationship. Their results suggested that faculty role models were associated with traditional gender stereotypes (eg, females conveying more “human” attributes, males more power/authority). Hierarchy was enforced, in part, through humiliation and shaming, and the medical school experience was characterized by competition rather than cooperation. Other qualitative studies have also highlighted the importance of role modeling in students’ learning of positive or negative values and behaviors in medical education.33-34

Some of the research examining the informal and hidden curriculum in medical education focused on specific aspects of the curriculum. For example, in the area of relationship-centered care, Haidet, Kelly, Chou et al35 developed and validated a survey to measure faculty role modeling related to relationship-centered care, student experiences of non-patient-centered behavior, and support for patient-centered behavior.
This same instrument was also used to conduct a cross-cultural examination of these behaviors and experiences. A number of other researchers have focused on the relationship between the informal and hidden curriculum and the professional socialization of students. For example, Karnieli-Miller, Vu, Holtman et al. conducted a qualitative study in which third-year medical students were asked to write and reflect on critical events (positive or negative) that taught them something about professional values. They identified 2 main spheres of influence: the medical-clinical interaction, which included positive and negative observations of role models, and the teaching-learning environment. Additionally, these researchers found the student narratives identified all major American Medical Colleges-National Board of Medical Examiners professionalism categories and described whether these critical experiences were from the clinical or academic environment.

In contrast to content-specific emphases, other work in medicine has focused on elements such as student assessment and evaluation, the use and prevalence of multi-cultural case examples, and the role of partnerships between academic medical centers and industry in shaping the hidden curriculum. The role of the hidden and informal curriculum in the selection of specialty areas in medicine has also been explored. Specifically, perceptions surrounding gender parity, the “female-friendliness” of programs, and career choice modeling by faculty have been examined.

The informal and hidden curricula may function in harmony or discordance with the formal curricula. When in harmony, it serves to reinforce and strengthen the attitudes, values, and understandings promoted by the formal curriculum. In contrast, dissonance between the explicit and implicit curriculum can lead to indifference or a negative view of a particular value. It can also undermine an explicit curriculum content area such as human sciences or evidence based practice, or even create the expectation that students should be the kind of physicians that their teachers are not. It may also lead to emotional stress and cynicism. Rabow, Gargani, and Cooke found that medical students’ perceptions of curricular discordance was significantly and negatively correlated with both student perception of educational quality and student regard for institutional end-of-life care values. Other strategies students employed in response to values conflicts included maintaining their values, compromising their values, or transforming their values to those of the “real world”. In summary, this literature suggests that, among other factors, student-faculty interactions, role modeling, the teaching environment, and clinical experiences and observations all exert significant influence on the informal and hidden curriculum. This influence can function to reinforce or strengthen the stated aims of the curriculum and professional values, or work at cross-purposes with programmatic goals and professional development. As no research has been published relative to the hidden or informal curriculum in physical therapy, the purpose of this study was to examine the informal and hidden curricula in professional physical therapist education as they are perceived and experienced by PT students. Specifically, the following research questions were identified: (1) Do PT students believe there are informal and hidden curricula in the didactic and/or clinical portion of their educational program? (2) If yes, how would they describe the informal curriculum in the didactic portion of their program? The clinical portion? (3) If yes, how would they describe the hidden curriculum in the didactic portion of their program? The clinical portion?

Elucidating these influences will allow physical therapy educators to explore how positive forces in the hidden curriculum may be strengthened and negative forces addressed and/or altered. Furthermore, greater congruence between the implicit and explicit curricula should allow for an improved student learning experience.

**METHODS**

**Subjects**

This study used purposive sampling of PT students in their final year of physical therapist education. This criterion was selected since students near the end of their educational program have had the most time to observe and experience the formal, informal, and hidden curriculum. Participating Doctor of Physical Therapy schools were recruited from accredited programs in the Midwest as a matter of travel and financial constraints of the researchers. A mix of public and private universities, as well as a contrast in institutional size and classification, was intentionally sought. Students were recruited by faculty from 3 cooperating programs, using a script provided by the researchers to describe the study. Focus group (FG) interviews were conducted on the university campuses. Enrollments of the sampled classes ranged from 30 to 45 PT students. Eight to 10 students from each of the 3 cooperating schools (N = 28) volunteered for face-to-face focus group interviews. Two focus groups ranging in size from 3 to 5 students were held at each participating school. Data identifying student race and ethnic origin was not collected. Demographic characteristics of the student sample are summarized in Table 1. Institutional characteristics are highlighted in Table 2.

**Research Design**

This study utilized qualitative research methods. Qualitative research is well suited to study complex educational environments, how learners make sense of their educational experience, and subtle learning relationships. A phenomenological qualitative approach using focus group interviews examined students’ perceptions of the informal and hidden curriculum in their educational programs. Focus groups that allow exploration of similarities and differences in perspectives and conversation among participants may bring out information related to the group’s values, norms, and culture. The intent of a phenomenological study is to try to understand the meaning of someone’s “lived experience” and to depict the essence of the experience. Recently, Nichols argued that “the phenomenological concentration on each person as an island unto themselves has now shifted to a concern for the interconnections between people; the ways that meaning is derived not by individuals, but by symbolic interactions among communities.” Physical therapist students and core/clinical faculty constitute such communities.

