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Editorial

The Hidden Curriculum of Orthopaedic Residency: Lessons No One Teaches but Everyone Learns

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By nearly every measurable standard, modern orthopaedic education has become increasingly structured and comprehensive.

Yet alongside this formal curriculum exists another education—one that is rarely written down, seldom discussed explicitly, and often remembered long after the details of a textbook chapter have faded. Ask any orthopaedic surgeon what shaped them most during residency, and many of the answers will have nothing to do with anatomy, biomechanics, or operative technique. This is the hidden curriculum of residency.

Every orthopaedic residency has a curriculum. It is carefully designed, regularly evaluated, and continually refined. Residents spend years mastering anatomy, biomechanics, surgical technique, clinical decision-making, and evidence-based medicine. They complete competency assessments, simulation training, milestone evaluations, board examinations, all intended to prepare them for independent practice. By nearly every measurable standard, modern orthopaedic education has become increasingly structured and comprehensive.

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The hidden curriculum encompasses the lessons that shape not only how residents operate, but who they become as surgeons. It is learned during difficult overnight call shifts, unexpected complications, challenging patient encounters, moments of criticism in the operating room, and quiet discussions with mentors after the day's cases are complete. These experiences teach residents how to ask for help, recover from mistakes, navigate difficult personalities, earn trust, lead teams, teach others, and gradually develop the judgment required for independent practice. Unlike technical skills, these lessons are rarely delivered through lectures or conferences. Instead, they are transmitted through observation, experience, reflection, and the example set by those who train us.

This hidden curriculum also extends beyond technical excellence. Becoming a successful orthopaedic surgeon requires far more than performing an operation well. It demands humility to recognize one's limitations, resilience to recover from setbacks, emotional maturity to receive difficult feedback, and the ability to build trust with patients and colleagues. It requires learning when to lead, when to follow, when to teach, and when to ask for help. These are fundamental components of becoming the kind of surgeon others want to work with and the kind of physician patients trust with their care.

Many of these lessons emerge naturally through experience, however acknowledging them explicitly may help residents recognize that the challenges they encounter are not signs of inadequacy, but expected milestones in professional growth.

We will explore several of these unwritten lessons through reflections from orthopaedic residents. Their stories highlight moments that are seldom included in residency handbooks yet frequently define training: learning to ask for help, recovering from mistakes, receiving criticism, building meaningful mentorship, navigating difficult personalities, teaching others, and earning autonomy. Naming these experiences makes them easier to discuss, normalize, and learn from. Residency teaches us how to perform operations. The hidden curriculum teaches us how to become surgeons.

LEARNING TO ASK FOR HELP

Residency is both incredibly rewarding and tremendously challenging. All of us have worked tirelessly to earn the privilege of being here, and with that comes the expectation that we will become increasingly self-sufficient. However, there are moments during training when asking for help is inevitable and is a sign of weakness, but rather a mark of sound clinical judgment.

Night float is the ultimate test. There is immense pride in representing the entire orthopedic surgery department overnight and sometimes alone. That autonomy is empowering, but it also comes with significant responsibility. Patients' care rests on your shoulders, and there is no attending bedside to validate each decision.

Eventually, you will receive a page that reads something like, "Jump from height. Leg deformity." Your stomach drops because you have no idea what you are about to encounter. You perform your trauma evaluation, complete a careful physical examination, and obtain the appropriate imaging. After scrutinizing the radiographs, you formulate a thoughtful plan. Perhaps it is an open subtalar dislocation. Maybe there is a homolateral Lisfranc dislocation.

Despite a well-reasoned plan, the reduction is unsuccessful. In that moment, it is common to feel as though you have failed. As surgical trainees, we often equate technical success with competence. Successful reductions and procedures performed independently are celebrated and can begin to feel like the expectation. When something does not go according to plan, imposter syndrome can quickly take hold. You begin to dread calling your backup, worrying that you are inconveniencing your senior resident or attending because you could not complete the job yourself.

However, that is the wrong way to think about it.

The patient always comes first. Multiple unsuccessful reduction attempts can worsen soft tissue injury, create iatrogenic fractures, and place neurovascular structures at risk. One phrase we often hear in our program is, "Load the boat." Once you have exhausted your reasonable options, it is time to call for reinforcements. In the moment, it is easy to forget that even our attendings seek advice from colleagues and mentors. Medicine has always been a team

sport. Experience does not eliminate the need for collaboration. It simply changes when and why we ask for it.

