

Professional Craft Knowledge and Curricula: What are we really teaching?

MESLEKİ SANAT BİLGİSİ VE ÖĞRETİM PROGRAMI: GERÇEK OLARAK NE ÖĞRETİYORUZ?

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Summary

Professional craft knowledge (PCK) refers to practical know-how needed to practise within a chosen profession. Educators develop curricula with a goal of sharing practical strategies for students to implement PCK. So, the students of health professions learn lectures and notes with these programmes. In this article, these subjects have been studied and some scientific results have been obtained.

Key Words: Professional craft, Curricula

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Özet

Mesleki sanat bilgisi, pratik olarak bilmeyi, yani seçilen meslekte pratik yapmaya nasıl gereksinim olduğunu verir. Eğitimciler, pratik sanat bilgisini uygulamakta öğrencilere pratik stratejileri paylaşma şansına ait programı geliştirirler. Böylece, sağlık mesleklerindeki öğrenciler, bu konudaki notları, dersleri bu programlarla öğrenirler. Bu çalışmada bu konular incelenmektedir.

Anahtar Kelimeler: Mesleki sanat, Öğretim programı

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Professional craft knowledge (PCK) refers to practical know-how needed to practise within a chosen profession. Educators develop curricula with a goal of sharing practical strategies for students to implement PCK. Explicit curricula are available to students in the form of course outlines, course notes, and lectures. However, perhaps even more powerful than explicit material in shaping future health professionals are values, assumptions and PCK taught through implicit means, such as, role modelling by educators in class and clinical practice. I explore some relationships between explicit, implicit and null curricula in this paper. When two or more concepts are explicitly espoused, implicit curricula can act to promote the values of one concept to the detriment of the other(s). This paper highlights the effects of com-

petition, rather than collaboration between and across curricula.

Know-how for healthcare students resides in acquisition of several complementary domains of PCK including competent, scientifically based healthcare delivery (scientific PCK or attention to measurable, physical dimensions of people) and holistic practice (holistic PCK or responsive attending to clients' physical, intellectual, social, spiritual, and emotional needs). Explicit teaching in one domain should augment the other. However, problems occur if implicit teaching of reductionist values, such as those taught in basic sciences, is preferred by educators over the demonstration of holistic values in practice. The dominant valuing of reductionist approaches at a study university (Conroy¹) (1) may prevent students from acquiring

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¹This chapter is based on selected findings from a work in progress. Sixteen medical, nursing and physiotherapy undergraduate students at a Canadian university gave multiple interviews, narrating reflections on their experiences and observations regarding their education to date. An interpretive phenomenological approach to the research offered an unprecedented glimpse into aspects of moral agency in these health science students. Pseudonyms mask their identities in this chapter.

and realising practical strategies to implement holistic values. Two ways that this dominant valuing is transmitted to students are: 1) educators implicitly demonstrating detached approaches to healthcare delivery when acting as role models in classroom and clinical areas; 2) distanced approaches resulting in an unacknowledged disregard for explicitly taught holistic health care concepts.

I describe three curricular influences and then look at how some of the underlying assumptions can affect teaching. Quotations from students' narratives illustrate the effects of the domination of reductionist values on the acquisition of holistic PCK. Suggestions to develop synergy between and across curricular influences complete the paper.

Three Curricular Influences

Many influences shape what students learn. Below I describe three influences that stem from curricula (2-4):

-*Explicit curriculum* includes formal instructional design. In healthcare programmes, it concentrates heavily on the acquisition of scientific PCK and skill including discipline specific knowledge such as anatomy and physiology, physical assessment skills (5) and procedures. People are viewed through a biological lens framed by specific diseased body parts. Explicit teaching in holistic PCK includes therapeutic communication skills and values including the idea of the client being more than the sum of biological parts, and client self-responsibility for wellness.

