

The Hidden Ethics Curriculum of Clinical Efficiency: How Time Pressure Reorders Moral Attention, Patient Voice, and Professional Values

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Abstract

Clinical efficiency is indispensable to safe, timely, and sustainable care, yet it may also function as an unacknowledged moral teacher when organizational tempo repeatedly determines what receives time, protection, and attention. This critical conceptual article examines how time pressure may become part of medicine's hidden ethics curriculum. Drawing on evidence from medical education, clinical communication, professional identity formation, patient-centred care, and learning-environment research, it distinguishes efficiency itself from the normative ordering that can arise when speed, task closure, and throughput repeatedly outrank listening, explanation, reflection, and relational continuity. The analysis proposes three linked constructs: redistribution of moral attention, compression of patient voice and deliberation, and practical reordering of professional values. It further argues that learners may interpret recurrent workflow priorities through role modelling, feedback, and experiential socialisation, while also resisting them or experiencing moral distress. Two manuscript-derived conceptual exhibits specify how operational tempo may acquire moral salience and where workflow vulnerability may emerge without treating these relationships as validated causal pathways. The principal contribution is the Hidden Ethics Curriculum Model, which links temporal organization to professional formation while preserving learner agency, contextual variation, and ethically justified haste. Implications concern curriculum design, faculty development, assessment, and organizational redesign. The model remains conceptual: no universal time threshold, causal effect, validated measure, or patient-outcome benefit is claimed, and brevity, expertise, or urgency may sometimes support rather than undermine ethically appropriate care.

Keywords: Hidden curriculum, Clinical efficiency, Moral attention, Patient voice, Professionalism, Medical education

Introduction

Efficiency as an unacknowledged moral teacher

Efficiency is usually discussed as an operational virtue: reduce delay, avoid duplication, complete necessary work, and steward scarce clinical resources. In medical education, however, temporal organization also shapes what learners repeatedly see protected or sacrificed.

Haruta's critique of temporal monoculture argues that educational systems oriented toward efficiency and outcomes may marginalize slower, relational, and reflexive forms of time [1]. The critical question is therefore not whether medicine should become "slow," but whether recurrent temporal priorities can acquire normative force. This article proposes that efficiency may function as a moral signal when learners infer from routine practice which obligations deserve interruption, continuation, or deferral.

Workflow makes that possibility concrete. A national study of resident doctors found administrative activity occupying substantially more training time than direct patient contact, illustrating how organizations distribute professional attention before any individual clinician

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decides how to use it [2]. The finding is context-specific and does not establish that administration is ethically inferior. It nevertheless supports a structural premise: patient-facing time is partly produced by institutional design. What is reliably protected within the workday can therefore become educationally visible.

Time scarcity may also alter the conditions of careful clinical work. Primary care physicians have described insufficient time as constraining attention and contributing to near misses, while sometimes portraying additional time as protective [3]. These qualitative accounts do not establish a causal risk coefficient. Their ethical significance is that some clinical goods require discretionary attentional latitude: opportunities to notice, revisit, contextualize, or remain with uncertainty.

Relational qualities are likewise not reducible to personal virtue. Systems-ethics work argues that institutions can enable or disable clinicians' capacity to act empathetically [4]. Learners observe both conduct and the conditions that make such conduct feasible. Yet efficiency is not an ethical wrong in itself. Biomedical ethics is plural, and obligations concerning autonomy, beneficence, nonmaleficence, justice, and related considerations cannot be settled by one operational criterion [5]. The concern developed here is narrower: when efficiency becomes an unexamined superordinate priority, organizational time may begin to teach a practical hierarchy that formal ethics never explicitly endorses.

The hidden curriculum as a moral mechanism

The hidden curriculum names what learners acquire from institutional routines, social relations, reward structures, and everyday practice beyond formal teaching. Contemporary review evidence shows that these informal environments can shape attitudes, values, professionalism, and professional identity [6]. The hidden curriculum can reinforce humane norms as well as contradict them. Its ethical significance arises because repeated practice can convert what appears operational

into what feels professionally expected. A timetable, supervisor response, queue, or tolerated shortcut can carry moral information without being presented as an ethics lesson. The relevant question is what the workplace repeatedly makes possible, difficult, praiseworthy, or dispensable.