Recognizing that you have reached the limits of your experience is not an admission of inadequacy. It demonstrates maturity, humility, and a commitment to safe patient care. As residents, we often measure ourselves by what our own hands accomplish. In reality, one of our greatest strengths is knowing when to use the many capable hands around us.

RECOVERING FROM MISTAKES

Many orthopaedic residents arrive at residency having spent years building a reputation for being reliable. We've worked hard, paid attention to details, and prepared endlessly for exams and cases. Mistakes were often infrequent, and when they did happen, they occurred in an environment designed for learning. As medical students, there was always another layer of supervision. A resident or attending would catch the missed diagnosis, adjust the plan or treatment before it ever reached the patient.

Residency changes that. For the first time, patients depend on your judgment. You perform the examination. You interpret the imaging. You reduce the fracture. You triage the situation and determine what deserves immediate attention and what can wait. And while in residency, there is still supervision, the responsibility feels different because now you are directly influencing patient care.

A patient arrived in the ED with a laceration to the volar aspect of an MCP joint with pulsatile bleeding from the wound. This requires pressure for hemostasis and confirmation of perfusion. The flexor tendons are uninjured, and the remainder of the exam was unremarkable. The wound was irrigated and closed. Success, onto the next consult.

A few days later the patient had follows up in the office, where a digital nerve injury was identified requiring repair. This was missed. What if the patient had never returned to the office? The error in evaluation lessened the injury and, if left untreated, would have completely changed their course.

Moments like this make you question more than the mistake itself. They make you question your judgment. Nearly every resident asks some version of those questions after a meaningful mistake. You can dwell on the encounter and replay it repeatedly, but feeling bad about a mistake does not prevent the next one.

Mistakes like this will change the way consults are evaluated. Become more deliberate, rely on routines, algorithms, and systematic approaches. Learn to slow down and re-evaluate the situation once the obvious injury has been addressed, because that is often when subtle injuries are missed. Residency isn't just about learning the fundamentals of orthopaedics, it's about learning from every patient encounter—both the positives and the negatives—and allowing those experiences to shape the way you practice.

One of the greatest strengths of residency is that we do not have to learn these lessons alone. Every senior resident and attending has patients and mistakes they still remember. Many of the tips and advice they pass along come from mistakes of their own. Hearing those stories reminds us that becoming a good surgeon is not about being perfect. It is about being honest about our mistakes, learning from them, and helping us grow in how we care for our patients.

LEARNING TO RECEIVE CRITICISM

You spend your first couple of years of residency building a reputation on the things you can control. You answer your floor pages. You see ED consults efficiently. You do every task that is asked of you. None of it requires talent, only discipline, and slowly you become known as reliable.

Then you get to the OR, and you have to prove yourself all over again, this time in front of people and with the stakes raised.

You can prepare for a case for days and still get something wrong in three seconds. That is going to happen, and the correction that follows is usually fair. The difficulty is what the correction does to the rest of the case. It stays with you. Part of your attention is still back on what you were just told, so you start falling behind and it can snowball. The pace of the operation does not adjust for any of this. By the end of a case that began with one small, correctable error, you can walk out convinced the whole thing was a failure, when what actually happened is that your own reaction to it compounded a single mistake. Learning to take the feedback, set it down, and keep operating is a skill in its own right, and it is one nobody sits you down and teaches.

What makes it land harder early on is that you often cannot tell how much the mistake actually cost. Was that surgeon preference, a way this attending likes it done, and no more correct than the way the last one wanted it? Or is it something the patient will feel in ten years? Without the experience to distinguish between the two, you default to assuming the worst. You carry that with you through the rest of the day. That instinct is worth defending. Catastrophizing a small mistake is, in its own way, evidence that you care whether you have harmed someone. But worry has a limited yield. The more useful response is to ask the attending directly what you got wrong and why, and then to make certain you do that step correctly the next time.