**Data Collection Procedures**

After obtaining written informed consent, including permission to audiotape, each student was asked to complete a short demographic information form. Participants’ full-time clinical education history was also collected and is summarized in Table 1. Ground rules for the focus group were reviewed and included: (1) there are no wrong answers, (2) positive or negative responses are appropriate, and (3) share ideas even if they differ. Based on the work of Hafferty, definitions of the explicit formal, informal, and hidden curriculum were provided to ensure participants understood what was meant by these terms. An example of informal curricula was also provided. This introduction was followed by a series of semi-structured open-ended questions and probes (Appendix) designed to gather descriptions and information about the students’ perceptions.
Table 1. Characteristics of Focus Group Student Sample (N = 28)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>85.7%</td>
</tr>
<tr>
<td>Male</td>
<td>14.3%</td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>25.8 (3.6)</td>
</tr>
<tr>
<td>Range</td>
<td>23–40 years</td>
</tr>
<tr>
<td>Institution (Physical Therapist Education Program)</td>
<td></td>
</tr>
<tr>
<td>Public</td>
<td>64.3%</td>
</tr>
<tr>
<td>Private</td>
<td>35.7%</td>
</tr>
<tr>
<td>Number of full-time clinical experiences completed at time of focus group</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>28.6%</td>
</tr>
<tr>
<td>3</td>
<td>35.7%</td>
</tr>
<tr>
<td>4</td>
<td>35.7%</td>
</tr>
<tr>
<td>Regions in which one or more clinical experiences were completed</td>
<td></td>
</tr>
<tr>
<td>South Atlantic</td>
<td>3.6%</td>
</tr>
<tr>
<td>East North Central</td>
<td>42.9%</td>
</tr>
<tr>
<td>West North Central</td>
<td>79.0%</td>
</tr>
<tr>
<td>West South Central</td>
<td>7.1%</td>
</tr>
<tr>
<td>Pacific</td>
<td>17.9%</td>
</tr>
<tr>
<td>New England</td>
<td>3.6%</td>
</tr>
<tr>
<td>Mountain</td>
<td>39.3%</td>
</tr>
</tbody>
</table>

Table 2. Characteristics of Focus Group Institutions (N = 3)

<table>
<thead>
<tr>
<th>Institution</th>
<th>Control</th>
<th>Student Body Size (rounded)</th>
<th>Carnegie Classification*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institution 1</td>
<td>Public</td>
<td>13,000</td>
<td>RU/H: Research Universities (high research activity)</td>
</tr>
<tr>
<td>Institution 2</td>
<td>Private</td>
<td>5,300</td>
<td>Master’s L: Master’s Colleges and Universities (larger programs)</td>
</tr>
<tr>
<td>Institution 3</td>
<td>Public</td>
<td>10,000</td>
<td>Master’s L: Master’s Colleges and Universities (larger programs)</td>
</tr>
</tbody>
</table>


and experience with the informal and hidden curriculum in the didactic and clinical education portions of their professional physical therapist education. The interview questions were informed by the literature on the informal and hidden curriculum. The researchers summarized responses back to the participants as needed to ensure accurate understanding. Each of the sessions lasted 60 to 90 minutes. Both researchers participated in the focus group interviews, with one taking the lead on questioning and one taking notes and participating in the probes. The researchers debriefed and made field notes immediately following each focus group. All focus group interviews were audiotaped for later verbatim transcription. The transcripts were sent to each participant for review and feedback to ensure accuracy.

Data Analysis
The taped interviews were transcribed verbatim and field notes were reviewed on an ongoing basis. The researchers independently coded the raw data. During discussion of this initial coding, the researchers agreed that a majority of the emerging themes related to the profession’s core values as defined by APTA in *Professionalism in Physical Therapy: Core Values.* The researchers then independently re-coded the data utilizing a framework that linked student learning related to the implicit curriculum with the core values (Figure). A constant comparative method was used to describe, code, and group dominant patterns, categories, and themes based on this conceptual framework. Please refer to Table 3 for a complete summary of identified themes.

Triangulation is a process of using multiple methods of data collection, multiple sources of data, or multiple investigators to increase credibility and dependability in qualitative research. Conducting focus groups with multiple students from 3 different physical therapist education programs provided a source of triangulation for the interview data. In addition, all interview data were read and independently coded by both researchers. Comparison of the coding results of this study found a high degree of consistency between the researchers. Where there were minor discrepancies, the researchers re-read the transcript and discussed the data until agreement on categories was reached. Saturation of data, where no new insights were occurring from the focus group interviews, was reached relative to the core values. However, additional research is needed to establish themes related to the hidden curriculum among types of physical therapy educational settings (ie, housed in a medical school or not, public versus private institution, etc).

RESULTS
The first research question asked whether PT students believe there are informal and hidden curricula in the didactic and clinical portions of their educational program. Our results indicated that all student participants believed that informal curricula were present in the didactic and clinical portions of the education program. For the hidden curriculum, the majority of students believed it existed in the didactic but not the clinical aspects of their curricula.

The Informal Curriculum
The second research question asked PT students to describe the informal curriculum in the didactic and clinical portions of their educational program. In addition to themes illustrating what students learned through the informal curriculum, 3 major influences depicting how this curriculum was impart-
ed emerged from these data. These influences included faculty, clinical education, and peers. Faculty influenced the informal curriculum through student observation of faculty members, faculty relationships, student-faculty interactions, as well as the assignments, examinations, and class activities that faculty designed and implemented. Student engagement with clinical instructors, as well as their observation of and participation in patient/client management and intra- and inter-professional relationships, defined the clinical education influence. Finally, peer influence was imparted through relationships between students. Themes associated with these influences and their connection to the physical therapy professional core values are described below.

