Facilitating practitioner research through critical companionship

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The investigation of practice by practitioners themselves is growing in nursing. It is now expected of many nurses that they will carry out research as part of their everyday practice, for example, in the case of consultant nurses. Nurses are also expected today to provide evidence-based care for their patients and their carers. Researching one's own practice, providing care based on rigorously gained knowledge of many types and giving a professional account of that practice are challenging activities for which many nurses need support. Based on that premise, this paper explores 'critical companionship' (Titchen, 2000; RCN, 2003), which can be described as a helping relationship based on trust, high challenge and high support, in which an experienced practitioner accompanies a less experienced practitioner on a learning journey. It is a means of enabling nurses to acquire, experientially, the knowledge and skills required for patient care and its development.

The concept of critical companionship is described within the context of a practitioner learning to investigate the nature and development of her own professional knowledge base and to transform her findings into potentially transferable ones. Findings relating to therapeutic use of self and its impact on patients are offered as an exemplar of this transformation process. In addition, a new conceptual framework for blending all types of knowledge through professional artistry is described. Collaborative testing of this framework within a critical companionship relationship is shown.

It is concluded from this piece of practitioner research that professional artistry is essential for genuinely evidence-based, person-centred care, and that it can be facilitated through critical companionship. The conclusion is also made, based on our own and others' work, that critical companionship is effective in enabling practitioners to gather, analyse and critique evidence from their own practice and to articulate this evidence to peers for critical scrutiny, public review and knowledge creation. The benefits of critical companionship for patients and carers are described.

Searching 'within' self
Reveals and creates knowledge
In and from practice

INTRODUCTION

If healthcare professionals are to give evidence-based, person-centred healthcare they must be able to make use of the diverse knowledge that they have acquired as a result of their intellectual, emotional and personal maturity. Their knowledge base will have been formed from propositional or theoretical knowledge derived through research and scholarship; professional craft knowledge acquired either directly through the senses or through the practitioner's critical reflection on practice, and personal knowledge accrued through life experiences (Titchen and Ersser, 2001). Systematic critique and testing enables the development of each kind of knowledge.

There is a growing trend in healthcare to use the term 'knowledge' rather than 'evidence' when discussing and researching the nature of professional practice, for example, in the knowledge utilisation and transfer field. We take the view that the term 'evidence' can be limiting because it is usually tacitly

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Evidence-based care,
Professional artistry

understood as research evidence. As expertise in professional practice is based on different types of knowledge, discussion in this paper centres around the nature of these types of knowledge, rather than around 'evidence' per se. Nevertheless, we keep to the current usage of the term, 'evidence-based practice', but by this we mean evidence provided by patients and their carers and evidence derived through the senses, socialisation, professional and life experiences of practitioners as well as through research.

The blending of the different types of knowledge appears to help practitioners use themselves therapeutically within the practitioner-patient relationship. However, some of these types of knowledge are often tacit and deeply embedded in the practitioner, and in the practice itself, which makes it difficult to establish if and how they are blended. The limited research in this field suggests that such blending requires critical review and an understanding of one's own knowledge base (Eraut, 1994). It also requires an understanding of how the different types of knowledge are created, verified and blended, and an evaluation of their usefulness in decision-making and acting in particular situations (Titchen, 2000; RCN, 2003).

Until recently, the blending of different types of knowledge was largely ignored and under-valued by practitioners, who were clearly doing it, but in barely conscious and unreflective ways. It was also often ignored and undervalued in research and education. Researchers and educators were mostly concerned with the creation, application and learning of propositional knowledge, in ways often far removed from practice itself. Thus the processes of generating knowledge in and from practice by practitioners and the blending of propositional knowledge with other forms of knowledge appeared somewhat mysterious and ineffable when people in the health sciences began to take more interest in them.

In this paper, some of the findings of a piece of practitioner research facilitated by a critical companion are presented. The research involved a practitioner exploring the knowledge embedded in her practice and using her new insights to test the results of previous research. This previous research (Titchen, 2000) had suggested possible ways in which the types of knowledge contributing to evidence-based, person-centred care are blended to enable the provision of such care. Through this practitioner research, a new conceptual framework has been created. This paper, therefore, shows that the knowledge being sought does not lie objectively somewhere 'out there' but 'within' the subjectivity of the individual practitioner. It also reveals how subjective knowledge can be transformed into knowledge that is potentially useful to others.

Revealing the artistry of practice 'within' requires special skills and attributes. These can be developed and enhanced in the practitioner through a critical companionship relationship (Titchen, 2000; 2001a; RCN, 2003). The critical companionship framework suggests ways in which an experienced researcher and facilitator can help practitioners to be rigorous in investigating their own practice. The framework is presented illustrated with a practical example.

