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(Article begins on next page)

1 **The hidden curriculum in Nursing Education: a scoping review**

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4
5 INTRODUCTION

6 The learning process involves much more teaching than what explicitly stated in the
7 formal curriculum (Kentli, 2009; Margolis et al., 2001). Even if not formally declared, the learning
8 process is rich of norms that convey, often unknowingly, moral, social, and cultural values (Ahola,
9 2000; Kentli, 2009; Margolis et al., 2001). For example, a message of equality can be transmitted
10 by the duty of wearing a school uniform, whereas respect of adult people can be conveyed using the
11 polite form when speaking to teachers (Raso et al., 2016). Students internalise these norms in order
12 to be fully and positively integrated within the educational process (Ahola, 2000; Kentli, 2009).
13 This phenomenon, noticed by researchers since the end of the 19th century (Durkheim, 1961), has
14 been put under the name of hidden curriculum by sociologist Jackson in his book *Life in Classroom*
15 (1968). Although many definitions exist, the phenomenon can be summarized as those “values,
16 dispositions, and social and behavioural expectations that brought rewards in school for students”
17 (Kentli, 2009, p. 86). As in primary school, the hidden curriculum plays an important role in higher
18 education too (Ahola, 2000). While in primary school the hidden curriculum transmits values of
19 society, social consensus, and integration, in higher education it functions to differentiating,
20 recruiting, selecting, and grooming students for adult occupational roles (Margolis et al., 2001).

21

22 **Background**

23 The hidden curriculum in health professional education allows students to develop their own
24 professional identity (Cook, 1991; Hafferty and O’Donnell, 2014; Tanner, 1990). Unfortunately,
25 messages transmitted via the hidden curriculum often do not correspond with those declared in the
26 official curriculum and formally taught at universities (Bell, 1984; Hafferty and Franks, 1994).

27 This discrepancy attracted the interest of medical educators during the '80 and '90 (Benbassat,
28 2013; Martimianakis et al., 2015). During those years, they realized that innovations introduced in
29 the formal curriculum concerning ethics and medical humanities were not acted in clinical practice.
30 Therefore, medical educators defined this issue as a “reform without change” (Hafferty and Franks,
31 1994).

32 Reflecting upon this issue, the sociologist Hafferty understood that health professional
33 learning environment is multidimensional and identified three interrelated spheres of
34 apprenticeship: the formal, the informal, and the hidden curricula (Hafferty, 1998; Hafferty and
35 O'Donnell, 2014). The first is “the stated, intended, and endorsed official curriculum” (Hafferty
36 1998, p. 404); the informal curriculum concerns “the unscripted, predominantly ad hoc, and highly
37 interpersonal form of teaching and learning that takes place among and between faculty and
38 students” (Hafferty 1998, p. 404); while the hidden curriculum is “a set of influences that function
39 at the level of organizational structure and culture” (Hafferty 1998, p. 404). More precisely, the
40 informal curriculum stands at the level of the social interaction between students and educators,
41 while the hidden curriculum requires to go still deeper in the learning process, trying to understand
42 the meaning that students give to those interactions and to the underlying organizational structure of
43 the institution. Although the hidden curriculum can be ascertained within any domain of the
44 learning process, Hafferty highlighted four areas researchers should pay attention to when exploring
45 it: 1) policy development (organizational features that convey what is important within the
46 institution); 2) resource allocation (the way the institution allocates resources will shape what
47 students learn about institutional mission and organizational values); 3) Institutional slang
48 (languages and metaphors contained into educational routes and regulation or used in clinical
49 settings); 4) evaluation (the choice of a particular evaluation tool tells something about which
50 competencies are valued) (Hafferty, 1998; Hafferty and O'Donnell, 2014).

51 Starting from Hafferty's insights, medical education developed an increasingly flourishing
52 literature about the hidden curriculum (Benbassat, 2013; Martimianakis et al., 2015). Most

53 researchers concentrated on negative consequences produced by misalignment of the informal and
54 hidden curricula with the formal one: loss of idealism (Babu et al., 2011), emotional neutralization
55 (Goldberg, 2008), acceptance of hierarchy (Cohen, 1998), and ritualized professional identity
56 (Martimianakis et al., 2015). On the contrary, just few authors focused on positive effects produced
57 by alignment between curricula: integrity (Brawer, 2006), effective communication (Curry et al.,
58 2011), and empathy (Wright and Carrese, 2001).