**Faculty**

Four themes emerged from these data related to faculty influence: professional relationships, standards of excellence, habits supporting excellence, and professional association involvement. As previously described, each theme was mapped to a core value and these results are organized in this manner.

*Compassion/Caring.* In APTA’s core values
document, compassion is defined as "the desire to identify with or sense something of another's experience; a precursor to caring."\(^{3(p1)}\) Caring is described as "concern, empathy, and consideration for the needs of others."\(^{3(p2)}\) In terms of faculty influence, student learning around this core value was centered on the expression of compassion and caring in the context of professional relationships. This theme is described below.

**Professional Relationships.** As noted above, a facet of becoming a PT that students learned from faculty included how professionals interact with others. Students described their learning related to this theme as encompassing relationships between physical therapy colleagues, as well as relationships with patients and other health care team members. These relationships were characterized by several indicators of the value of compassion and caring, such as concern and consideration for the needs of others, support, respect, and effective communication. One indicator, for example, was depicted by student participants as a holistic approach by faculty towards faculty-student relationships and patient care. In particular, students likened their relationships with faculty to family, and described faculty members as caring about them personally and demonstrating an interest in their lives beyond the classroom. The following description of a student's relationship with faculty exemplifies this aspect of compassion/caring:

I feel like this is my second family...I feel like I can talk to my professors like...they're my mom or dad, and then just – I mean...they're caring and understand that you're human, that you have needs... (Focus Group 1)

Students also saw faculty-student relationships as a model for how they should interact with their patients and clients as described below:

...Taking your patients and treating them as a whole person...they're not the 'new patient'; they are your patient, and they have a life and they have emotions...so I feel what our professors are doing...they're not just teaching us classes, they're teaching us life skills, so that when you go out in the clinic...you're looking at more than just their [the patient's] knee pain or their ankle sprain.... (FG 2)

In addition, informal curricular messages about a holistic approach to patient care were present in the assignments and class activities designed by faculty. One student stated:

*We talk about in classes...how to handle patients, just being curious and realizing that they're people...and that's brought up a lot in patient handling and ...tutorials. 'How would you handle this patient differently? How will you treat them as a real person, not just a pathology?' There's also a little bit of compassion, which I think is another strong value... (FG 3)*

Respect in professional relationships was another aspect of compassion/caring that emerged in relation to interactions with faculty as well as patients. Specifically, participants described relationships between faculty and students that embodied mutual respect and collegiality. As part of this, students mentioned calling faculty by their first names and having faculty members' home phone numbers. One student (FG 5) also noted, "We respect them [faculty] immensely, but we can joke around with them," while others (FG 6) felt that faculty "generally have respect for our [students'] knowledge." Respect was also learned through observation of faculty-faculty interactions as described by this participant:

...just through interactions, like even watching...the professors interact with one another if they're teaching together. We have some professors that are more—like they'll joke around with each other, but they still—on a professional level, you can tell they still are very respectful of one another... (FG 2)

Support was another compassion/caring-related component of professional relationships that emerged in student descriptions. Students repeatedly expressed that they felt supported by the faculty in terms of availability, willingness to answer questions, and openness to providing assistance in other ways. One participant (FG 3) stated faculty "...never give the impression that they're being bothered by asking more questions or having an idea..." and another noted that the academic coordinator of clinical education had often told them:

...If you're ever having a hard time in your clinicals, and you're crying, cry to me. Tell me whatever. [She] gave us her personal cell phone number in class one day and said, 'If you ever have a concern, call this number. At 3:00 in the morning it doesn't matter.' (FG 6)

A final aspect of professional relationships which students described learning informally via faculty observation was how to communiate and interact with patients as illustrated by a student who stated:

...when we're having a lab and they're demonstrating on a student, I think in the way they interact with the student...they show how we should be interacting with our patients... (FG 2)

Other informal curricular messages influenced learning related to professional communication skills. For example, participants (FG 4) noted that group projects taught them "...to be able to address conflict in a constructive manner...rather than avoiding it or being passive." Another aspect of professional communication conveyed informally to students was the importance of confidence, described by 1 participant here:

His [the faculty member's] big thing is confidence...because like practicals...you may not get the right answer, but if you say it firmly, he's more apt to nod, but if you're, 'uh,' he'll try and trip you up. (FG 6)

**Excellence.** The core value of excellence is defined as, "physical therapy practice that consistently uses current knowledge and theory while understanding personal limits, integrates judgment and the patient/client perspective, embraces advancement, challenges mediocrity, and works toward development of new knowledge."\(^{3(p3)}\) Two themes associated with faculty influence and the core values of excellence were identified. These were standards of excellence and habits supporting excellence.