That information is not encountered uniformly. Qualitative evidence comparing medical students from different social positions indicates that hidden-curriculum experiences and associated moral injury can differ across learner groups [7]. This cautions against treating "the learner" as a single recipient. Power, belonging, identity, specialty culture, and access to supportive supervisors may affect which norms are visible, credible, resistible, or costly to challenge. A hidden ethics curriculum of efficiency, if present, would therefore be unevenly experienced rather than mechanically transmitted. Some learners may have greater permission to request more time, question workflow, or depart from a senior's pace; others may experience the same acts as professionally risky.

The most direct bridge between tempo and formation comes from accounts in which learners describe an informal imperative to "speed up," alongside broader evidence that role modelling is a central route through which professional identities are formed [8, 9]. The proposed mechanism is not passive absorption. Learners observe what seniors stop for, what they hurry through, which delays require justification, and which forms of relational work are treated as optional. Repetition can normalize these patterns; praise, correction, and informal feedback can reinforce them; alternative role models can interrupt them. The moral mechanism lies in the contrast between professed values and enacted priorities: clinical organization can teach a ranking without ever stating that ranking as doctrine.

Table 1 makes that contrast explicit by comparing formal ethical messages with the operational signals that may accompany them in efficiency-pressured settings.

Table 1. When professed ethics and operational tempo send different messages

Formal educational message	Recurrent hidden operational signal	Possible learner interpretation	Evidence status
Attend to the patient as a person.	Relational inquiry is readily compressed when work accumulates.	Personhood matters after visible tasks are secured.	Proposed interpretation grounded in preceding evidence.
Invite participation and explanation.	Conversation must fit within preallocated workflow space.	Voice is legitimate when it does not disrupt flow.	Proposed; not a universal encounter pattern.

Professionalism includes reflection and judgment.	Rapid closure is easier to reward than unresolved deliberation.	Competence may appear synonymous with smooth throughput.	Proposed interpretation.
Ethical commitments apply across learners and patients.	Capacity to slow workflow varies with hierarchy and belonging.	Moral discretion may be unequally available.	Evidence-informed equity interpretation.

Note: This manuscript-original synthesis does not claim that formal and hidden messages always conflict or that efficiency pressures are experienced uniformly.

How time pressure redistributes moral attention

Time pressure does more than shorten encounters; it can change what receives active consideration. In studies of shared decision-making adoption, clinicians identify limited time as a barrier to sustained deliberative practice [10]. The conceptual claim advanced here is that time functions as a scarce carrier of moral attention. Under constraint, clinicians may still recognize multiple obligations, yet only some can be enacted with depth. Immediate diagnostic tasks, visible risks, documentation, and closure may become easier to protect than uncertainty, narrative detail, preference clarification, or reflective pause. “Redistribution” therefore describes selective practical attention, not disappearance of ethical concern. The mechanism is proposed at the level of enactment: limited temporal capacity changes what can be explored now, postponed, delegated, abbreviated, or left unresolved.

The selectivity becomes more consequential when complexity increases. Physicians managing multimorbidity describe time limits as complicating prescribing and deprescribing decisions that require prioritisation among interacting conditions, treatments, and patient circumstances [11]. This does not show that complex care is always rushed, nor that additional minutes alone solve the problem. It supports a bounded

inference: limited temporal capacity can intensify trade-offs among competing forms of attention. The ethical concern is not speed per se, but whether the same kinds of morally relevant information are repeatedly deferred because they are harder to standardize, document, or close. If such deferral becomes patterned, learners may observe not merely what takes time, but what is repeatedly permitted not to take time.