Feedback from an attending, however sharp, at least comes with an explanation. They are supposed to know more than you and being corrected by them confirms nothing you had not already conceded. Co-residents are more complicated. Scrubbing with a senior is one of the better parts of the job. But you cannot help measuring yourself against them, and against the version of them you imagine existed at your level, who was presumably smoother than you are now. Nobody in residency talks much about the cases that went badly, so you end up assuming you are the only one who has had them. You are not. You simply never hear about anyone else's.

The lesson is to take their advice seriously, because nearly all of it was purchased somewhere. The senior who tells you exactly where to put your hand during an exposure is telling you because they got it wrong once and remember what that felt like. That is precisely what makes them worth listening to. An attending who has performed the operation

500 times may find it genuinely difficult to explain a step that has long since become automatic. The resident two years ahead of you still remembers when it wasn't automatic and can tell you what they were thinking when it finally began to work.

The mistakes and the criticism are not obstacles standing between you and the training. They are the training. You are here to learn, and it would be a strange and boring five years if you had arrived already knowing everything. What sustains you is the improvement itself, the moment you notice you have quietly become better at something than you were a few months ago. That progress is not linear. There will be days you move backward, cases that go worse than the one before, and feedback you did not see coming. But if you step back far enough, the line rises, and it rises because of the criticism, not in spite of it.

BUILDING MENTORSHIP

Transitioning from medical school to residency is not something we accomplished alone. While hard work and perseverance are essential, mentors often play an equally important role in shaping us into the physicians and surgeons we aspire to become.

One common misconception is that the ideal mentor must share a similar background, gender, or career path. In reality, some of the most influential mentors may have completely different life experiences. What matters most is finding someone who is genuinely invested in our growth, encourages us and provides honest guidance along the way.

It is also important to recognize that no single mentor can fulfill every role. One mentor may provide research opportunities, another may help develop surgical skills and offer career advice, while someone else becomes a trusted source of support during difficult moments. It truly takes a village. Building a network of mentors with different strengths provides a more well-rounded perspective than any one individual could offer.

It is also important to understand the difference between mentorship and sponsorship. A mentor teaches, advises, and helps navigate challenges. A sponsor goes one step further by using their influence to advocate when opportunities arise, whether that is recommending someone for a leadership role, fellowship or speaking on their behalf when they are not in the room. Both are invaluable, but they serve distinct purposes throughout our careers.

Perhaps the most meaningful lesson is that the strongest mentoring relationships are rarely created by asking, "Will you be my mentor?" Instead, they are cultivated through repeated, intentional interactions. Reaching out to learn about a mentor's career over coffee, asking thoughtful questions, seeking feedback, following through on advice, and keeping mentors updated on your progress all build trust over time.

Those conversations often evolve naturally. A discussion about career paths may lead to collaborating on a research project, working together on an educational initiative, or spending time in the operating room. As the relationship grows, professional conversations become personal. Mentors learn about our goals and families, and we learn about theirs. What began as a simple conversation gradually develops into a relationship built on mutual trust and respect.

Rather than pursuing the title of "mentor," we should focus on building authentic relationships. When genuine connections are developed over time, mentorship and, ultimately, sponsorship often follow naturally.

MANAGING DIFFICULT PERSONALITIES

Residency is not the first job most of us have had, but it may be the first where we are responsible for getting things done that we cannot accomplish on our own.

A lot of us came through healthcare from the bottom. You were a tech, a scribe, or a research assistant, and the work was mostly doing what you were asked. Someone told you what needed doing, and you did it, and doing it well was the entire job. You were the lowest person on the totem pole, and you understood that, and it was, in its own way, uncomplicated.

Residency inverts that. You are still near the bottom, but now the day only moves if other people move it. You need the tech to turn the room over. You need the nurse to deliver medication before transport. You need the radiology technician to complete imaging, pharmacy to release the antibiotic, and the floor to call you back about the drain. Almost nothing you are responsible for can be accomplished by working harder yourself.

And these people do not report to you. They have their own assignments, their own priorities, and someone else asking them for something urgent at the exact moment you are. Early on, it does not feel like a difference in priorities; it feels personal, as though someone has decided to make your day harder.

It is not. Everyone in that hospital thinks their patient is the most important patient in the building. Your patient with the hip fracture is the most important person in the world to you. It is one of nine things on the nurse's list. That is not indifference. That is arithmetic. Understanding what other people are carrying does not make the friction disappear, but it does turn a personal slight back into a logistical problem, and logistical problems can be solved.