-*Implicit curriculum* is sometimes referred to as the hidden curriculum. Although not formally acknowledged, educators may, upon reflection, admit to it. Attitudes towards people, procedures, health care organisational proceedings, authority, for example, are subtly passed on to students. Implicit teaching in clinical areas may negate principles taught in class (6-8).

-*Null curriculum* refers to what is consciously or unconsciously excluded from student's education. It eliminates items not prioritised as having enough importance to teach in an overloaded program. However, omission in teaching of certain concepts can mask deeply ingrained prejudices against particular ideas or groups of people.

As one student, Annie, perceptively noted:

We're going to be learning by watching how they act to a certain extent and obviously some of it will be copying ... what they do ... We're not just going to be copying blindly but I think there is some transference that happens and we *will pick up* some of these behaviours [her emphasis].

Curricular Influences and Underlying Assumptions in Action

Explicit teaching in healthcare PCK includes a) scientifically based healthcare, b) "principlism"-based ethical decision-making, c) holistic approaches to care. Two potential outcomes can occur in classroom/clinical practice if reductionist-based PCK jockeys for position with holistic PCK:

1) values associated with reductionist scientific endeavours override those inherent to holistic healthcare. Scientific practitioners value technical competence, objective distancing from "the problem", statistical proof for claims to "best care". Holistic practitioners value ethical principles such as compassion, caring, collaboration, particularity, reciprocity and practical connection to clients viewed as "whole persons" (9,10).

2) "space" for holism is similarly overtaken by a more reductionist approach to ethics as expressed in Beauchamp and Childress' (11) principlism theory. Principlism advocates the use of four particular principles as seemingly paramount to other ethical principles. Some values, such as truth telling and autonomy, are common to the two ethical approaches of principlism and holism. However, when two reductionistic approaches to healthcare, as found in principlism and scientific investigations, are combined, holism runs the risk of being excluded or diminished.

I argue that reductionist approaches to persons foster a lack of respect for, and an objectification of, them. Distancing from people supports paternalistic modes of practice, wherein the attitude of the practitioner suggests that clinicians are the only authorities in healthcare. Such practice might be derived from at least three implicit assumptions, operationalised by educators, which mitigate against holistically therapeutic practice.

These interrelated assumptions are:

- superiority of science
- principlism will cover all aspects of everyday ethics
- practitioners are arbiters of health knowledge.

Although educators may reject these assumptions consciously, they sometimes imbue classroom/clinical practice. Whilst recognising that many professionals deliver caring, compassionate, clinically competent, collaborative practice, I selected the following excerpts from student narratives to illustrate counterproductive curricular influences on PCK acquisition. Thus, practitioners do not appear in the best light.

Assumption 1: Superiority of science

This assumption advances the idea that modern science can understand and predict ways to cure disease. The comfortable feeling this “certainty” engenders, accompanied by a drive for efficiency, helps to counter unease that there are many “unknowns” about the human side of health care. Modern biotechnological advances have helped to foster this assumption. Nevertheless, it is recognised in preliminary courses, that the human element in healthcare must be addressed with students. One introductory course explicitly teaches ideals of holistic healthcare such as:

- a person’s value is greater than the sum of their bodily parts
- practitioners enable the full expression of person’s physical, emotional, intellectual, social and spiritual potential
- compassionate care for the person as a unified entity is a given
- client-centred responsibility for healthcare

The sheer volume of classroom hours devoted to subjects such as anatomy, pathophysiology, and other scientifically related material, helps to push holistic concepts taught in the introductory course to the recesses of student attention. The human body is compartmentalised into organs and systems. Heavy reliance upon explicit and implicit teaching of scientific reductionism encourages a belief that application of research-based knowledge alone equals “excellent” care. With an emphasis on

what is statistically proven for the larger population, there is a risk of forgetting the art of responding with compassion and respect for the particular concerns and understandings of individual clients. In an environment where body parts are examined more intensely than the whole person, moral issues arise because people are categorised. Such objectification of people is incongruent with holistic ideals.