RESEARCHING 'WITHIN'

Person-centredness rests on an ethic of care. Increasingly, clinically effective care is seen as being both evidence-based and person-centred. This means that the right treatment, given in the right way, for the right patient, at the right time, is delivered in ways that address the needs and concerns of a particular patient, as he/she sees it. Evidence-based and person-centred care both draw on holistic professional practice knowledge and particular sets of

values. Professionals, therefore, have to be aware of their own professional knowledge base, which will include their personal knowledge and values and how they put all these into action. By using a range of theoretical tools and perspectives, subjective knowledge and know-how can be transformed to become potentially transferable to other settings, people and contexts (Titchen and Ersser, 2001).

Within the framework of critical companionship, we used analytical tools that were developed through empirical research (Manley and McCormack, 1997; Higgs and Titchen, 2000; Titchen and Higgs, 2001a; Titchen, 2001a; 2001b), and put them to work with evidence from McGinley's portfolio of evidence which she compiled for recognition of her expertise in her specialty (RCN, 2003). Through this process, we transformed evidence from McGinley's clinical practice to knowledge that is potentially transferable to other healthcare professionals in other fields of practice.

McGinley began her investigations in the Royal College of Nursing Expertise in Practice Project (RCN, 2003) by developing a portfolio of systematic, rigorous and verifiable evidence with the help of her critical companion, Brendan McCormack. Since then, McGinley and Titchen have worked together within a critical companionship relationship to extend further McGinley's understanding of her professional knowledge base and how she can become a critical companion to her colleagues.

CRITICAL COMPANIONSHIP IN PRACTITIONER RESEARCH

Critical companionship is a relationship that is built on trust, challenge and support. A critical companion is an experienced facilitator (often, but not necessarily, a colleague) who accompanies a practitioner (or team or organisation) on an experiential learning journey towards the provision of evidence-based and person-centred care. The purpose of the journey may be to become a reflective practitioner, a practitioner-researcher or member of an effective team, or to create a culture of effectiveness in the workplace or organisation.

The framework was initially developed and tested through action research, in combination with a phenomenological case study (Titchen, 2000)*. It was verified as being effective in enabling practitioners to present robust evidence of their positive impact on their patients, colleagues and organisation (RCN, 2003).

Critical companions seek to promote evidence-based, person-centred care by helping practitioners to become more aware of:

1. How they bring self as a human being into their relationship with the patient/client (this will include their values)
2. The nature of their own professional knowledge base that informs their practice and how it was generated.

The first area can be thought of as the ontology of practice (Freshwater, 1998; Higgs and Titchen, 2001), which refers to our ways of being; for example, being sensitive or authentic in our relationships. The second area can be conceptualised as the epistemology of practice; that is, what we know, how we

* The critical companionship framework is influenced by five theoretical perspectives: critical social science (eg Freire, 1985); humanistic existentialism (eg Rogers, 1983); a spiritual perspective based on a form of moderated love (Campbell, 1984); creativity and imagination in professional practice (Seizing the Fire Collaborative, 2002); and by a phenomenological perspective concerned with the lived experience of practice, learning and researching.