A critical account must preserve the case for haste. Prehospital emergency personnel make ethical decisions under urgency, incomplete information, and rapidly changing risk, demonstrating that speed may itself be morally required [12]. Delay can harm; concise communication can be appropriate; expertise can make relational work more efficient. The relevant distinction is therefore between necessary haste and structurally imposed hurry. The former answers the clinical situation; the latter may arise from staffing, documentation, scheduling, or throughput arrangements only loosely connected to the patient’s immediate needs. **Figure 1** represents this manuscript’s proposed mechanism: operational tempo may narrow discretionary attention and render certain priorities educationally salient, but the pathway is conditional, reversible, and neither causal nor universal.

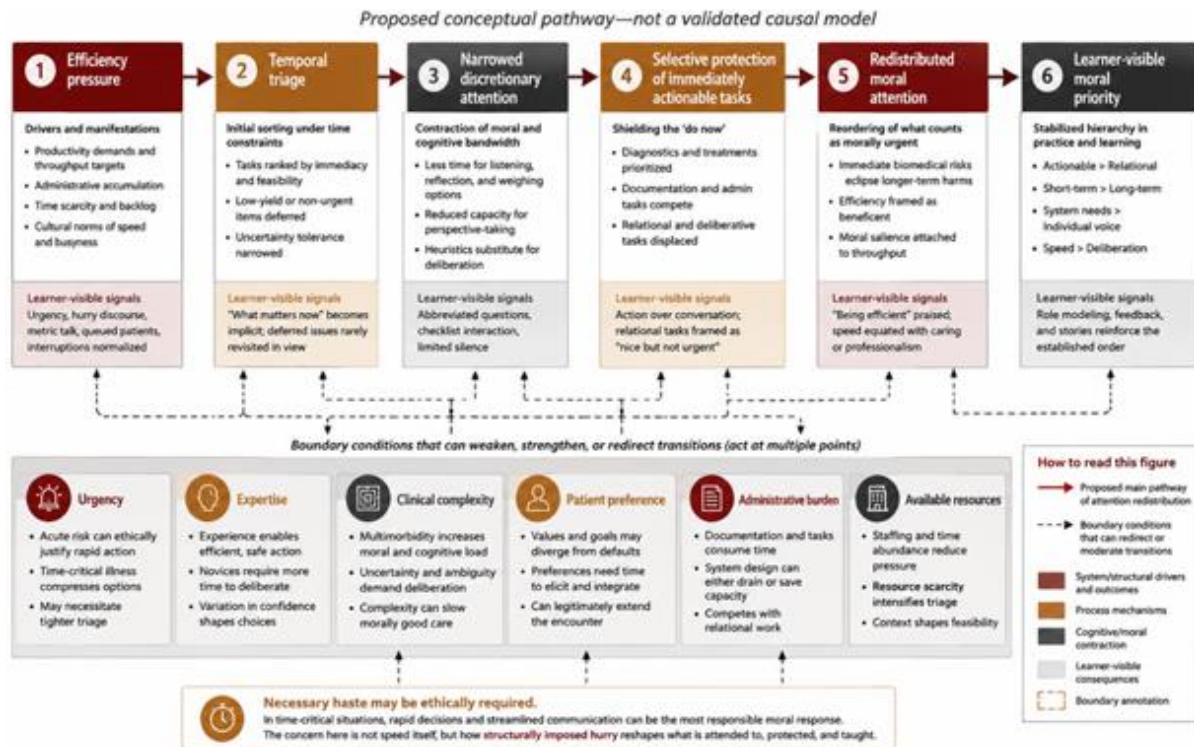


Figure 1. From operational tempo to learner-visible moral priority: a proposed attention-redistribution chain