59 Nursing literature about the hidden curriculum first appeared during the '80 (Bell, 1984).
60 The debate developed during the following years relating it to the nursing theory/practice gap (Bell,
61 1984; Cook, 1991; Ferguson and Jinks, 1994; Tanner, 1990). Theory/practice gap means that the
62 theoretic concept, formally taught to students in classrooms, do not find practical application in the
63 clinical context attended during training (Bell, 1984; MacMillan, 2016; Tanner, 1990). In particular,
64 nursing researchers reported that, when the content transmitted via the formal curriculum does not
65 correspond with that conveyed via the hidden one, the theory/practice gap is perpetuated and the
66 learning process is thwarted instead of facilitated (Allan et al., 2011). The narrowing of this gap and
67 the alinement of nursing curricula require to know what falls outside the formal curriculum (Allan
68 et al, 2011; Cook, 1991; Day and Benner, 2014). For this reason, recent literature calls for the need
69 to identify what has been written about the topic specifically in the nursing education field (“The
70 AMS Health Professional Initiative: exploring and beginning to build a foundation for sustainable
71 impact : stage 1 consolidated reports,” 2011). Therefore, the objective of this study is to map the
72 literature about the hidden curriculum in the field of nursing education.

73

74 **Method**

75 Scoping review aims at providing greater conceptual clarity about a broad topic in a particular field
76 of inquiry (Arskey and O'Malley, 2005). A unique definition of scoping review does not exist
77 (Arskey and O'Malley, 2005). Furthermore, discrepancies in nomenclature between “scoping
78 reviews,” “scoping studies,” “scoping literature reviews,” and “scoping exercises” may lead to

79 confusion (Levac et al., 2010). In this article, “scoping review” is used with consistency with the
80 framework offered by the Johanna Briggs Institute Reviewers’ Manual (“Reviewers’ Manual:
81 Methodology for JBI Scoping Reviews,” 2015). The framework is comprised of the following key
82 phases: (a) identifying the research question; (b) identifying relevant studies; (c) selecting the
83 studies; (d) charting the data; and (e) collating, summarizing, and reporting the results. The optional
84 consulting stakeholders phase has been excluded (f).

85

86 *Identify the question*

87 The search question which guided the study was “what and how much did researchers write about
88 the hidden curriculum in nursing education?”

89

90 *Identifying relevant studies*

91 From April to November 2017 two authors independently searched the MEDLINE/PubMed,
92 Scopus, EBSCO/CINAHL, Cochrane library databases indexing peer-reviewed bio-medical
93 literature, by combining the keyword ‘hidden curriculum’, ‘nursing education’ with no time and
94 language restrictions. The reference lists of relevant studies were also scanned. The software
95 package Mendeley was used to manage bibliographies and references.

96

97 *Selecting studies*

98 Two authors independently read titles and abstracts selecting articles relevant to the topic. They met
99 several times to refine the search strategy and compare findings (Levac et al., 2010; “Reviewers’
100 Manual: Methodology for JBI Scoping Reviews,” 2015). Articles not referring to nursing education,
101 or where hidden curriculum was not the focus of research were excluded. The Preferred Reporting
102 Items for Systematic reviews and Meta-Analysis (PRISMA) flowchart (Moher et al., 2009) was
103 used to show the process of study selection (Figure 1).

104

105 *Data charting*

106 According to the framework by Arskey and O'Malley (2005) data charting has been conducted both
107 with analytical and narrative approach. First, two researchers extracted quantitative (numbers and
108 publication year) and qualitative analytical data (publication, study location and source type) by
109 using a standardized and shared data extraction tool. Secondly, Hafferty's four domains (policy
110 development, institutional slang, evaluation, resource allocation) guided the mapping of the content
111 (Hafferty, 1998). Two researchers independently read the text and deductively pointed out which
112 domains have been explored within each paper.

113

114 *Collating, summarising and reporting results*

115 Analytical data were elaborated creating an Excel spreadsheet (2013) that included the number of
116 published records, the year of publication, the study location, and the publication and source type.
117 Quantitative data were then analysed with descriptive statistics (frequencies and percentages). The
118 narrative charting approach has been used with two different purposes. On the one hand, it has
119 allowed comparing the objectives, the samples, and the methods of research articles (Table 2). On
120 the other hand, it has been used to illustrate which domain has been paid attention to by each
121 study included in this review, according to Hafferty's four domains (policy development, resource
122 allocation, institutional slang, and evaluation), given that a single study can range from none to
123 more domains (Table 3).