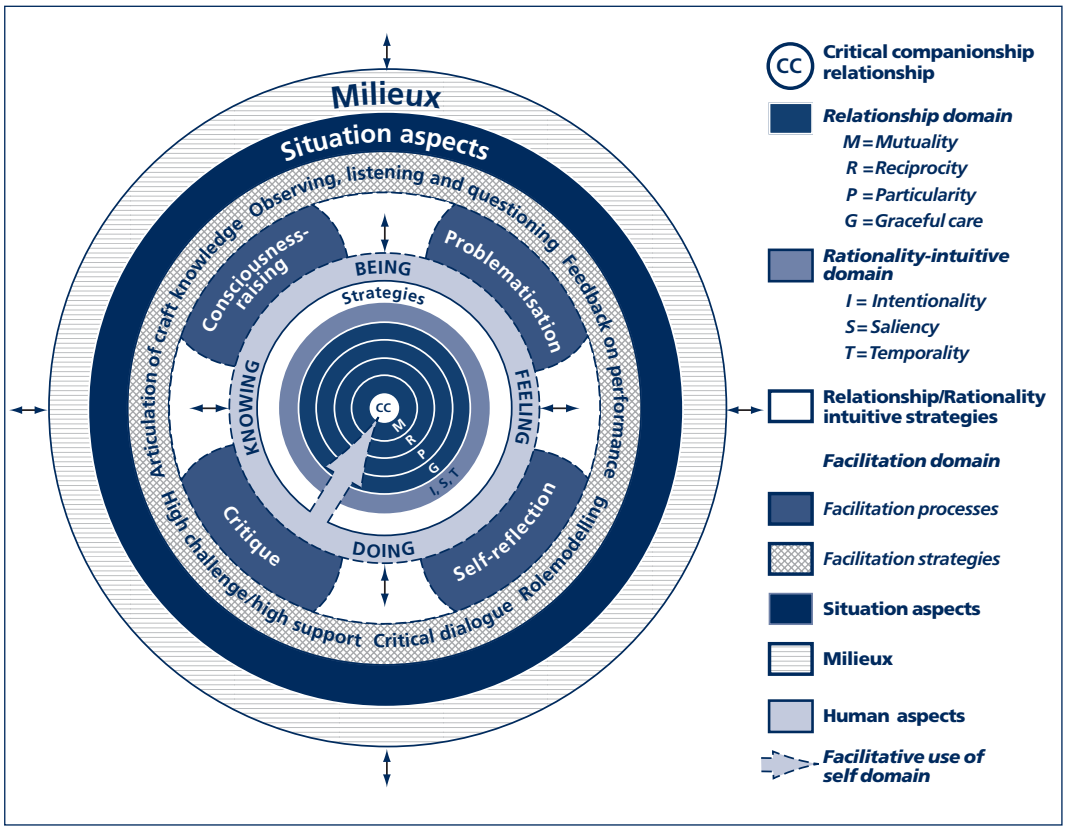


FIGURE 1
Critical companionship: A conceptual framework for facilitating practitioner research (Titchen, 2000)

know it and how we create it. McGinley's increased awareness of her own ontology and epistemology of practice opened up the possibility of her scrutinising her ways of being and knowing in practice. This awareness helped her to create knowledge both in and from her own practice.

THE FRAMEWORK

The conceptual framework of critical companionship is laid out in a series of overlapping circles (Fig 1), which represent various practical know-how domains (Titchen, 2000; 2001a). There are three domains — relationship, rationality-intuitive and facilitation domains. Each consists of a number of processes and associated strategies. In addition, there is an overarch of facilitative use of self domain.

The relationship domain

This domain is concerned with setting up and sustaining the relationship with the practitioner. It has four processes: mutuality; reciprocity; particularity; graceful care. These processes stand in a 'pre-requisite relationship' with each other, with mutuality being the most dependent. For effective mutuality, all the other processes in the relationship domain must be used and well developed by the critical companion.

Mutuality (working with)

The critical companion and practitioner work together in a carefully negotiated partnership. Critical companions are alert to the practitioner's readiness to learn about practitioner research, making use of opportunities for

shared experiences. They build on the practitioner's starting point and offer the practitioner their knowledge and experience as a resource for solving research problems and helping them to learn from research experience.

Strategies
- Creating equality in the relationship, especially in hierarchical organisations where a companion who is more senior or who has research expertise would be seen as the more powerful
- Sharing responsibility with the practitioner for the structure, process and outcomes of the relationship
- Helping the practitioner to understand the research situation

Reciprocity (reciprocal closeness, giving and receiving)
Mutual, collaborative, educative and empowering exchange of feelings, thoughts, knowledge, interpretations and actions. Both companion and practitioner recognise that they receive gifts of care, concern, satisfaction and wisdom from each other.

Strategies
- Negotiating
- Receiving
- Learning.

Particularity (knowing the practitioner)
Getting to know and understand the unique details and experience of the practitioner within the context both of the research and of the practitioner's life (as far as he/she wishes to disclose). Once the companion knows 'where the person is at', this is taken as the starting point from which the practitioner is helped to learn from his/her own research experience. The practitioner is seen as a unique, whole person, as well as a colleague with individual needs that can be met in different ways.

Strategies
- Observing the practitioner's situation and responses; facilitating and listening to the practitioner's stories and self-reflection; picking up on cues and clues
- This understanding of the practitioner is used in combination with the companion's own self-knowledge, professional craft knowledge (know-how) about doing research and facilitation of learning theory to design and evaluate unique learning experiences.

Graceful care (using all aspects of self)
Support given to the practitioner by the critical companion through touch and use of body language (including posture, speed of movement, tone of voice) to express both who he/she is as a person and his/her response to the practitioner, which makes the practitioner feel personally valued, thereby promoting emotional, psychological and intellectual growth.

Strategies
- Being genuine and expressing self as a person
- Being generous with self, knowledge and time
- Giving undivided attention
- Being physically and emotionally present with the practitioner in times of

stress, disappointment and frustration; listening, engaging and giving reassurance
- Maintaining a balance between absence and too much emotional closeness with the practitioner
- Dealing with own negative, difficult or inappropriate emotions
- Using humour to provide support
- Valuing the practitioner as a person and his/her unique professional contribution.

Rationality-intuitive domain

This domain has three processes: intentionality, saliency and temporality. These are practical tools to help the use of the relationship and facilitation processes. While the three processes are, therefore, prerequisites for the relationship and facilitation domains, they are not prerequisites for each other, which is why they are set out in the same ring.