Compression of patient voice and deliberation

If moral attention is redistributed, patient voice becomes vulnerable not because every short encounter is deficient, but because participation requires opportunities that are easy to compress. Patients discussing perioperative code status describe the importance of meaningful dialogue, trust, and appropriate timing around decisions with substantial personal significance [13]. From this, “compression of patient voice” is defined here as a reduction in the practical opportunity to elicit, clarify, contextualize, revisit, or deliberate about preferences. It is deliberately broader than visit duration and narrower than a claim that brief care is necessarily poor. Compression can occur through agenda narrowing, premature closure, omitted preference checking, or making participation contingent on the patient formulating concerns quickly enough to fit the workflow. Communication research in palliative care similarly identifies effective communication as relational as well as informational, involving clarity, attunement, responsiveness, and space for patients and relatives to process what is being discussed [14]. These findings arise from a particular clinical context and cannot establish a universal minimum encounter length. They do, however, show why moral adequacy cannot be inferred from

minutes alone. A highly skilled clinician may accomplish substantial relational work efficiently, while a longer encounter may still silence the patient. Some patients also prefer rapid, focused exchanges. The critical variable is whether temporal conditions preserve a meaningful opportunity to understand, question, disagree, reconsider, and make preferences consequential to the decision. Compression also has an equity dimension. Health-service evidence shows that some populations’ experiences are systematically missing from quality evidence because of barriers in access, sampling, communication, and representation [15]. Time scarcity is not the sole cause of such exclusion, but it may compound it when patients require interpreters, supported decision-making, disability accommodations, trauma-sensitive pacing, additional explanation, or repeated opportunities to formulate preferences. A uniform tempo can therefore impose unequal participation costs. The ethical test is not equal minutes but adequate deliberative opportunity relative to need. Efficient care remains compatible with patient voice when organizations recognize heterogeneity, create routes for clarification and return, and avoid treating conversational friction as evidence that the patient is inefficient.

Reordering professional values

Clinical time pressure need not make clinicians abandon professional values. A more defensible possibility is practical reordering: values remain verbally endorsed but differ in operational salience when they cannot all be enacted simultaneously. Educational environments matter to this process. A prospective cohort comparison found differences in empathy and patient-centredness trajectories across clerkship structures, while not establishing that one structure causally produces those outcomes [16]. The broader implication is modest: professional dispositions develop within arrangements of continuity, workload, supervision, and patient contact. When organizations repeatedly protect some forms of work and squeeze others, they may influence which professional goods learners most readily perceive as central.

Professionalism also contains goods that are difficult to reduce to throughput. Work exploring *yarigai* emphasizes meaning, purpose, and the felt worth of being a physician as relevant to how professionalism is understood [17]. Such meaning is culturally situated and should not become another universal metric. Still, it exposes a conceptual limitation in efficiency-dominant accounts of good work. Listening, accompaniment, reflective judgment, tolerance of uncertainty, and

maintaining a sense of patient personhood can be professionally valuable even when their contribution is not immediately visible in task completion. Conversely, efficiency can serve these same goods when it removes duplication or administrative waste. The problem is not measurement or productivity as such, but allowing measurable completion to become the default proxy for professional worth.

Professional norms are also experienced from unequal social positions. First-generation medical students, residents, and physicians describe tensions between formal professionalism expectations and the dominant institutional norms through which those expectations are interpreted [18]. This does not invalidate professionalism standards; it shows that their meaning and enforceability are contextual. Learners with less power may face greater costs for slowing a team, questioning a senior, or insisting that an unresolved concern deserves more time. The manuscript therefore proposes that time pressure may reorder not only tasks but the practical hierarchy of professional goods: responsiveness, efficiency, explanation, empathy, equity, continuity, and reflective judgment remain present, but their operational protection can become asymmetrical. **Table 2** distinguishes mechanisms of this reordering from possible consequences and counter-readings.

Table 2. Mechanisms through which efficiency pressure may reorder professional goods in practice

Mechanism in pressured work	Immediate practical consequence	Professional good made vulnerable	Counter-reading or boundary
Temporal triage protects tasks with immediate closure.	Reflective or relational work is deferred.	Attentiveness and judgment.	Triage can be ethically necessary in urgent care.
Workflow rewards visible completion.	Less measurable work appears discretionary.	Explanation, continuity, meaning.	Efficient systems can free time for these goods.
Uniform tempo spans heterogeneous encounters.	Greater communication needs carry higher participation costs.	Equity and patient voice.	Equal pace need not mean equal opportunity.
Repetition normalizes prioritization.	Operational success may be mistaken for normative priority.	Plural professionalism.	Learners can resist or seek counter-models.