**Standards of Excellence.** One aspect of the informal curriculum that students learned from faculty included an understanding of how excellence was defined in physical therapist education. In this context, excellence was associated with high levels of performance and the mastery of large amounts of content. For example, 1 student described the performance expectations as follows:

I remember our professor giving us a pretty livid lecture in an anatomy lab and going, 'If you get a 76% on the anatomy test, you'll only know 76% of the material, and your patient expects you to know all the material, not just limiting it to the grade, but...to truly understanding what's going to be applicable in your career. (FG 1)

Another noted:

...the message I got from the program was perfection...that was loud and clear to me... (FG3)

For 1 program in particular, this standard of excellence was strongly linked to the program's reputation:
Meeting these expectations was described as requiring “a driving work ethic” (FG 3) and involving an intense workload as illustrated below:

They give you and they keep giving and they keep giving and keep demanding from you, and it’s shocked me with how much I can actually do as a person... it feels like they tore me down to build me up to this better person... (FG 1)

While the standards of excellence were consistently described as high, students also noted that these standards were not always clearly defined and varied between faculty members. As these participants stated:

...As far as... the practical exams go... sometimes I think between teachers... one is thinking of a certain standard and then the other one might not be quite on the same plate, so that’s a little frustrating sometimes. (FG 2)

...Many folks I’ve heard in the hallways... want to know who their tester’s going to be because, our performance, we change it depending on who we have... (FG 3)

Habits Supporting Excellence. Students also learned habits or behaviors supporting excellence from the faculty through the informal curriculum. These habits encompassed approaches to learning and clinical practice that facilitated achievement of the standards of excellence described above and included critical thinking, reflection, lifelong learning, and stress management. For example, participants expressed that they were both learning how to think as well as becoming aware of biases. One student stated:

I feel the professors are teaching us to seek further knowledge and not just take at face value what somebody says. Just because somebody is doing this doesn’t mean it works. Go find out if it works for yourself. One, by doing it and seeing the result you get with patients, and two, see what the literature says, because once you’re done with school, you’re done, and it’s your responsibility... (FG 1)

Students also noted that critical thinking was encouraged through written exam questions, oral components to practical examinations, and the incorporation of research across all of their course work. Faculty made students aware of their biases but also encouraged them to make independent decisions. For example, 1 participant noted:

...we do talk about bias and how to separate your biases from your treatment as well, but... I thought it was emphasized, we know our professors do have bias, but a lot of them are really good at saying... don’t take this as the word... (FG 5)

Students also perceived an emphasis on reflection and observed modeling of this habit by faculty as exemplified in the quotes below:

Well, as far as the self-assessment in particular, I think it’s just kind of a thread that we had every semester, and we had our review with the faculty and it also involved, ‘Well, what do you think are your weaknesses? What do you think are your strengths?’ (FG 6)

And I really like that it’s not just us. We’re not just required to reflect. We know that the faculty is reflecting through the course evaluations. (FG 4)

In terms of lifelong learning, students made particular note of the fact that faculty were learning alongside them by keeping up with current literature and engaging in continuing education. As 1 student commented:

I mean, our faculty... they still keep up on their research. They’re still reading and coming up with new things like, ‘Oh, I just read this article yesterday,’ so they come into class and share it with us... (FG 1)

The final habit supporting excellence identified by students was stress management. This stress was related to management of the curricular load associated with physical therapist education as well as performance during practical examinations and during clinical education experiences. For example, as 1 student noted, “One thing that the assessments or the practical tries to teach us is to perform under stress...” (FG 3).

Professional Duty. A final core value imparted by faculty through the informal curriculum was professional duty. In particular, the aspects of professional duty related to “involvement in professional activities beyond the practice setting” and “promotion of the profession of physical therapy” were influenced by faculty. (FG 3)

Professional Association Involvement. This theme involved learning to value and engage in activities associated with APTA. Students described learning this through faculty encouragement, completion of assignments requiring them to use APTA resources, and faculty role modeling. For example, respondents commented:

They just encouraged us to get involved... when issues are coming up, there will be teachers who will say, ‘This is going on,’ or in a lot of classes, they’ll print off actual pages or articles from the websites and give them to us, so they try to use the stuff from APTA as much as possible and just really encourage it. (FG 2)

...I feel like involvement in the APTA is something that’s really strong in the faculty, so if you go to a conference, you see faculty members... there’s a reinforcement to keep involving yourself, because you see that example being set. (FG 4)

Clinical Education

Five themes emerged from the data related to clinical education experiences: (1) patient-therapist relationships, (2) teamwork, (3) evidence-based practice, (4) patient/client management, and (5) health care environment. These themes were associated with the core values of compassion/caring, excellence, and integrity.

Compassion/Caring. Similar to what students experienced with faculty, participants described the implicit influences of the clinical education environment on the development of caring and compassionate ways of being and interacting.

Patient-therapist relationships. Students described informal learning of caring and compassion through observation of the interactions between the therapist and the patient in the clinical setting. The power of role models is illustrated in the following quote:

I think the clinical is where I learned more of that compassion piece and empathy, just by watching how patients would respond to how their therapist was interacting with them. But that really showed more about how important that is in patient care, just by the way that a patient would be able to respond or whether they felt like their needs were being met or heard... (FG 3)

Another student (FG 2) noted, “…at both of my clinicals, they really stressed patient care, their concerns need to come first.” Students also learned from negative role models as conveyed in the quote below:

Sometimes when you see a therapist do something that you don’t approve of, you
learn from that, like 'I never want to be like that'...you can learn from the bad things too. (FG 5)

Teamwork. The importance of teamwork, with the patient at the center, was clearly learned by students through observation and participation in clinical education. This value was reinforced through both positive and negative examples. As 1 participant noted:

...we all have our own piece of the puzzle, and if we try and do it by ourselves, it might not be as good as if we would have asked someone else to give their input as well. Working by yourself isn't always better for the patient. I saw my PT go out and ask for help, because she knew she needed some of that assistance in different experiences. (FG 1)

Students also learned about social and political nuances related to interprofessional work as illustrated by this participant:

I think too, some of the politics between interacting with other professionals...you have to make sure you're being respectful, or even with specific relationships, like this doctor really doesn't like to be emailed...figuring out what's going to make the best communication with each person... (FG 5)

In addition, an appreciation for other professionals and the value of collaboration was engendered through clinical education. As 1 student commented:

I feel it's just the interaction with other clinicians that you don't get to experience. You learn about it and you learn about how you're supposed to meet with people that are working on the same patient as you, but until you see them work together to meet a common goal, that's huge in the clinic, and that was a big thing for me to see an OT and a PT really figure out what they're going to do with this person to get them to transfer without weight bearing on 3 different appendages... (FG 1)

Excellence. Two themes were identified that were associated with the influence of clinical education and the core value of excellence. These themes were evidence-based practice and patient/client management. Furthermore, this was an area in which students experienced dissonance between what they had learned in the classroom and what they experienced in clinical practice.

Evidence-based practice. All of the students described a strong emphasis on evidence-based practice in the didactic component of their educational programs. During their clinical education experiences, however, students informally learned that the plan of care was not always based on the evidence. Some students (FG 5) noted that while their clinical instructors valued evidence-based practice and were interested in research, there were, "...still some things that my CI was like, 'Well, this is what we do, because this is what it's [always] been.'" Another student commented:

...we're very heavily focused on evidence-based, and so a lot of us had the perception that things that don't have evidence research behind it is, not to be rude, but kind of crap...until we went to our clinicals and saw some of these things put to practice and actually working. (FG 6)

Patient/Client Management. Students also experienced dissonance around standards of excellence related to the process of patient/client management. Physical therapy examination was one area in which they observed conflicts between what they learned in the classroom and what the standards of practice were in the clinic. These conflicts centered on the level of specificity needed for physical therapy examination as well as the balance between thoroughness and efficiency. For example, 1 student noted:

...I think it's very important for us to learn...each specific manual muscle test. But when we were out...in that acute-care setting and you have a patient in the bed...everything is just gross...I feel like we should maybe get a little bit more, 'But this probably what you'll do in the clinic'...so just a little bit more reality of what really is going to happen when you get out there... (FG 2).

The importance of prioritizing efficiency was emphasized by another student who stated:

I think CIs teach a lot about what's important...all the information we were taught [in class] to do in an eval would take you 3 hours, and it's not appropriate for every patient, so I think the CIs are really important at teaching, you know, this is the important part of this for this particular patient...just discerning for efficiency... (FG 6)

Similar conflicts between classroom teaching and clinical reality were also observed by students in relation to documentation. As 1 student noted:

I would say 1 thing is that...I think when you get out into the clinic, a lot of what is pitched in class and what we talk about, I think I see a lot of corners being cut in the clinic, and it's because what's discussed in class is ideally what the APTA would like to see from you in terms of documenting or systems review or whatever it may be. This is what the profession has for their expectation. And you get into the clinic, and it's 'Well, yeah, but we really don't have time for all that' or 'Why do we need to do that?' (FG 4)

This was a conflict that students found difficult to resolve as this student reflected:

...You don't want to be the person, though, telling your CI, 'Well, no, this is what we did in class, and this is the right way...' (FG 4)

Students also observed practice variability in approaches to patient/client management within and across different clinical settings and geographical areas. As 1 student observed:

I would say just—I had 2 ortho ones [clinical experiences] in different parts of the country, and the protocols were so—like just for a simple ACL, how philosophies are so different between physicians and the same with physical therapists, but I was surprised by kind of just the difference between regions of the country, how there's not just one best way to do it. (FG 5)

Variability in practice standards as modeled by clinical instructors was also observed:

Coming from...my first clinical, my CI was head of the rehab department. He was just a very recent graduate of a tDPT program, so he was all about a lot of the things that we were doing in class. Going to my second internship, where the CI was not a member of the APTA, had not really done a lot as far as continuing education. I think you learn a lot about what you want to do, but also a lot about what you don't want to do."(FG 4)

Integrity. The core value, integrity, is defined as "steadfast adherence to high ethical principles or professional standards; truthfulness, fairness, doing what you say you will do, and 'speaking forth' about why you do what you do."[96] The major theme related to clinical education and the core value of integrity was the health care environment, particularly challenges associated with productivity and reimbursement.