Intentionality (acting with intention)

Deliberately using all the critical companionship strategies.

Saliency (knowing what matters)

Knowing both consciously and intuitively what is important from both the critical companion's and practitioner's perspectives. Significant cues and clues are used to plan learning strategies and to address what matters.

Temporality (time, timing, anticipating)

The critical companion should understand the need to attend to what has happened in the past, to what is happening now and be aware of what could develop in the future. Action should be taken at the right time and at the right pace for the practitioner, anticipating his/her needs.

Strategies
- Acknowledging the past, present and future
- Making focused time
- Timeliness
- Regulating the speed of interaction or the balance of any conversation.

The facilitation domain

This domain is concerned with helping the practitioner to examine and critique his/her clinical/research practice. It has four processes: consciousness-raising; problematisation; self-reflection; critique.They do not have prerequisite relationships with each other.

Consciousness-raising

Making practitioners more aware of the tacit and taken-for-granted knowledge they have of daily clinical practice, and recognising the nature of this knowledge. This includes raising their awareness of their intuition and behaviour, and the effect they have on others while practising as clinicians, practitioner-researchers and critical companions. Heightening their awareness means that the following processes can be used to review their knowledge critically, so beginning the task of turning this into knowledge that is useful to others.

Problematisation (raising awareness of problems or issues)

The practitioner is helped to become aware of, and to critique, the tacit understandings that have grown up around repetitive, routinised practice.

Areas may be pointed out that might need attention but are not perceived by the practitioner as being problems or issues. Where practitioners do see a problem but cannot find a solution, the critical companion helps the practitioner to see things from a different perspective. If practitioners are unaware of inconsistencies or contradictions in their practice, the companion gently points them out.

Self-reflection *(facilitation of critical investigation of self and practice)*
A cyclical process in which practitioners critically reflect upon and evaluate their experiences, thinking, intuitive actions and use of creative imagination in a particular situation. The critical companion helps them to describe the important features of their actions and behaviours, what happened, and their thoughts and feelings. The companion encourages the practitioner to focus on positive feelings and deal with negative ones.

Furthermore, the companion supports the analysis by making practitioners aware of their thinking and reasoning processes. New knowledge is linked with that the practitioners already know. The practitioners are then helped to draw conclusions about these experiences, to use theory to deepen their understanding, and then to use their conclusions to inform action plans.

Critique *(developing new knowledge through debate)*
A collaborative, critical reflection on an experience and the situation in which it took place. Personal and professional issues and meanings in the situation are uncovered, and the influence of cultural, social, historical and political factors/constraints are explored. The companion and practitioner debate these in the light of their newly gained insights, understandings and interpretations of practice. Refined understandings are then used to develop new knowledge; for example, about a particular aspect of clinical knowledge or about how to change a situation within the practitioner's own sphere of work, but within social, cultural, historical and political constraints.

Strategies
- Role-modelling research practices, for example, how to subject evidence from multiple sources to systematic critique, critical control and review
- Articulating craft knowledge about research practices, for example, through telling stories, describing one's logic, rationale, intentions, what it is hoped to achieve, and how, in relation to, for instance, analysing and interpreting evidence from practice
- Observing, listening and questioning the practitioner going about his/her everyday work and asking questions (McAlpine et al, 1998); for example: 'What sense were you making of the situation? 'What options were running through your head?' 'Why did you make the choice you did?' 'What was the consequence?' 'Why did you say or do (a specific thing) at that point?' This questioning strategy brings embedded know-how to consciousness, offering the opportunity for critical review and evaluation
- Feeding back on the observations and conversations
- High challenge/high support (Johns, 1997) in relation to the development of research knowledge and skills and to any professional development the practitioner wishes to undertake through the research process
- Promoting creativity and use of imagination through creative arts media such as painting, poetry writing, movement, and clay modelling
- Critical dialogue to review and evaluate the knowledge that has been revealed through all the above strategies.

The situation
This is the focus of the critical companionship or the broad aspects of the situation under examination (in this case, the facilitation of practitioner research).

The milieux
This represents the opportunities for reflection that can be seized or created by the critical companion. Little arrows indicate the antennae through which critical companions sense what is happening both internally and around them.

The overarching facilitative use of self domain
The big arrow shows how critical companions take themselves as a person into their relationship with the practitioner researcher, that is, their own being, knowing, doing and feeling. The dotted lines around the arrow indicate how the companion 'picks up' the necessary bits of practical know-how—in the relationship, rationality-intuitive and facilitation domains — and blends them into a unique mix for working with each situation. This domain is overarching: all the other domains and strategies interplay here, and are shaped by the personal qualities of the critical companion, the particular situation and the opportunities available to work together. There are any number of patterns and combinations, as the dotted lines show. This blending of know-how and bringing ourselves into our work as critical companions is part of professional artistry (Titchen and Higgs, 2001a).