Note: Rows are manuscript-proposed mechanisms synthesized from the preceding analysis. They indicate conceptual vulnerabilities, not measured frequencies, rankings, or causal effects.

How learners internalize efficiency norms

Learners do not encounter efficiency only as a policy; they encounter it as repeated professional conduct. Evidence that medical students' prior experiences influence their judgments about the acceptability of professional behaviours supports the idea that experiential exposure helps calibrate what feels normal [19]. The application to efficiency norms is proposed rather than directly demonstrated. Repeatedly seeing

respected clinicians interrupt some tasks but not others, apologize for some delays but normalize others, or praise smooth throughput without discussing trade-offs may shape expectations about what competence looks like. Experience becomes a reference point against which formal teaching is interpreted, especially when the same pattern recurs across supervisors and settings.

Professional identity formation theory provides a broader architecture for this process. Identity develops through

socialisation, role modelling, mentoring, reflection, and participation in professional communities [20]. Efficiency pressures can enter this architecture because they organize the situations in which role models act and feedback occurs. Learners may infer that “good” clinicians keep moving, minimize unresolved conversations, or absorb excessive administrative work without protest. But internalization is not inevitable. Some recognize contradictions, preserve alternative commitments, seek counter-role models, or experience discomfort precisely because institutional priorities conflict with their ethical expectations. Strategic compliance can also look like endorsement while privately leaving the underlying value judgment unchanged.

The distinction between exposure and endorsement is therefore essential. A hidden ethics curriculum is better

understood as a field of interpretive pressure than a deterministic transmission system. Norms can be accepted, conditionally adopted, strategically performed, contested, or refused. Hierarchy influences the costs of these responses; specialty and jurisdiction alter temporal expectations; expertise changes what can be accomplished quickly; patient preference changes what respectful care requires. A further educational risk is meta-learning: learners may come to believe not only that some activities deserve less time, but that naming the trade-off itself is unprofessional because competent clinicians are expected to cope silently. **Figure 2** translates these arguments into a nonquantitative vulnerability matrix, identifying workflow moments where patient voice, professional values, moral attention, and learner interpretation may become differentially exposed to compression.

	Patient voice	Moral attention	Professional-value enactment	Learner-visible message
1. Agenda setting	Exposed: agenda narrowed	Context-dependent: immediate issues prioritized	Context-dependent: responsiveness versus listening	Exposed: flow sets the agenda
2. Complexity exploration	Exposed: context omitted	Exposed: uncertainty deferred	Exposed: judgment compressed	Exposed: complexity appears as delay
3. Preference clarification	Exposed: preferences under-elicited	Exposed: values displaced	Exposed: autonomy proceduralized	Exposed: consent becomes closure
4. Explanatory dialogue	Context-dependent: questions constrained	Context-dependent: attunement compressed	Exposed: explanation shortened	Context-dependent: brevity rewarded
5. Closure / documentation	Potentially protected: return route preserved	Context-dependent: unresolved issues carried forward	Potentially protected: continuity documented	Potentially protected: unfinished concern can still count

Conceptual vulnerability matrix; categories are manuscript-proposed and context-sensitive.

This original conceptual matrix maps workflow moments where efficiency pressure may expose patient voice, moral attention, professional-value enactment, and learner interpretation to compression. Categories are qualitative and context-dependent, not measured intensity, rank, or risk.

Alt-text: A five-row workflow matrix crosses five clinical moments with patient voice, moral attention, professional-value enactment, and learner-visible message. Rust, amber, gray, and white cells carry text labels and no numeric scale.