Junior residents are their own version of this. You will hand off a task and watch it get done in a way you would not have chosen, and the instinct is to correct it, because you have a way that works and you know it works. Sometimes the correction is warranted. Often it is not, and what you are actually watching is someone arriving at the same place by a different road. The consult gets seen. The patient gets splinted. The note gets written. That it did not happen in the order you would have chosen turns out to matter a great deal less than you thought it would, and the sooner you can tell the difference between a junior doing it wrong and a junior doing it differently, the more useful you become to them.

And when something genuinely is done poorly, it is seldom because they did not care. It is because they did not know. Which is exactly where you were standing not long ago, and exactly why you are the one who can explain it to

them. You still remember what it was like to not understand this, and that memory is the whole reason you are useful here. It is the same question you were asking as an intern, only now you are standing on the other side of it.

The same instinct applies everywhere else in the hospital. Let your juniors do it their way when it is not something you feel strongly about. Let the nurse set the room up the way she likes it. Let the tech bring you the splint material he prefers. Not everything has to be done exactly the way you would do it, and most of the time, when you insist, you are not protecting the patient; you are protecting a preference. You gain very little by winning those, and you spend something every time you do. Then, when you actually need something, and you hold your ground and say so, people believe you. They have figured out that you do not ask unless it matters, and that reputation gets you further than any single argument you could have won along the way.

Learning to work with people you do not always agree with is not a way of surviving residency. It is a substantial part of the job you are training for. At the end of the day, everyone works to take care of the patient. When it gets tense, that is the thing to come back to, and most of the time you find you agree about more than you thought.

LEARNING TO TEACH

No one tells you when you become a teacher.

There is no lecture on the transition, no milestone that suddenly changes your role from learner to educator. It simply happens— almost without you noticing.

At first, it is the smallest things. You show a rotating medical student which splinting supplies to grab before a reduction or you teach the intern how to set up a traction pin, where to stand during a procedure, or how to anticipate what the senior resident will need next. At the time, it feels less like teaching and more like making your day run a little smoother.

Soon, you are explaining consults to the new PGY-2 on trauma. You give your advice on how to balance an overflowing pager, how to prioritize multiple consults, how to write good notes quickly, and when it is time to ask for help. You are no longer simply repeating information—you are passing along the practical wisdom that someone once shared with you.

By chief year, teaching has become woven into your daily routine. You may not even notice it anymore, but nearly every patient encounter, call shift, and operation includes an opportunity to guide someone less experienced. From guiding an intern in the workup of septic hip arthritis to walking a PGY3 through a hip fracture call case, without realizing it, you have become the person you once depended on.

Teaching is one of residency's most powerful hidden curricula because it develops long before anyone gives you the title of educator. It begins with small acts of generosity—taking an extra minute to explain, demonstrating instead of doing, allowing a junior resident to struggle just enough before stepping in. Those moments shape not only the learner but also the teacher.

Perhaps the greatest surprise is that teaching deepens your own understanding. Explaining why a reduction works, talking through a fracture, or guiding someone through surgical steps forces you to organize your own knowledge and expose the gaps in your thinking. Concepts that once felt intuitive become deliberate. As the saying goes, you do not truly understand something until you can teach it.

Just as important, residents learn that great teachers do more than transmit knowledge. They create environments where questions are welcomed, mistakes become opportunities for growth, and learners feel psychologically safe enough to admit uncertainty. Nearly every resident can recall the senior who made them feel foolish for asking a question—but they remember even more vividly the one who answered without judgment, encouraged them to try, and quietly built their confidence.

The hidden curriculum teaches that education is not reserved for faculty. Some of the most influential teachers in orthopaedic residency are residents themselves. We all have that reduction technique that "X" resident taught us that we then pass down to our junior who then has their reduction technique because of you. Every explanation given during a call shift, every operative pearl shared between cases, and every calm conversation after a difficult consult shapes the next generation. By the time residency ends, you realize that while you came to learn how to operate, you also learned how to teach—and in doing so, became the kind of surgeon others will one day remember.