DOING PRACTITIONER RESEARCH

In the Expertise and Practice Project (RCN, 2003), McGinley and McCormack used a variety of methods and data sources to gather robust, verifiable evidence for critical scrutiny. Methods included McGinley's own critical reflections on the care of her patients; 360° feedback from her role set (colleagues who would give her honest, challenging, constructive and detailed feedback about her care); and a user narrative by someone to whom she was giving care. Some of the evidence gathered is presented here as a story to show McGinley's ways of being human and the acting out of her values and her ways of knowing. McGinley and Titchen engage in a critical dialogue with the story. To differentiate between story and dialogue, the former is italicised.

THE STORY: MAEVE McGINLEY'S BLENDING OF DIFFERENT TYPES OF KNOWLEDGE TO OPTIMISE PERSON-CENTRED CARE

The scene is set by McGinley's summary reflection on reading her user's narrative. The user, Kate, is the mother and carer of McGinley's patient, Joseph, an 18-year-old with an undiagnosed neuro-degenerative condition. Pseudonyms have been used here to ensure anonymity of both the patient and his parents. Kate was interviewed by McCormack, who analysed the narrative using the attributes of expertise (Manley and McCormack, 1997) (thereby, role-modelling a data analysis method to McGinley). These attributes are: holistic practice knowledge; knowing the patient; saliency; moral agency, and skilled know-how. We hear more directly from Kate and McCormack later.

> McGinley*: I feel that this narrative is a very powerful piece. It reflects enormous trust in me by Kate to so willingly share her story with Brendan. The narrative would appear to indicate clearly that in this case, as a clinical*