Figure 2. Workflow points where efficiency pressure may become ethically and educationally visible

The hidden ethics curriculum model

The preceding analysis supports individual connections but not a validated end-to-end mechanism. The model treats clinical efficiency as a possible hidden ethics curriculum only when temporal organization becomes recurrent, visible, and normatively interpretable. Critical phenomenological work on patient personhood shows

that supervisors can reproduce structural pressures or create practices that protect the patient as a person within clinical teaching [21]. Efficiency pressure is therefore interpreted through relationships, local routines, and pedagogical action rather than transmitted directly from “the system.”

A second distinction concerns what professional formation includes. Work reconciling competency-based education with professional identity formation emphasizes tensions between observable “doing” and the development of professional “being” [22]. Efficiency becomes ethically educational when speed, completion, or smooth flow comes to stand in for fuller qualities of judgment. The warning concerns allowing what is easiest to observe to define what is most important, not competency-based education itself.

Third, learner response may include resistance. Residents’ moral distress has been linked to institutional constraints that restrict their ability to act in accordance with perceived professional obligations [23]. Although context-bound, that evidence supports an alternative to simple socialisation: discomfort may signal continuing ethical commitment. A learner who experiences pressure to hurry a difficult conversation may be recognizing a conflict rather than failing to adapt.

Fourth, the learning environment is not neutral with respect to inclusion. Educational analysis in graduate medical education argues that inclusion depends on institutional conditions rather than representation alone [24]. In the proposed model, this is an equity moderator: authority to request more time, question workflow priorities, or resist a senior’s tempo may be unequally distributed.

Taken together, the Hidden Ethics Curriculum Model proposes a conditional sequence: temporal organization structures what can receive attention; recurrent attentional patterns shape conditions for patient participation; repeated enactment makes some professional priorities more visible than others; and learners interpret those patterns through supervision and institutional culture. Responses may include internalization, strategic compliance, resistance, or distress. Professional formation is context-sensitive and shaped by supervisory and institutional environments rather than by individual reflection or competency attainment alone [21, 22, 24]. The sequence is a proposed diagnostic architecture, not a causal law: it invites scrutiny of what workflow teaches while preserving counterexamples in which efficient care protects patient voice, relational practice, or ethically necessary speed.

Counter-curriculum and organizational redesign

If clinical efficiency can teach implicitly, an adequate response cannot consist only of adding explicit ethics content while leaving the surrounding temporal order

uninterrogated. Reviews of hidden-curriculum improvement strategies show that informal learning environments can be addressed deliberately through interventions operating at learner, faculty, curricular, and organizational levels, although the strength and consistency of evidence vary [25]. The counter-curriculum proposed here is therefore not an anti-efficiency curriculum. Its purpose is to make practical prioritization visible: when care is hurried, what is being protected, what is being sacrificed, who bears the cost, and whether the trade-off is clinically necessary or organizationally produced. Such questions convert tempo from an invisible background condition into an object of ethical examination.

One practical route is to make contradictions between formal professionalism teaching and lived workflow discussable. A student-driven clerkship intervention demonstrates the feasibility of treating hidden-curriculum experiences as explicit educational material rather than leaving learners to interpret them privately [26]. Applied to efficiency, learners could examine cases in which speed protected safety, cases in which administrative pressure displaced patient-facing work, and cases in which a concise encounter remained deeply patient-centred. The objective would be interpretive discrimination, not a reflexive preference for slowness. Counterexamples are essential because the model fails educationally if “more time” becomes a substitute for ethical judgment.

Organizational redesign must also attend to whether learners can safely name such contradictions. Qualitative work on professionalism lapses indicates that trust, power, and agency shape whether difficult episodes become opportunities for transformative learning [27]. Debriefing a rushed conversation is unlikely to function as counter-curriculum if the learner risks being labelled inefficient for questioning the conditions that produced it. Faculty therefore need authority and psychological room to discuss workload, documentation, staffing, hierarchy, and uncertainty as ethically relevant features of the learning environment.