Animal experimentation is also used for explicit introductions to scientific health care. Repeated films showing the severing of cat’s nerves unsettles Peter:

Everything is based on animal research... pretty exclusively until it gets to clinical work where its applied to, ... performed on human subjects in a different way and then you get human results and there is absolutely no acknowledgement whatsoever ... from any of the profs, that there is even a moral issue in this fact ... and even among the students who just accept ... it seems normal to them that they don’t even blink an eye.

Peter’s last sentence suggests that despite the concomitant explicit valuing of holistic practice, educators implicitly transfer an atomistic model to first year students. In addition, the professor may not consider the “client as person”, but only see the “patients as a body part to be repaired”. Wider ethical implications of animal experimentation upon healthcare delivery are not addressed by the professor.

Students, expected explicitly to quickly assimilate huge amounts of scientific minutiae, do not have time to question the relevancy of the information to a client’s particular situation. Learning may become rote, a blur of pathophysiology and microbiology, rather than a critical, reflective experience. Fast-paced learning coupled with implicit emphasis on speed in client encounters encourages the objectification of clients and students alike.

Peter recounts:

Here I am, the first time in a hospital, the first time dealing with the patients, and [the instructor] is sitting over me going “quicker, quicker, quicker” [with my treatments]. [my parentheses]

Brief, hurried encounters diminish chances of practising therapeutic communication and caring skills taught explicitly in introductory courses. Students are expected to be able to rationalise their time, their knowledge and their emotions. Absent is recognition of the moral dimension when treating people as objects on a statistical conveyor belt. Rowan tells a similar story to Peter's:

You've never even seen the patient before. And they'd have like at least 1000 past medical problems, and I'm sorry. It's going to take me an, at least an hour to do this ... He dumped, he dumped this ... patient on me and said "I'll be back in seven minutes. Like ask, find out what's wrong with her and I'll be back in seven minutes". So I looked at her and I'm like, 'So tell me your entire life story in seven minutes'.

These accounts suggest that it is left to students to develop the artful know-how of interacting holistically in fast-paced practice settings. One can infer from this evidence, and from findings in other research studies of newly qualified practitioners (12-15) that students need role models who articulate PCK in practice to help them, for example, to get to know the client as a person or to use the initial assessment as an opportunity to establish a therapeutic relationship.

Annie recounts a Dante-esque scenario where in all pretence of relating to the client as an autonomous, dignified participator in healthcare was dropped by physician and nurse. She outlines a situation where the client was seen as a "diagnostic problem" and not as a person in pain. Client dignity was stripped by the situation and by practitioners' thoughtless exposure of her body to a roomful of students:

This person's screaming on the table ... we felt powerless ... watching what was happening ... The doctor would just go on with this thing ... "We see this part of the colon and this and this and I don't see any problems" and describing how the endoscope works as though everything was normal and fine ... I think the major [problem] was that ... he wasn't trained to show how this works ... to students. He wasn't trained to ... take care of his patient either. I

think he was relying on the nurses to do that and they didn't... He was just trained to do an endoscopy and make sure that this person was fine or not fine or what the disease was.

This narrative suggests educators explicitly teach the value of scientific knowledge. Implicitly, they can teach how to treat humans in an objectified, distanced way. Such objectification is reinforced when clients are referred to by their bed number or by a diseased body part. Strategies that respect the dignity and unity of persons are not taught in such practices.

Assumption 2: Principlism will cover all aspects of everyday ethics

Principlism, as espoused by Beauchamp and Childress (11) and as taught in formal lectures, champions four ethical principles: autonomy, justice, beneficence, and nonmaleficence. Proponents of rule bound, duty-based principlism reduce ethical debate to a balancing and prioritising of these four principles when searching for universalisable solutions to ethical dilemmas. In emphasising these particular principles or values, other values such as connection, caring, collaboration, and community-oriented morality taught in holistic healthcare are excluded. Lectures present case studies to students, framed within principlism's values, when considering what the practitioner should do in the client's best interest. In situations described to me, rarely was class time allotted for participatory discussion although that prospect was dangled tantalisingly in front of students. Such discussions might encourage exchanges between students and educators in consideration of practical strategies of how to use holistic principles in clinical settings. Interestingly, students did not report any instances of principlism being utilised explicitly in their clinical experience, in spite of the fact that up to three blocks of lecture time were allotted to teaching a principlism-based approach to ethical decision-making.