124

125 RESULTS

126 Fifteen articles have been included in the study. As shown in **Table 1**, papers about the hidden
127 curriculum in nursing education first appeared in 1984 (Bell, 1984). There is a gap in the literature,
128 between 1992 and 2005, while more than the 60% of articles retrieved has been published during
129 the last 5 years.

130 Sixty percent of the literature is represented by research articles, the rest are discussion papers and a
131 book chapter. The search through peer-reviewed databases found only English language records.
132 Most literature included (about 60%) was published in English speaking countries (Australia,
133 Canada, USA, and UK), the rest by Islamic Republics of Iran and Pakistan (24%).

134

135 The methods used by research articles are illustrated in **Table 2**. Seven studies out of 9 (78%) used
136 a qualitative design, mostly through content analysis. Data collection was mainly conducted through
137 students interviews (Karimi et al. 2014; Karimi et al. 2015; McKenna and Williams 2017; Kenison
138 et al. 2017), although some examples of educators or nurses interviews do exist (Allan et al., 2011;
139 Jafree et al., 2015). The objectives fulfilled by the studies were varied, however, three main focuses
140 of research can be identified. More precisely, authors are trying to: describe it (Mosalanejad et al.
141 2013; Salehi 2006); determine which forces contribute to its formation (Karimi et al. 2015; Karimi,
142 Ashktorab, Eesa Mohammadi, et al. 2014b) or drop it in different educational context to verify its
143 impact (Allan et al. 2007; Kenison et al. 2017; McKenna & Williams 2017; Karimi et al. 2014a;
144 Jafree et al., 2015).

145 **Table 3** shows that nursing literature covers all four Hafferty's domain. The most explored one is
146 resource allocation, considered by more than half of the analysed articles. Considerably less
147 attention has been drove upon the other domains, mentioned by two or three authors each. In three
148 research articles no domain has been identified (Karimi et al., 2014a; Mosalanejad et al., 2013;
149 Salehi, 2006).

150

151 DISCUSSION

152 The aim of this study is to map the literature about the hidden curriculum in the field of nursing
153 education using as a framework of reference the Hafferty's (1998) four domains.

154 The review is based on 15 articles: a small number suggesting that the hidden curriculum has been
155 rarely assessed by nursing researchers (Hafferty and O'Donnell, 2014; McKenna and Williams,
156 2017). Our findings reveal a gap of literature between 1993 and 2003, as also reported by previous
157 literature (Zannini et al., 2011), together with a raising of publications between 2012 and 2017.
158 Probably, the attention is growing since nursing researchers realised that the hidden curriculum is
159 essential in the teaching of professional values (Day and Benner, 2014; MacMillan, 2016).
160 Furthermore, the literature calls for a deeper exploration of the phenomenon (Aled, 2007; Allan et
161 al., 2011; Karimi et al., 2015), and this need seems to be met by the increasing number of research
162 article since 2006. By examining nursing research objectives, one may notice that they are very
163 diverse one from another. The three focuses represented by nursing literature shown in **Table 2**
164 (description, formation, and impact) correspond to those pointed out by Haidet and Teal in medical
165 education (2014). However, unlike medical literature, the majority of papers does not aim at
166 describing the hidden curriculum (Haidet and Teal, 2014); rather, nursing literature most often
167 assesses the impact of the phenomenon by dropping it in different learning contexts. This focus is
168 essential in order to plane and evaluate intervention strategy that aim at addressing the phenomenon
169 by reducing its effect (Haidet and Teal, 2014). Hence, one may argue that nursing education is
170 showing a greater need to get the control and direct the hidden curriculum. Concerning the methods,
171 authors explored the phenomenon almost with a qualitative approach, through students' interviews.
172 Actually, students' perspective could be the most direct way to enter the hidden dimension: they
173 have the potential to reveal what is happening in the learning environment by allowing researchers
174 to understand the intrinsic and implicit messages that shape the training (Hafferty and O'Donnell,
175 2014; Zannini et al., 2011). Concerning study location, our findings show that, besides English-
176 speaking countries where research activity is traditionally consolidated, publications belong from
177 Islamic Republics of Iran and Pakistan. The hidden curriculum is influenced by the socio-cultural
178 background where education takes place (Bowels and Gintis, 1976; Giroux and Penna, 1979;
179 Kentli, 2009; MacLeod, 2014; Margolis et al., 2001). It is plausible that Eastern researchers have

180 been attracted by the hidden curriculum since they recognise that Asian society is characterised by a
181 ahierarchical culture and strong social bonds that highly affect the phenomenon (Karimi et al.
182 2014a; Karimi et al. 2015; Jafree et al. 2015). As exemplified by Jafree et al. (2015), Pakistani
183 patients do not let female nurses administer therapy to them. Consequently, female nursing students
184 learn coping strategies, such as non-disclosure or withdrawal of treatments.