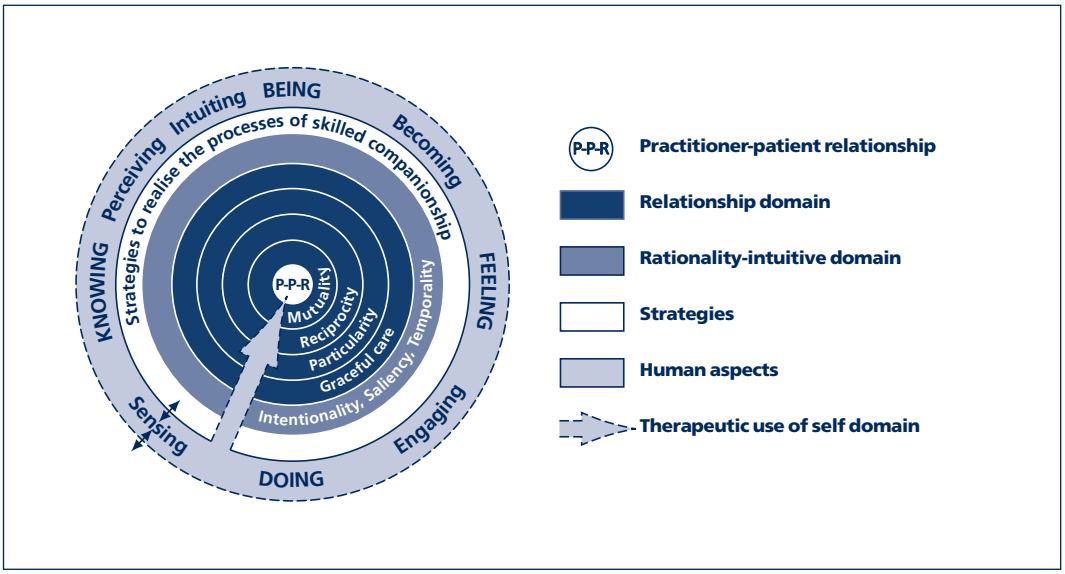


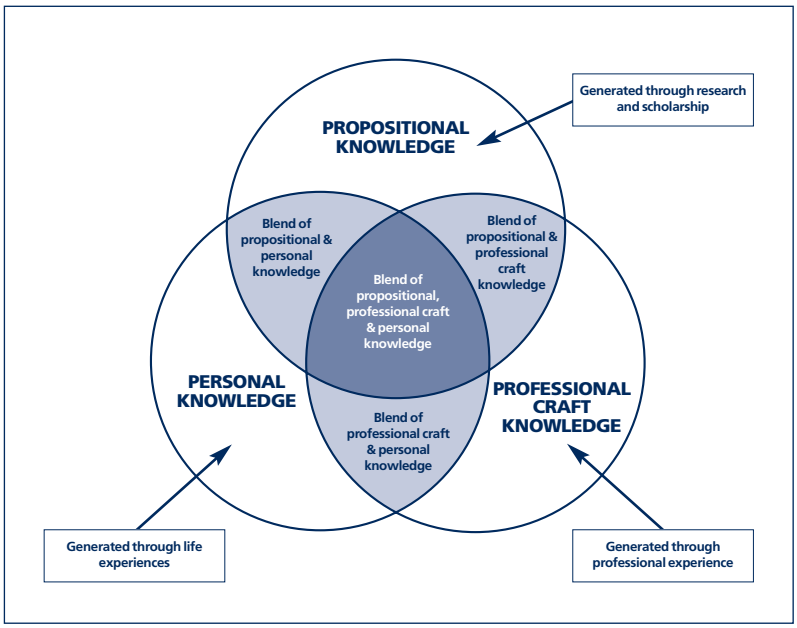
FIGURE 2
Skilled companionship: A conceptual framework for person-centred care (Titchen, 2000)

practitioner, I demonstrate all the attributes of expertise and am an effective, skilled companion for the carers, patient and others involved in this case.
It appears to be demonstrated in this narrative that I was able to identify [where others had failed] that Joseph might not be emptying his bladder fully and that that could be the cause of his many and frequent infections.
Using Titchen's (2001b) 'skilled companionship' model (Fig 2) to analyse my expertise within this narrative, I sensed that I clearly demonstrated expertise as a skilled companion to Joseph and his carers. My domains (relationship, rationality-intuitive, therapeutic use of self) appeared to be strong and very well-balanced. I seemed to manage effectively the fine interplay between my intuitive and rational judgment and between my theoretical and professional craft knowledge.
The practical strategies that I had adopted to realise the process concepts within the domains appeared to have been effective. For example, within the narrative it is highlighted how I was able to identify the key risk factors for the patient through using my holistic knowledge (saliency), and how I would speak to doctors on Kate's behalf because I sensed she felt uncomfortable contacting them, as she felt they did not always listen to her (particularity). How I demonstrated graceful care with this patient appeared to be illustrated, for example, when Kate said: 'Maybe it's just Maeve herself, the person she is; she just makes it easy to relax with her.'

Higgs and Titchen (2000) offer a typology for holistic professional practice knowledge (Fig 3). The three types of knowledge shown in the typology — propositional knowledge, professional craft knowledge and personal knowledge — are clear in McGinley's evidence. They appear seamless in her practice. She uses them simultaneously, which is represented by the overlap of the three circles. She shapes or influences her propositional knowledge, her working knowledge (professional craft knowledge) and her 'attitudes' and 'concern' (personal knowledge — awareness of her values), each with the other, as represented by the circles where they overlap with one other circle only and, in the centre, where they all overlap. By shaping or influencing, we mean that each type of knowledge imbues the other with some of its

FIGURE 3

A typology for holistic professional practice knowledge



characteristics and thus changes it in some way. This transformation is discussed later later.

In McGinley's narrative above, it can be seen that she wants affirmation that skilled companionship (see Fig 2) is evident in her practice. Skilled companionship is a conceptual framework that describes three knowledge domains of person-centred health care — the relationship domain, the rationality-intuitive domain and the therapeutic use of self domain. (Note the similarity with critical companionship.) She finds strong evidence of all three domains and feels that they are in balance. This balance and the interplay she mentions between the domains and between rational thinking and intuition within the therapeutic use of self domain, is professional artistry. We return to the notion of professional artistry later when looking at the transformation of knowledge, its use and creation. First, we look at some of the skilled companionship know-how in action.

McGinley refers above to 'saliency', by which she means the ability to know both consciously and intuitively what is important and needs to be attended to from both the practitioner's and the patient's/carer's perspectives. Practitioners focus on significant cues and clues, and plan care that will address what matters both to them and to patients/carers.

McGinley also refers to 'particularity', which means getting to know and understand the unique details of a patient/carer, as a person, within the context of both a specific illness and the context of the person's life. In addition, she points out 'graceful care', which means using all aspects of self; for example, using one's body to convey feelings; being creative and imaginative; showing appropriate emotions; being engaged with care; being generous, and offering wholehearted caring. Within graceful caring, more than anywhere else, can be seen a practitioner's way of being — ontology in action.