The broader design principle is contextual rather than remedial: hidden-curriculum and professional-identity processes can be surfaced deliberately, but intervention should not be reduced to individual reflection detached from the structures that learners repeatedly encounter [25, 26, 28]. Protected reflection, alternative role modelling, workflow redesign, and explicit discussion of trade-offs should be treated as complementary

possibilities whose educational effects remain to be established. The distinction between necessary haste and ethically consequential compression also requires a way to decide when a temporal pattern should trigger

curricular reflection, supervisory response, or organizational redesign. **Table 3** provides that diagnostic layer.

Table 3. Diagnostic criteria for deciding when clinical tempo becomes a counter-curriculum target

Diagnostic dimension	Question to ask	Lower-concern pattern	Counter-curriculum trigger	Appropriate level of response
Clinical necessity	Is the accelerated pace required by the patient's immediate condition?	Speed follows acuity, instability, or a genuinely time-sensitive decision.	Acceleration persists without a patient-specific clinical justification.	Case reflection → workflow review
Value displacement	What professional good becomes harder to enact under the prevailing tempo?	Prioritization is temporary and the displaced concern remains clinically recoverable.	Listening, explanation, uncertainty, continuity, or patient participation is recurrently treated as expendable.	Supervision → curriculum → system
Recoverability	Can what was deferred be meaningfully restored later?	A clear return pathway exists and unfinished concerns are deliberately carried forward.	Deferred questions, preferences, or ethical concerns routinely disappear after task closure.	Team process → documentation design
Distribution of temporal burden	Who must adapt most to the imposed pace?	Additional time is flexibly allocated according to communication or clinical need.	Patients or learners with greater support needs repeatedly bear the cost of uniform pacing.	Programme → organizational redesign
Learner discretion	Can a learner legitimately slow, question, or revisit the encounter?	Temporal judgment can be explained without reputational penalty.	Slowing down is interpreted as incompetence, inefficiency, or failure to cope.	Faculty development → assessment review
Norm repetition	Is the pattern exceptional or recurrent?	Compression is episodic, situation-specific, and explicitly explained.	The same temporal trade-off recurs across supervisors, rotations, or clinical settings.	Learning-environment review
Reason visibility	Are learners shown why acceleration or delay is justified?	Supervisors make temporal reasoning explicit.	Learners observe pace but must infer its ethical meaning from behaviour alone.	Supervisory practice
Organizational controllability	Could the pressure be reduced without compromising legitimate clinical priorities?	Constraint arises primarily from unavoidable clinical demand.	Documentation, staffing, scheduling, task allocation, or workflow design repeatedly creates avoidable compression.	Organizational redesign
Ethical contestability	Can the prevailing temporal priority be questioned?	Teams can debate whether a trade-off was justified.	Efficiency assumptions operate as unquestionable defaults rather than reasons requiring justification.	Team culture → leadership
Persistence after recognition	What happens once the problem has been identified?	Temporal conflicts prompt adjustment, follow-up, or redesign.	The same conflict is repeatedly acknowledged but normalized as "just how the system works."	Escalation → institutional action

Note: **Table 3** is a proposed diagnostic framework rather than a validated assessment instrument. No single criterion establishes an ethically problematic hidden curriculum. Concern increases when several dimensions converge, particularly when compression is recurrent, organizationally modifiable, difficult to contest, and associated with loss of recoverable patient or professional concerns.

Implications for ethics education and faculty development

The central educational implication is that ethics curricula should teach learners to recognize the moral meaning of temporal allocation. Traditional case discussion often asks what ought to be done once the

ethically salient features of a case are already visible. The proposed framework adds a prior question: which features became visible, which disappeared from attention, and how did workflow help determine that distribution? Teaching could therefore use real or reconstructed clinical episodes to compare necessary

haste, skilled brevity, avoidable hurry, and structurally produced compression. Faculty should resist turning these categories into fixed labels; their value lies in disciplined questioning about context, patient need, urgency, reversibility, and whose interests are served by acceleration.