Health Care Environment. The current health care environment is demanding, rapidly changing, and tightly tied to financial
constraints. Productivity is closely monitored and creates dilemmas for students in patient care, as described by this student:

...I had a hard time drawing the line between productivity and then also providing quality care, because...in our curriculum...generic abilities are focused on so much, but then when you go into clinic, the real world, it's like how many minutes do you have? What was your productivity today? And that adds a lot of pressure...in one of my clinicals...I wanted to be there for the patient more, and the CI was...all about productivity...I always struggle with...where to draw the line between how much can I justify staying back after my hours. (FG 4)

This struggle was set in the context of the realities of clinical practice, as 1 student put it:

Or, you know, make sure you aren't rushing, and you need to complete the full eval...and you get out there and...there's no time to do any of the stuff we're supposed to be doing. It's hard because...it is a business and their department is under pressure from the people up higher to be making more money and getting more people in. And it's, well, we have to worry about the patient more than the money, but business people don't really care about that, so it's kind of a tough situation that a lot of places are in. (FG 1)

Reimbursement was another area that raised issues of integrity for students during clinical education. This was associated both with limits to visits and the provision of unnecessary care in order to qualify for greater reimbursement, as noted by this student:

...we learn all the ideal things and then you get to the clinic, and you realize maybe some of them aren't realistic, so you have to do the best you can within the means of the patient and the clinic, and you know, insurance limitations or maybe the patient's schedule limitations. (FG 5)

Another student commented:

...I've also seen the opposite. Instead of trying to decide how long to spend with a patient, having patients who are very sick but are in their RUG levels for Medicare and having to get a certain number of minutes and being at the end of certification, and we had a patient who had Stage IV cancer and was dying...and we have to get 53 minutes today...and so that was a very big struggle for me... (FG 4)

Peers

The influence of peers also emerged as an important part of the informal curriculum in physical therapist education. Two themes were identified from the data related to peer influence: (1) family, and (2) teaching/learning. These themes were associated with the core values of compassion/caring and excellence.

Compassion/Caring. In terms of compassion/caring, students were connected with each other based on shared experience. As 1 student noted, "...we live together, we eat together, we are in the classroom all day long together, all night we're studying..." (FG 6)

Family. As with faculty, peer relationships were also described in the context of family and all that family typically engenders (support, relationship, shared experience). One student stated:

...it's kind of like a big family. If you have a problem, you're usually calling, or if...you're stressed out about something, you know 45 other kids are stressed out about it as well, so you have that comforting thought right there... (FG 2)

The student culture was not perceived to be competitive, but a team environment, emphasized by the following student statement:

...in the first year, it is said, but it's a little more hidden per se, that it's a non-competitive environment. We're supposed to help everybody along, and we're a team. We're all in the same boat. We're all stressed. Let's just pull together and make the best of it... (FG 3)

This culture also fostered a sense of support described by 1 student as follows:

...a sense of unity that we are all going through the same thing and knowing that we can rely on each other and that it's okay to be vulnerable with this group of people...it's taught me a lot about getting through stressful things...more than 1 perspective to take. (FG 1)

Excellence. The core value of excellence was influenced by peers in 2 ways: (1) facilitation of teaching/learning related to the didactic and clinical education curriculum, and (2) strategies for managing life in a professional program.

Teaching/Learning. Students spoke about how their learning was supported through sharing knowledge and experience with one another. This included learning about the clinical education experiences of their classmates as well as each class member's different strengths or skills. For example, 1 student (FG 3) commented, "...I enjoyed learning about...their clinical experiences. Some people learned a different technique and they'd show us...and now it's in my tool box also." They also spoke of how classmates supported their learning because they had diverse approaches to class content. This respondent supported that notion in the following statement:

...we definitely teach each other a lot and have different ways of thinking about stuff. I know that there are certain professors that I just don't think the way they do, so I really have a hard time understanding it, but some of my classmates understand how they say it and can translate into my language so that I can understand a little better...so I think we help each other out a lot... (FG 2)

Students also taught each other strategies for approaching and managing life while in professional school. For example, 1 participant commented:

I feel like just managing school...everyone has their own way of dealing and managing stresses in their lives and what's going on, so just seeing...the way they do that...you're finding new ideas and you're finding new ways of doing things by just talking with your classmates and seeing how they're doing things. (FG 2)

Hidden Curriculum

The third research question asked PT students to describe the hidden curriculum in the didactic and clinical portions of their educational program. Two major influences on student learning and development associated with the hidden curriculum emerged from the student descriptions. These influences were the physical environment and policy. The physical environment influenced the hidden curriculum through messages the students perceived from the physical locations of program departments within institutions, space configurations and purposes, and available equipment. Student behaviors and actions, shaped and encouraged by formal and informal policies and practices, delineated the policy influence. Three themes related to the influences of the hidden curriculum, all of which were associated with the didactic portion of the curriculum, were identified. These themes and their connection to the physical therapy professional core values are described below.
Physical Environment

The theme that emerged from the data related to the influence of the physical environment was faculty relationships. This theme was associated with the core value of compassion/caring.

Compassion/Caring. Focus group (FG) participants described the implicit influences of the physical environment on promoting positive relationships.

Faculty relationships. Relationships with faculty were described as enhanced when the faculty were physically located near one another, when office doors were consistently open, or when there was shared social space in which students and faculty could interact informally. These notions are reflected in the following student statements:

...I feel like a lot of times when we're eating lunch in the lounge, the faculty use the microwaves and stuff in the lounge too, and use the fridge, so it's kind of nice because we have that interaction there...and that fosters that open communication... (FG 2)

...the professors—their offices are pretty accessible, so you could be studying and have a quick question and run up and ask a question and peek your head in, so they're pretty accessible, and it's nice that everything is in 1 area. (FG 5)

Excellence. The theme of educational quality was associated with the physical environment and connected to the core value of excellence.