185 Moving on to the mapping of nursing literature according to Hafferty's framework, research
186 findings cover all four domains (policy development, resource allocation, institutional slang, and
187 evaluation).

188 Policy development conveys messages about what is valued by institutions, through organizational
189 features such as clinical placement assignments, tutor-recruitment processes, availability of
190 services, etc. (Hafferty, 1998; Zannini et al., 2011). Overall, nursing literature shows that if
191 institutions do not adopt policy development that reflects professional values, these will be impaired
192 since the beginning of the educational process, because the hidden curriculum exposes students to
193 conflicting values (Chen, 2015; Kenison et al., 2017; MacMillan, 2016). Some example are offered
194 by the analysed papers at the level of both educational and healthcare institutions (Chen, 2015;
195 Kenison et al., 2017; MacMillan, 2016)

196 As far as educational policy development is concerned, Chen (2015) affirm that assigning students
197 to clinical placement is not always a transparent process. Rather, a preferential treatment might be
198 reserved to those who know the 'right' person and use their connections to obtain the desired
199 placement. This unfair process impairs the value of ethic integrity taught by the formal curriculum
200 (Chen, 2015). MacMillan (2016) discusses that clinical instructors are often short-term employees
201 who are assigned to be preceptor on the basis of availability or even without their knowledge. This
202 selection does not guarantee that clinical instructors are nurses engaged with the formal curriculum,
203 able to show students the practical application of what they learnt at school. The danger is that
204 students might believe that what they learn at school is useless since they do not see it in practice

205 (MacMillan, 2016). Healthcare institutions are mentioned by Kenison et al. (2017), reporting an
206 impairment in the delivery of care to patients who are not mother tongue, because of inadequate
207 interpreter services availability. This finding suggests a discrepancy with the formal curriculum,
208 which emphasizes care access for all (Kenison et al., 2017).

209 The domain of resource allocation is the most explored by nursing researchers, according to our
210 findings. It is plausible that, in an environment where needs exceed availability (Zannini et al.,
211 2011), the way resources are located attracts the attention of researchers much more than other
212 domains. The term resource can be referred to both human resources, namely students (Allan et al.,
213 2011; Bell, 1984; Jafree et al., 2015; Karimi et al., 2014b; McKenna and Williams, 2017), or
214 material resources; such as spatial arrangement (Cook, 1991), and placement of object in the space
215 (Karimi et al., 2015). Concerning this domain, nursing findings show how the misalignment or
216 alignment of the formal and hidden curricula influences the learning experience.

217 The formal curriculum states that students shall not be employed to provide direct nursing care
218 during trainings. This does not mean they do not participate in nursing daily activities, rather, they
219 should learn through supervised participation in clinical work (Allan et al., 2011). Unfortunately,
220 hidden curriculum's exploration show that students are used as workforce during clinical
221 placements, with a lack of supervision on the performed activities (Allan et al., 2011; Bell, 1984;
222 Jafree et al., 2015). Authors state that these discrepancies are due to staff shortage (Jafree et al.,
223 2015), or clinical instructors believing that students can learn only by working independently (Allan
224 et al., 2011). Consequently, students are left alone in front of their leaning needs; this can cause
225 students demoralization, which can interfere with the learning and professional development, since
226 they not really know what they are expected to do. Students have to learn on their own to be
227 proactive in constructing learning opportunities in order to benefit from clinical experience (Allan
228 et al., 2011; Brammer, 2006).

229 Although the worrying reality described by authors, one should not forget that clinical trainings
230 allow students to experience autonomy, which is a rewarding learning stimulus and an essential step
231 in the process of professionalization (Karimi et al., 2014a). Obviously, mentors' supervision must
232 be guaranteed to prevent errors due to unexperienced students (Jafree et al., 2015). It is possible
233 that negative experiences and students' demoralization could be prevented by clearly stating what
234 they can expect from trainings, by specifying in the formal curriculum that students are required to
235 become responsible of their learning needs. Mc Kenna and Williams (2017) findings about the
236 hidden curriculum in near-peer learning sessions (namely senior students engaged to teach to junior
237 ones) proved that, currently, junior students are used to ask senior ones about clinical expectations,
238 whatever the lesson is about. Sing that students felt the urgency to understand expectations that are
239 not openly stated somewhere else. The authors demonstrated also that near-peer teaching is
240 beneficial for senior students too. In fact, identifying with junior peers, they become more
241 responsible and develop teaching skills (McKenna and Williams, 2017).