Here is Kate's experience of graceful care:

> Kate: *Maeve's just so easy to talk to … Maeve wouldn't keep saying: 'Just ring me any time in work' if she didn't mean it. I would be a bit reluctant to ring [just] anybody. I would feel happier if I was*

going to have to ring anybody, [that] Maeve would be the first person I would go to.
McCormack*: Really. Why's that?*

Kate: *Because she just makes herself so available. She makes you feel comfortable that, if you ring her, you don't feel like you're bothering her. She's so busy, and I'm aware that she is busy, but she never gives that impression — she always gives you the impression that she has plenty of time for you. You know [that] she'll come in and see you.*

McCormack: *Yes. So did that make you feel cared for at the time?*

Kate: *Yes, definitely ... Maeve's more like a friend now. We think Maeve's a friend rather than a nurse. I find her easier to talk to than anybody else that's coming in, plus the fact because she has seen Joseph in so many different sorts of situations and moods and different things, she sees the picture. Maeve just seems to be able to pick up on things. It's unbelievable, you know. She understands better than anybody … She's genuinely interested in what is going on here. She is concerned about Joseph as a person and she's concerned about us as his family.*

McCormack comments here:

McCormack: *Throughout the interview, Kate spoke of Maeve like a 'family friend', and indeed in discussion with Maeve she spoke of the family like her friends also. Maeve is the first point of contact for Kate and clearly she relies on Maeve to clear a path through the complexities of the health and social care system that she has to cope with. Maeve is clearly a skilled companion to Kate. She spoke passionately about Maeve's caring approach to Joseph, her care about her [Kate] as a carer and care about the whole situation …*
Many theorists have identified 'being a friend' as a component of the therapeutic caring relationship (Boykin and Schoenhofer, 1993). Here, Kate talks freely of the importance of Maeve's friendship. Maeve has broken the boundaries that often exist in a professional caring relationship ('we think Maeve's a friend rather than a nurse'). She sees the whole picture and works with Joseph and his mother to make appropriate decisions.

This last sentence shows saliency and mutuality in action. Mutuality means working with, rather than doing to, and describes the working together of the practitioner and the patient and family in a genuine partnership. For example, McGinley's knowledge of the healthcare system enables Kate and her husband to make a variety of decisions and to plan their consultations with the doctors to gain as much as they could from the experience.

Kate: *I spoke to Maeve on the phone and she was more or less sort of saying to me: 'Sit down and write down the things you want to ask and think about it, and go through a few of the things that we have been talking about'. So that did help me because I did that.*

Kate experiences mutuality that is linked with McGinley's extensive knowledge base and which is beneficial for her:

> Kate: *Maeve listens to everything you say. She thinks about it and maybe comes up with a few suggestions, but she leaves it open, you know; she leaves a lot open to us to decide …*

McCormack points out that of all the qualities that McGinley possesses and that are valued by Kate, her ability to listen is the one she appreciates most:

> Kate: *Maeve respects what you say; … if Maeve suggests something, I will listen and I'll think about it because of who she is, because of the way she behaves, because, as I said, Maeve is like a friend and everybody feels the same about her …. She doesn't start criticising anything we do, even if it's not what she agrees with. She never criticises you … or makes you feel that what you're doing is wrong.*

Kate regards McGinley's combination of bringing herself as a person into her care (personal and professional craft knowledge) and her technical expertise (propositional knowledge) as being therapeutic:

> Kate: *Because Maeve's coming into the house, she sees everything that's going on … I feel comfortable with Maeve being in the house — I don't feel I have to put on a show for her … and she knows all the different things that are going on. She's very knowledgeable, so if Joseph does have a problem, I find that [because] you have Maeve here you've a better chance of finding out exactly what's wrong … even if you go to the doctor …. and then she can liaise with the doctor.*

So where is this story leading? Together with an increasing amount of research evidence (Brown, 1986; Bottorff, 1991; Taylor, 1992; Ersser, 1997; Binnie and Titchen, 1999; Edwards, 2002), the story is demonstrating that using a wealth of technical, propositional knowledge is not enough for some patients and families. They also want professionals who know-how to offer a partnership, who value patients'/carers' knowledge and facilitate their involvement in care and decision-making. They want professionals who know-how to offer their propositional and professional craft knowledge as a resource and how to tailor this knowledge to help their particular situation and illness experience.

Furthermore, they want professionals who know-how to make themselves approachable and who are 'more like a friend'. Some patients also want technical knowledge, practical know-how and personal knowledge, and they want these provided in a seamless way.

This evidence from patients/clients and their families suggests that they feel the professional role is enhanced by the therapeutic use of self. There is an increasing amount of evidence that professionals such as McGinley also feel that their professional role is enhanced by the blending of different types of knowledge (Benner, 1984; McMahon and Pearson, 1991; Ersser, 1997; Binnie and Titchen, 1999).

The story and critical dialogue have indicated how different types of knowledge were used by McGinley to optimise evidence-based, person-centred care. They also begin to show how using analytical frameworks to understand her practice better begins to transform her knowledge into a form that other practitioners can potentially use. McGinley's story continues below to show how she developed the capacity to create and blend knowledge in her practice.