Educational quality. Students perceived the quality of the physical surroundings and equipment to be related to the quality and value of their education. In addition, they viewed it as reflecting the educational priorities of their program. For example, 1 program had group study rooms that were accessible in the evenings. Students from this program noted, "...I think they promote group study quite a bit..." (FG 5). Similarly, a student noted:

...We see updated equipment a lot. I participated in a research project and got to see firsthand all this research equipment and how they have put money into that every year to make that better. (FG 1)

Institutional differences were more clearly represented in this theme. For example, 1 student from a program that was part of an institution with a medical school stated the following:

...the space is definitely an issue for us, and not being able to get into the depart-

ment after 4:30...we are in a med school, but sometimes I feel like we aren't quite part of the med school because of the fact that the med students do have access to the building 24 hours a day and they can stay, but we're not allowed to...we're part of the med school, but I feel like we're not technically part of the med school. They kind of just put us in our hallway, and we're supposed to stay there. (FG 2)

Similarly, at an institution where the physical therapist education program was located on a satellite campus (without all the facilities and services of the main campus), students noted:

...I'm getting a fine education here. I mean the DPT program is phenomenal, but...it almost feels like it's an afterthought here...a second rate citizen almost. (FG 4)

Policy

The influence of policy was related to both formal and informal program policies and their implementation. One theme, professional association involvement, was identified from the data related to policy. This theme was associated with the core value of professional duty.

Professional Duty. Student level of involvement in professional activities was clearly influenced by program policies and practices.

Professional Association Involvement. Students were keenly aware of and discussed the influence of policies related to APTA membership and participation. For example, a number of the programs included in this study had policies requiring students to be members of APTA. In the case of 1 program, there was an alumni fund supporting half the cost of APTA membership dues for each student. Students clearly perceived this as a statement about the values of the programs in which they were enrolled. In addition, students mentioned policies that supported conference participation, such as funding and time off from class, as important elements that taught them about professional duty. As 1 student stated:

Well...just recently this last weekend...we had student conclave, and a lot of schools, they don't allow their students the time off to...travel and go to it, but here they give us off Thursday and Friday, so we have time to travel there and actually go to it if we want... (FG 2)

Another student noted:

...the [importance of the APTA] is evi-

enced by the promotion of the confer-

ences, the time off that's given to us, that's excused. If you want to go to a confer-
ence...you don't have to make those [days] up in the clinic... (FG 4)

DISCUSSION

The results of this study indicate that PT students do believe that informal and hidden curricula are present in the didactic and clinical aspects of their programs. The themes that emerged from these data describe what students were learning from the implicit curriculum, and the majority of this learning was associated with the informal curriculum. Only 3 themes (faculty relationships, educational quality, and professional association involvement) were tied to the hidden curriculum. All of the identified themes and related student learning were linked to 1 of the following core values: compassion/caring, excellence, integrity, and professional duty. In contrast, none of the themes described in this study mapped to the remaining core values of accountability, altruism, or social responsibility. In some cases, students from individual schools made statements associated with these values but they did not surface as themes that were evident across the physical therapist education programs included in this study. This finding is in juxtaposition to a recent study in medicine in which all of the professionalism categories identified by the American Medical Colleges-National Board of Medical Examiners were identified by medical students.40 These values may be differentially inculcated at particular institutions based on mission or institutional type. For example, many religiously-affiliated institutions are particularly committed to social justice and, as such, the informal or hidden curriculum may differentially impact student learning at programs within these institutions as it relates to social responsibility. This finding may also suggest that while these are identified as stated values of the physical therapy profession, the reality may be that they are not actually lived out in our professional culture. This would be consistent with a recent study of social responsibility in physical therapy in which PTs valued volunteerism personally, but did not view it as a professional responsibility.57 As such, these values warrant further study, and educational programs may wish to consider the extent to which they are expressed in both academic and clinical settings.

Furthermore, these data suggest that the mechanisms by which the informal and hidden curricula are imparted to students include the influence of faculty, clinical education, peers, the physical environment, and policy.
These influences are consistent with those described in other disciplines. For example, the impact of the physical environment and policy has been explored in nursing and pharmacy. Similarly, faculty and peer influence on the informal curriculum have also been established in dentistry and medicine, and the impact of clinical education has been identified in nursing. The premise communicated through the informal curriculum in medicine as described by Haidet and Stein was the avoidance of uncertainty. This theme was identified, to some extent, by PT students in this study. Specifically, students associated the importance of confidence and avoiding the appearance of uncertainty in their interactions with patients and clients with the informal curriculum. One argument is that a confident demeanor may be associated with patient comfort and trust in their health care provider. Conversely, over-confidence could also be associated with a failure to seek assistance when needed, or the failure to admit to, reflect on, and learn from errors. Finally, students also appeared to be learning important elements of interprofessional practice through the informal curriculum. In particular, it is of note that most of the interprofessional competencies identified by the Canadian Interprofessional Health Collaborative (role clarification, patient-centered care, team functioning, interprofessional communication, and interprofessional conflict resolution) and the Interprofessional Education Collaborative (values/ethics for interprofessional practice, roles/responsibilities, interprofessional communication, and teams and teamwork), were evident in student descriptions of learning related to the influence of clinical education and the core value of compassion/caring.