242 This latter finding is of particularly interest, since it exemplifies that the hidden curriculum has
243 good outcomes, too. In fact, studies have mostly been highlighting the negative ones, as it happens
244 also in medical literature (Martimianakis et al., 2015). It is certainly important to look for what does
245 not work in the learning process, but this focus has contributed to give a negative image to the
246 hidden curriculum, which is seen as a phenomenon to uncover, to address, and to manage (Hafferty
247 and O'Donnell, 2014; Martimianakis et al., 2015). Recently, authors called for the need to not to
248 obscure the positive teachings embedded in the hidden curriculum, rather this latter should be
249 underlined in order to help students managing contradictions between what is taught and what is
250 practiced (Hafferty and O'Donnell, 2014; Martimianakis et al., 2015). In fact, since the beginning
251 of the debate, author understood that clinical activity is full of exquisite examples of nursing care,
252 which are obscured by organizational features (Joe Bell, 1984; Tanner, 1990): students should be
253 helped to see good nursing practices to overcome discrepancies between theory and practice.

254 Another aspect of this domain, suggest that even the spatial arrangement can convey unintentional
255 messages (Cook, 1991; Karimi et al., 2015). For example, long rows of chair in front of a desk in
256 classrooms or doctors who own their own changing rooms: all these elements tell us, respectively,
257 about relationship between students and teachers or among different professionals and their position
258 in a pre-established hierarchy (Cook, 1991; Karimi et al., 2015). It is plausible that the division of
259 spaces that students encounter during trainings is helpful in developing a sense of belonging, which
260 previous literature proved to be fundamental in the construction of professional identity (Del Prato,
261 2013). However, other authors, stated that division of spaces according to professions might
262 represents a major barrier to the implementation of interprofessional collaboration (Russell et al.,
263 2006). Based on these findings, instructor should be aware that even the educational and clinical
264 setting transmit teachings, and students should be helped in overcoming spatial limitations that
265 prevent the collaboration with other professionals.

266 The domain of institutional slang shows that the languages contained in nursing regulations, norms,
267 textbooks, and used in everyday clinical practice convey teachings through the hidden curriculum
268 (Aled, 2007; Cook, 1991; Zannini et al., 2011). Those are languages rich of slang, abbreviations and
269 metaphors who often belong from the military field (i.e. “fighting the war against cancer” (Cook,
270 1991)), which do not reflect the value of caring. Rather, it is a way of writing and speaking that
271 perpetuate the biomedical disease/cure model, which probably spread since doctor have long been
272 the authors of nursing text-books (Cook, 1991). The same issue has been raised, more recently, in a
273 study about the learning of patient-centred communication skills: during trainings students do not
274 act the principles of patient-centred communication, even though they proved to have fully
275 understood and interiorised them during lessons (Aled, 2007). The author ascribed such discrepancy
276 to the hidden curriculum. More precisely, students perceive that being accepted by the nursing staff
277 is an important step in professional development, consequently they adopt their communication
278 style even when in contrast with what they learnt in theory (Baldwin et al., 2014; Carlson et al.,
279 2010).

280 Tanner (1990) reminds that clinical routine is full of exquisite example of caring practices that are
281 obscured by this dehumanising, standardised way of speaking. Clinical instructor have to make
282 them visible to the students, helping learners to retain the high regard for humanity they usually
283 came with. Hence, address the hidden curriculum requires first faculty development, not curriculum
284 development (Day and Benner, 2014; Tanner, 1990).

285 The domain of evaluation choices tells which competencies and knowledge are valued by the
286 educational system. According to the findings illustrated by nursing literature, the enhancement of
287 competencies is conveyed by the content being evaluated (Day and Benner, 2014), the evaluation
288 tools being used (Day and Benner, 2014; Jafree et al., 2015), and the timing of evaluation
289 (MacMillan, 2016).