Assessment requires similar caution. A current scoping review shows substantial heterogeneity in how professionalism is assessed across undergraduate and graduate medical education [29]. This article does not propose a new score for “ethical slowness.” Instead, existing assessments could be examined for the signals they send when visible task completion is rewarded but explanation, listening, appropriate escalation, or recognition of an ethically important delay remains difficult to credit. Assessment design should permit a learner to justify why an encounter needed more time, why a concise interaction was appropriate, or why unresolved uncertainty warranted follow-up. The educational object is reasoned temporal judgment, not duration itself.

Faculty development is especially important because supervisors translate system pressures into learner-visible practice. Programmes could help faculty narrate trade-offs that would otherwise remain tacit: “I am shortening this conversation because the patient is unstable,” or, conversely, “we are continuing because this preference changes what treatment is acceptable.” Making reasoning audible can prevent learners from interpreting pace alone as the professional norm. Faculty can also model repair by returning to an interrupted concern, acknowledging when workflow displaced a patient’s question, or explicitly challenging unnecessary administrative compression.

Systematic review evidence on professionalism education shows heterogeneous interventions, outcomes, and sustainability, cautioning against assuming that workshops or reflection sessions will produce durable behavioural or clinical effects [30]. Accordingly, faculty development should be linked to the learning environment rather than positioned as compensation for it. Scheduling, supervisory expectations, documentation burden, escalation routes, and assessment incentives may need examination alongside teaching. The goal is curricular alignment: formal ethics, enacted supervision, and organizational tempo should not routinely communicate incompatible accounts of what good clinical work requires.

Research propositions and limitations

The proposed model yields testable propositions but currently exceeds the evidence supporting its individual links. First, greater structurally imposed time pressure should be associated with more selective omission or deferral of relational and deliberative activities, after accounting for urgency, complexity, expertise, and patient preference. Second, recurrent exposure to such patterns should predict changes in learners’ interpretations of professional priority, with supervision, hierarchy, and inclusion moderating that relationship. Third, settings that preserve opportunities for explanation, return, and reflective justification despite high throughput would constitute important negative cases.

Measurement remains a major limitation. A scoping review of instruments assessing clinical encounter duration and pace shows that temporal properties can be measured, but available approaches do not operationalize moral attention, patient-voice compression, or the proposed hidden ethics curriculum [31]. Learning-environment professionalism patterns can also be repeatedly assessed institutionally, demonstrating feasibility for longitudinal environmental measurement without validating this model [32]. Future work should combine time-motion data, recorded-interaction analysis, patient-reported participation, longitudinal identity interviews, and multilevel learning-environment measures. Natural experiments following scheduling, staffing, or documentation changes would strengthen inference. The present synthesis remains limited by heterogeneous qualitative, observational, conceptual, and review evidence; jurisdictional variation; uncertain transfer across professions; and the absence of a validated threshold for “too fast” or “slow enough.”

Conclusion

Clinical efficiency is ethically necessary but morally incomplete. This article has argued that temporal organization may become part of medicine’s hidden ethics curriculum when recurrent workflow priorities teach, without explicit instruction, what deserves attention, whose voice can interrupt the schedule, and which professional goods remain protected under pressure. The proposed contribution is not a claim that speed dehumanizes care. Necessary haste can prevent harm, expertise can make communication both concise

and relational, and inefficient systems can themselves diminish patient care.

The critical issue is whether organizational tempo becomes an unexamined ranking device. Moral attention can be redistributed, patient participation can be compressed, and professional values can be practically reordered even while formal commitments remain unchanged. Learners may internalize these priorities, comply strategically, resist them, or experience distress. Ethics education should therefore examine workflow as well as doctrine and treat temporal judgment as an institutional as well as individual responsibility. The Hidden Ethics Curriculum Model remains a conceptual synthesis requiring prospective, multilevel, cross-context testing; it supplies no universal time threshold, validated causal pathway, or evidence of clinical effectiveness. Its purpose is diagnostic: to make visible what clinical systems may already be teaching through the allocation of time.

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