So what kind of ethical approach to clinical action was demonstrated if neither principlism nor holistic orientations were articulated explicitly in clinical practice? A reductionist, distanced approach, as encouraged in scientific work (7), and as used when balancing principles in classroom lectures, shone through implicitly in many clinical encounters. Although principlism theory advocates

client autonomy and dignity, the “object of interest” for the scientifically oriented practitioner might comfortably “default” to body parts or technical dimensions of care, rather than a therapeutic engagement with people’s concerns. Thus, for the scientifically and principlism oriented practitioner, a quick acceptance of universal solutions to ethical decision-making can occur, resulting in practitioner-dominated decision-making and lost opportunities for connection with autonomous clients.

Holism favours personal, contextualised solutions to ethical dilemmas where in the client is an active decision-maker. Collaboration between practitioner and client in healthcare is important. When role models implicitly pay close attention to technical/psychomotor skills, such as the respirologist in the following excerpt, opportunities for holistic PCK building are lost, such as practical strategies for connection to clients. The respirologist nullifies any particularised, holistic connection to the person to whose chest he is listening. Care -to supersedes caring- for. Annie observes:

My doctor in particular doesn’t seem to listen much to what the person says. I’m a little biased in the sense that I feel he’s not a very good role model because he, he’s not ... doing the things [*implicit*] that we’ve been at least told so far [*explicit*] that seem to be good, ... but in any case, yes, he, he’ll do the small things, like listen to the chest, check the oxygen pressure because he is a respirologist ... and ask the person how they’re doing a little bit. But ... nothing ... too important. Nothing too ... caring [*null*] [my parentheses].

Assumption 3: Practitioners are arbiters of health knowledge

An implicit assumption that practitioners are arbiters of knowledge in matters pertaining to health sits comfortably with reductionist scientific practice and decision models. The “doctor knows best” belief promotes paternalistic practice versus client self-responsibility for healthcare. Paternalistic practice may be an attempt by practitioners to avoid emotional over-engagement with clients and to ensure “best care” for clients who have less medical knowledge than practitioners. However, the balance might swing easily towards under-engagement with, and distancing from, clients.

Evidence that students in the study acquire the PCK of power-differential-maintenance between professional and patient suggests that students are exposed to paternalistic communication in practice. Peter, in reflecting on his first year, notes that he prefers the use of the holistic term “client”, rather than the more patronising “patient”. He dislikes the common practice of referring to a person by their disease. However, by third year, Peter also refers to someone as “The Stroke”. As mentioned earlier, calling a person by their disease is a distancing technique frequently used in “caring” professions. It reflects the importance placed on body parts and pathology over seeing persons holistically. How has Peter learned this practical strategy for maintaining the power differential and depersonalised care? It appears that subtle, disrespectful communication between clinicians and their students and their clients demonstrates a power imbalance that favours the clinician, in both relationships, and role-models the following strategies.

The power differential is maintained in various ways. For example, a typical instructional mode in medicine involves bedside rounds where up to eleven students ring the bed, observing clinician and client. Annie notes:

Often ... consent from the patient for us to be there is asked once we’re at the bedside ... I don’t think it’s fair to assume that they know it’s a teaching hospital so they should be all right with that and they know that you’re a medical doctor, so it’s “okay”.

The power imbalance is exacerbated by implicit treatment of clients as objects of observation. Paying lip service to client autonomy can occur when educators fail to demonstrate strategies which uphold client dignity and partnership in their care. Annie is acquiring holistic PCK, demonstrated by her attention to the client’s dignity, without the benefit of expert role modelling:

This person is very vulnerable and not necessarily happy or ... not necessarily in a good state of mind or strong. I know every time I feel very uncomfortable and I have a tendency to ... lag behind the group to thank the person personally before I leave.