As with compassion/caring, the core value of excellence was also influenced by both the informal and hidden curriculum through faculty, clinical education, peers, and the physical environment. Taken together, the themes identified in relation to this value (Table 3) suggest that students are learning many behaviors associated with achieving excellence through the informal curriculum. These behaviors included approaches to learning and clinical practice such as critical thinking, reflection, lifelong learning, and learning from others. In particular, the importance of reflection has been noted in the education and physical therapy literature for a number of years, and it was heartening to find this emerge as a significant aspect of the informal curriculum from student perspectives. One theme related to the hidden curriculum was educational quality, which was identified for the core value of excellence. Specifically, the location of the program and its available resources affected student perceptions of educational quality and the position of physical therapy relative to other health care professionals. For example, the location of the physical therapy department and the quality of the facilities and equipment in comparison to other disciplines on campus were clearly important influences on the hidden curriculum relative to student learning about the health care team, the value of their education, as well as institutional and programmatic priorities. Similar findings related to the physical environment and perceptions of hierarchy among health care practitioners were identified in nursing.

One theme, health care environment, was identified for the core value of integrity. This theme, along with components of 3 of the themes associated with excellence (standards of excellence, evidence-based practice, and patient/client management), highlighted areas where the standards of excellence or integrity espoused in the academic setting did not match those of the clinical environment. This phenomenon has also been identified in other disciplines such as nursing, pharmacy, and medicine. In particular, identified areas of dissonance or difference between the academic and clinical setting were related to requirements for specificity and thoroughness of physical therapy examination, the application of evidence-based practice, documentation, productivity, and reimbursement. While other literature has suggested that students face with values conflicts may maintain their values, compromise their values, or transfer their values to the “real world,” this study did not specifically address how students coped with the differences they observed between the expectations of the academic versus the clinical setting. As such, this is an area that warrants additional research. In terms of excellence, the finding of varied standards between faculty and across clinical settings is another area that should be addressed by physical therapy educators and practitioners in the future. If the profession does not agree on standards of practice, students will continue to have difficulty discerning what truly excellent practice looks like. In addition, it may be that educators could better acknowledge these differences and assist students to navigate perceived conflicts between academic teaching and clinical reality.

The core value of professional duty was associated with faculty and policy influences and related to the theme of professional association involvement. The results of this study clearly indicated that faculty role modeling was a powerful informal influence on students’ perceptions of the professional organization and expectations for professional involvement and membership. Similarly, formal and informal policies that supported time off to attend conferences and encouraged membership were clearly influential in...
teaching students about this value.

Limitations
Due to funding constraints, this study was limited to focus groups at 3 physical therapist educational programs in the Midwest. Incorporation of a greater number of institutions with geographic representation across the United States is necessary in order to draw broader conclusions about physical therapy education. The role of institutional type and mission in the expression of the informal and hidden curriculum should be further examined. In particular, it is possible that the profession’s core values are differentially emphasized and expressed across programs. While some values appear to be universal, perhaps others are not. Future research is also needed to focus on how students cope with dissonance between the academic and clinic setting. It may be that physical therapist education programs need to better prepare students to maintain their values in the face of such dissonance. In this case, exploration of methods that support students to successfully navigate these conflicts would be warranted.

CONCLUSION
The purpose of this qualitative research study was to examine the informal and hidden curricula as perceived and experienced by PT students. Participants in this study did believe that informal and hidden curricula were present in the didactic and clinical portions of their educational programs. This implicit curriculum was imparted to students through the influence of faculty, clinical education, peers, physical environment, and policy. Themes illustrating what students were learning from the informal and hidden curricula were linked with the core values of compassion/caring, excellence, integrity, and professional duty. In particular, student learning related to compassion/caring was associated with attributes of successful relationships, including a holistic approach, support, respect, professional communication and collaboration, teamwork, and shared learning. Dissonance within the informal curriculum was identified as it related to examination and evaluation, documentation, practice standards, and approaches to productivity and reimbursement. These, as well as the strategies used by students to cope with this dissonance, are areas that warrant future exploration. In addition, the physical environment was influential in either facilitating or inhibiting positive faculty-student and interprofessional relationships, and sent clear messages to students regarding programmatic quality. Finally, both faculty and policy had a significant influence on professional duty as it related to membership and participation in APTA.

REFERENCES


### Questions

1. a. Given the definition of “hidden curriculum,” do you believe there is a “hidden curriculum” in the didactic portion of your physical therapist (PT) program? If so, please describe what you perceive is the hidden curriculum.

   b. Do you believe there is a “hidden curriculum” in the clinical education portion of your PT program? If so, please describe what you perceive it to be.

   **Potential probes for question #1:**
   - What do the physical surroundings of your PT school communicate to you?
   - What does the amount of time spent on various content areas in the curriculum communicate to you?
   - How does assessment/evaluation contribute to the hidden curriculum?
     - Didactic assessment/evaluation
     - Clinical education assessment/evaluation

2. What are the values of your PT program as you perceive them? How did you learn about those values?

3. Describe the consistency or inconsistency you see of theoretical care (what you have learned in the classroom) with clinical care.

   **Potential probes for question #3:**
   - What have you seen faculty and/or clinical instructors do or say that surprised you? Describe a positive and a negative example.

4. Describe your interactions with faculty and other students. What topics do you discuss? What is the context of your interactions? What do you like or dislike about your interactions with faculty and/or other students?

5. What do you learn about the informal curriculum by observing your didactic and clinical faculty? Please describe what they role model.

6. Do you perceive any conflicts between the explicit and the informal and/or hidden curriculum?

**Potential wrap-up questions:**
- Of all the things we discussed today, what to you is the most important?
- After the moderator reviews the purpose of the study, participants will be asked, “Have we missed anything?”