290 Day and Benner (2014) argue that student nurses spend a lot of time learning in clinical settings, but
291 are most often graded on written assignments and exam scores that mime the multiple-choice
292 question (Day and Benner, 2014). Such evaluation strategies often fail to assess the practical know-
293 how which derives from the understanding and use of knowledge in particular, meaningful contexts.
294 For this reason, the authors claim that nursing education privileges theory over practice for
295 knowledge development (Day and Benner, 2014). Probably, the evaluation of practical knowledge
296 could be facilitated using evaluation tools that allow faculty to go deeper into students'
297 understanding, such as short papers and case reports suggested by other authors (Jafree et al., 2015)

298 Lastly, Macmillan (2016) focuses the attention on the fundamentals of care, which are usually
299 taught and evaluated during the first year of course, and never revisited during the following years.
300 According to the author, the choice of evaluating these competencies only during the initial year,
301 unwittingly transmits the idea that that this care process is a very basic task that can be carried out
302 by almost anyone. Hence, the author suggest to revisit them through a theoretical or evidence-based
303 lens during the following years (MacMillan, 2016). One may conclude, that faculty should be

304 aware that even the timing of evaluation can tell something about how much a content or a
305 competence is valued by the learning process.

306 Overall, nursing literature analysed through Hafferty's four domains offers a unitary picture of
307 different examples of how the hidden curriculum operates within nursing education. However, it
308 was not possible to identify any domain in two articles (Karimi et al., 2014a; Mosalanejad et al.,
309 2013), while a paper clearly mentions other domains (Kenison et al., 2017). This datum suggests
310 that there could be other aspect of particular relevance related to nursing education, which are not
311 included in Hafferty's framework. In particular, many authors refer to role modelling when
312 exploring the hidden curriculum (Karimi et al., 2015, 2014c; Kenison et al., 2017; Salehi, 2006).
313 Role model refers to students observing and subsequently adopting educators' behaviour; it is an
314 informal, ubiquitous and haphazard way of learning, and there can be either positive or negative
315 role model (Rabow, 2014; Ratanawongsa et al., 2005). As one may notice, role modelling seems to
316 fit with Hafferty's definition of the informal curriculum, rather than the hidden one. It is plausible
317 that a reader, going throughout nursing literature about the topic, may wonder whether authors are
318 writing about the hidden curriculum or the informal curriculum. Actually, Hafferty himself (2014),
319 has recently stated that the boundary between curricula is very subtle, and not every author has the
320 same idea of thinking about the hidden curriculum. Concerning nursing education, the concept
321 might seem even less defined because of the paucity of literature, which is even poorer when
322 considering just articles that aim at describing it, as shown by this study. Possibly, a clarification of
323 the concept in the field of nursing literature is needed to facilitate the coherent and consistent use of
324 the term, and the development of further research (Rodgers and Knafl, 2000).

325 **Limitation**

326 The exclusion of grey literature and limiting the search to peer-review databased might have led to
327 lose some paper coherent with the scope of this study. However, being the hidden curriculum a

328 broad phenomenon, which needs further analysis in the field of nursing education, it was preferred
329 to avoid articles of potentially low quality that could create more confusion about the concept.

330

331 CONCLUSIONS

332 The hidden curriculum of nursing education is a broad, poorly explored phenomenon, which is
333 culturally specific to the region where the study takes place.

334 The mapping of the literature, following Hafferty's four domains, has allowed to a better
335 understanding of how institutional choices, at the level of organizational culture, influence students'
336 internalization of professional values stated in the formal curriculum.

337 Trying to uncover this learning dimension, nursing researchers focused their attention on the
338 negative consequences of the hidden curriculum, linking the debate to that of theory/practice gap.
339 Findings suggest that professional values, such as caring value, equality, and patient centeredness,
340 are strongly hampered by educators' behaviour and by organizational features of both educational
341 and health institutions (namely universities and hospitals), where the learning process takes place.

342 However, in order to address effectively the hidden curriculum, authors should leave apart what is
343 wrong with the issue and look for the alignment between curricula, which facilitates a professional
344 development coherent with nursing values and the bridging of theory to practice. Furthermore,
345 educators should be "trained to train", engaged with the formal curriculum and aware of the
346 existence of the hidden curriculum.

347 Finally, the hidden curriculum is a broad phenomenon that can be explored and thought in different
348 ways (Hafferty and O'Donnell, 2014). The poorness of nursing research about the issue, and the
349 subtle boundary with the informal curriculum, make sometimes difficult to understand what the
350 author think the hidden curriculum really is. A clarification of the concept in the field of nursing
351 education would be desirable to facilitate its coherent and consistent use.

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