Tutorial discussions, regarding accessibility of professionals to clients and knowledge sharing with them, are consistent with explicit holistic lecture content about client dignity and autonomy. However, that dignity is diminished in clinical areas if clients are perceived, implicitly, without evidence, as emotionally or intellectually incapable of digesting medical information. "One doctor said, 'Most patients you'll see are dumber than you are' ... And that was just last week", reports first year student Louis. There may be a failure to recognise that it is the use of medical language, and not the client's intellect, that might be building barriers to the client's understanding of health problems and solutions. Practical strategies to communicate scientific knowledge in everyday language at bedside teaching rounds were often absent. In the beginning of his programme, Rowan felt people should be more informed by staff about their diagnosis and prognosis. However, he agreed by the end of his third year that patients should not be "confused" by telling them in the early days of investigation and treatment what their disease was or what the proposed course of medical action would be. He believed the average person could not contend with too many variables. Through adopting the implicit beliefs of his role models, he acquired the PCK used in paternalistic practice. He did not know how to put into action the principles, taught in holistic class content, that related to client self-responsibility for healthcare and of collaboration between practitioner and client.

Detached observation of clients as if they were objects under a microscope, promotes emotional distancing from clients. "I couldn't actually reach out to that person at that moment. Still feel like I was behind some glass wall observing" states Annie. She was semi-paralysed by hierarchical constraints and the implicit detachment personified in the "clinician". Sometimes practitioners capitalise on a client's inability to talk and therefore inability to convey consent to student presence and teaching. Rowan described the removal of a respirator so that the students could take turns listening to breath sounds in spite of obvious client discomfort. A strong implicit message is sent to students that the client is an object of learning, an abstract tool for instructive purposes. Similarly when students are taken to see colonoscopies on a sedated

person, no consent may be requested, leaving clients dimly aware of student presence. Informed consent, respect for the person, autonomy, compassion and caring appear disregarded.

The idea of the client as an active, willing, autonomous partner in a collaborative quest for health is not being transmitted in practice (null curriculum) to the student. Missing are practical strategies to realise collaborative ideals. In keeping both physical and emotional distance from people, an implicit message is sent to students and clients alike that detachment is acceptable practice in a hierarchical structure. In recognising that implicit message, Shane and Annie hope they will experience positive, long lasting learning to prevent them from objectifying clients through their own verbal and body language. They hope to remember not to maintain the physician-client power differential through being condescending and arrogant.

Shane: in my learning experience, I'm looking, watching and not doing all that much yet, mostly observing ... When I see something that I like, ... whether it's the way a doctor talks to the patient or, which you see a lot of ... I ... put it away and when I see stuff I don't like, which I see a lot of-condescension, arrogance- and I'll file that away and also as a kind of caveat to myself that I didn't like it ... so don't fall into that trap at age 35 when I'll probably be a doctor ... I think ... the doctor-patient relationship is ... even more than the educator -student relationship, a one way street.

Annie: Having the whole group in there, makes the interaction seem ... as though ... there's this huge distance between us and them, as though we're observing this tiny little animal in a cage and I don't think that's fair. I think it's a great gift that they're giving to us ... of sharing what they're living and their experiences ... My first experience in the hospital was like that and it bothered me for the whole week after ... I don't know if that'll change. I've been told that, that's the way it's going to be throughout my whole residency unfortunately.

In communication classes, students are taught to view the person in a holistic way. However, implicit curriculum presented in practice placements

desensitises students to patients' humanity, emotions and needs. Students' experiences of role models' behaviour, towards both themselves (8) and clients, sets the scene for disengagement from people who are suffering. They learn strategies to achieve disengagement such as, physical aversion to client contact. As suggested in the above excerpts, this desensitisation occurs because students are exposed to repetitive "stripping of clients" dignity by practising professionals. Rowan had some troubles with emergency room doctors and nurses when trying to find out if a woman on a stretcher in the hallway could have some water:

So I go to the doctor. "Is it OK if this woman has a glass of water?" "Oh, why are you bothering us with this?" [They reply.]... So then the next time I walk by the woman I avert my eyes ... after 3 or 4 times this happens, ... that I get no help from the nurses or from the doctors, I don't want to help these patients anymore that are lying in the hall.