EARNING AUTONOMY

Residents yearn for the opportunity to perform skills independently. As an intern, the first time you are allowed to attempt a reduction alone often feels like it's long overdue. In the operating room, taking control of the bovie or the saw can feel like a faraway dream when you hold retractors for what feels like the millionth time. And more often than not, when the time finally comes for you to demonstrate the skills you have learned through observation, it turns out to be… really hard. So how does a resident differentiate when they are actually prepared to perform a skill from a skill that will require some hand-holding? And how does an attending decide when it is an appropriate time to cede control to their trainee?

Of course, we start with small skills and build up to bigger ones. You begin by performing tasks that can be fixed if done incorrectly–sutures, minor procedures in the emergency room–and build up to those for which the surgeon only gets one real shot. But in between points A and B, familiarity between mentor and mentee builds; sometimes through direct exposure and sometimes through word of mouth.

The intern who makes clean splints atop a good reduction gets kudos from the patient at their follow-up visit. The resident who correctly preps the OR during a junior rotation is invited to perform the approach sooner rather than later. The trainee who presents a case plan and asks questions about areas they feel they don't fully understand

a day or two before a challenging case is later endowed with earlier solo operative time. Attention to detail and forethought demonstrate to the attending surgeon that a trainee is actively considering the next step, how to proceed safely, and how to make a positive impact on patients, rather than just completing the tasks at hand.

The resident who performs mental repetitions each time they watch an attending perform a technical maneuver is the one who asks thoughtful questions. The resident who simply watches the attending perform the skill - without thinking through what comes next, or how the attending positions their body, or why they choose the implant they do - becomes the surgeon who operates that way "because that's how I've always done it."

Failure to communicate an incomplete understanding of an operative maneuver, followed by performance of that maneuver, signals to the attending that the resident is willing to act brazenly. Conversely, a preemptive expression of discomfort with a skill, followed by questions on how to perform a step safely, even just a second before performing that task, demonstrates to the attending a sense of security. To be holding a blade, a millimeter from cutting, only to stop and double-check something, reassures the surgeon that allowing that trainee to proceed is more likely to be safe. And, when error ensues, as it inevitably will, being willing to admit fault and ask for help reassures the surgeon that you are a trainee who can be trusted with increasing independence.

Assiduousness, communication, and humility earn autonomy in the operating room.

BECOMING THE SURGEON YOU WANT TO BE

Everyone knows something you don't, which means there is something to learn from everyone—patients, nurses, technicians, surgical colleagues, coworkers, friends, and family. We are meant to be lifelong learners. You do not have to agree with everything you are taught, and you certainly should not accept every lesson blindly, but there is always—*always*—something to be learned.

Do not underestimate the Temin effect. Residency is a prime example of a "10,000 hours" mentality, but failure to acknowledge how diversity of thought makes your unique viewpoint an asset is to underutilize one of your greatest weapons as a clinician; perspective. Expanding your horizons through hobbies, non-medical areas of study, and cultural immersion creates knowledge to be harnessed towards innovation. Leonardo da Vinci waited until the 15th page of a resumé he wrote in 1482 to mention that he was pretty good at painting; he didn't see his abilities in a narrow lens despite being considered a master artist. Look at problems with wide eyes, and when you are stuck, seek a new perspective.

And lastly, you cannot control your emotions, but you can control your reactions. Be the surgeon who keeps a level head when things go wrong, who has a plan B, C, and D, and who respects their human response to stress. Your telomeres will thank you for it.

CONCLUSION

Residency will always be measured by operative volume, examination scores, milestones, and technical proficiency. Those metrics are important, but they tell only part of the story. The hidden curriculum—those unwritten lessons learned through difficult conversations, unexpected setbacks, trusted mentors, and moments of vulnerability—is what ultimately shapes not only how we operate, but who we become.

We remember the first complication that kept us awake at night, the senior resident who taught us how to navigate a difficult personality during a patient consult, and the attending who responded with patience and kindness rather than anger when we made a mistake. These experiences shape professional identity in ways that cannot be captured by operative logs or milestone evaluations.

Long after residents forget the details of a textbook chapter, they remember the people who showed them how to handle the moments for which no textbook could prepare them: the attending who taught them how to disclose a complication, the senior resident who answered a late-night phone call without judgment, and the mentor who trusted them with their first independent operation. These are the lessons that rarely appear in a curriculum yet often define the surgeon a resident ultimately becomes.

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