Slowly Rowan is detaching himself from being connected to needy people and assuming the remote professional mode of the (implicit) role models around him. Louis comments: "I think isolation in medical school helps exacerbate isolation in the hospital". He observes that as a student, "you sit on your haunches and you analyse the world from a very distant point of view". Practitioners may be fearful of becoming overly involved with clients. Nevertheless, they are not demonstrating practical strategies to achieve a balance between over and under engagement with others as client-centred practitioners manage to do (14,16).

Conclusions

To become rounded professionals, health care students need to acquire and integrate a number of PCK domains, i.e., the practical strategies for delivering (1) scientifically based health care and (2) holistic care. It has been shown that educators' implicitly held values and assumptions can shape students' ultimate learning through supplanting some explicitly taught concepts in favour of others. In this case, the concepts of holistic care (and its valuing of the client as a participant in care decisions) were overridden by those of scientifically-based care (and its valuing of the superiority of science).

This overriding was demonstrated by the kind of practical strategies that students were exposed to and those to which they were not. I conclude, therefore, that the values and assumptions explicated by practising professionals determine the substance of the PCK that students acquire in the clinical setting. The implicit teaching, offered through their role-models' behaviour in the heat of clinical action, is likely to form the basis of students' most powerful and long lasting learning.

The observations of this chapter suggest that student's clinical experiences often fail to furnish them with examples of practical strategies for bolstering client collaboration in healthcare. Instead, they are exposed to the strategies of paternalism, depersonalisation, objectification and distancing. Distancing by professionals from their clientele is an implicit enactment of the scientific mode of disengagement with the "object" of interest. The data suggest that, over time, it is these latter strategies that are acquired and practised by students.

The tensions and incongruities between the explicit, implicit and null curricula need to be critically debated, if parallel curricular paths are to be articulated, integrated and implemented. Commitment to this debate presupposes a collaborative learning culture in the educational setting. In addition, it is likely that faculty and clinicians will need support in developing and implementing genuinely integrated curricula. The following suggestions, therefore, are offered for debate, critique of practice and development support.

1. The philosophical and ethical bases of practice and of educational goals, as determined by faculty, should be examined.
2. Kushe's (17) suggestion that ethics teaching should concern itself with the affective or dispositional aspect of ethical practice could be considered.
3. Faculty and involved clinicians should be encouraged, individually and collectively, to critically reflect upon and articulate their fundamental values, assumptions and ideals.
4. Faculty's commitment to the values and assumptions, identified as desirable by the faculty in pursuit of excellent practice, should be assessed.

5. Faculty should be helped to identify differences between espoused values and values in action—perhaps by inviting students to share their experiences of clinical education and really listening to what they have to say.

6. Explicit curriculum should be re-examined in light of balance, approaches, emphasis and assumptions, such as those examined in this chapter, to consider what students are encouraged to value.

7. Educators could engage in critical reflection upon their practice and upon alternative ways of teaching, involving clients and students in the process.

8. Educators and practitioners could be helped to become aware of the nature of PCK and how its acquisition can be facilitated.²

9. Critical companionship skills could be developed in good clinical role models.³

10. Opportunities should be provided for tutorial discussion about contradictory practices and about how students can (a) retain their own beliefs and values about holistic, therapeutic health care and (b) how they might change culture/worldviews in the future when they have the authority to change practice.

In all of the above, educators might find it useful to work in partnership with their clinical colleagues by developing in-service education based on good practice and mutual learning. Titchen and Higgs (18) suggest one such approach.

²see Chapter 3

³see Chapter 9

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