McGINLEY'S KNOWLEDGE-CREATION AND BLENDING STORY

McGinley shows in the following quote taken from her portfolio that she felt that propositional knowledge contributed to the development of her professional craft knowledge. She discovered this by using new language and frameworks that enabled her to investigate her practice:

> *'Relating Titchen's (2000) conceptual frameworks to my clinical practice and understanding the language she used when explaining them, initially, seemed like an impossibility.'*

However, McGinley found that reflection, through action learning (McGill and Beaty, 1998), helped develop her understanding:

> *'I could really see, as we reflected at the end of each action learning set [in the Expertise in Practice Project], the various domains of knowledge and learning strategies that had been used and how they were actually used. This enabled me to get a real grasp and understanding of what I had been trying to read in terms of the conceptual frameworks and structured reflection (Titchen 2000; Johns 2001).*
> *If someone challenged me now to explain my own expertise or even to analyse someone else's, as an expert I feel I could not only articulate my thoughts clearly because I have frameworks and languages to help me to do so, but also [that] I could identify aspects of that expertise that may require development.'*

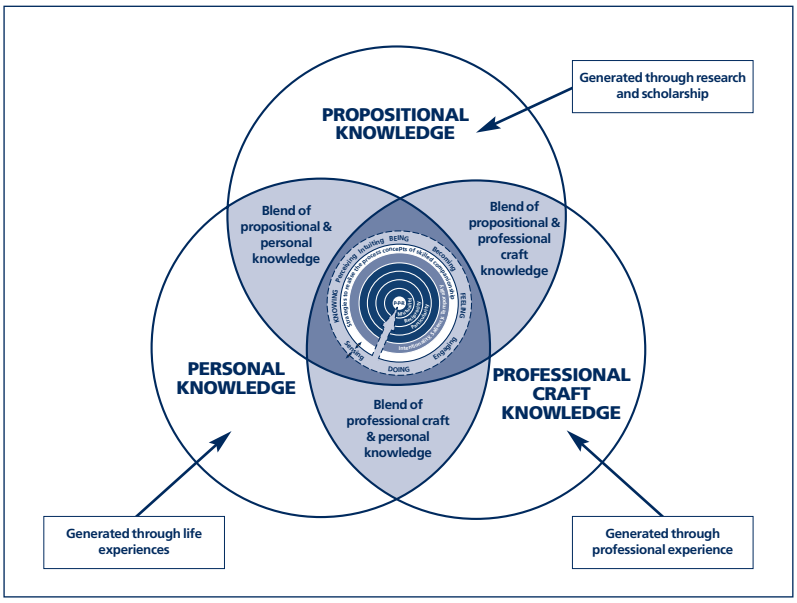
Since the completion of the project, we have further investigated how McGinley blended self and professional knowledge. First, her care of Joseph and his parents was examined:

> Titchen: *[Referring to Fig 3] How did you blend your knowledge to make your care person-centred?*

> McGinley: *While I brought all three forms of knowledge with me on my first visit to Joseph and his family, how I blended them together was shaped by the situation or context in which I found myself, particularly my understanding of what Joseph, Kate and Sean's [Kate's husband] specific needs were at that time, where they were at, balancing that against any risks and the need to prioritise actions to minimise any risk.*
> *I used my own personality to gain the information I needed to know the whole person I was trying to help; in this case that included Kate and Sean. I uncovered what kind of help they felt they needed and where they were at. I blended my different forms of knowledge in such a way so as best to help them. For example, when I initially visited, it was my propositional knowledge that played an important function, combined with my personal knowledge. This combination directed my decision to do the scan quickly to get an objective clinical diagnosis and help reduce anxiety levels.*
> *When I was doing the fuller assessment of Joseph and initiating some treatment, I used more professional craft knowledge, combined with personal knowledge and, to a much lesser extent, propositional knowledge. Blending of the different types of knowledge is, I feel, brought about by what you call 'professional artistry'.*
> *For me, this means looking at the whole person you're trying to help, asking what kind of help they need, where they are at and then shaping the*

FIGURE 4

Skilled companionship: A strategy for blending self and professional knowledge through professional artistry



types of knowledge or weaving them together to help the patient and/or carer to get the best out of the intervention to help them cope with where they are at at that particular time.

Titchen: *How did you check out the validity of the different types of knowledge and the blend and their usefulness in your work with Joseph and his family?*

McGinley: *By critically reflecting when in the actual situations and after my visits to Joseph's home, particularly when writing up his notes. I also checked these things by discussing my thoughts and actions with other nurses and other professionals involved in Joseph's care.*
In particular, I shared the different types of knowledge I was using with the hospice nurse who had been involved with Joseph and his family for a number of years. She was very much in agreement with my understanding of the case and the approach I was taking. When I spoke to the urologist this was another opportunity in which I was able to validate the different knowledge I was using — their blend and usefulness. He agreed not only with my clinical diagnosis, but also with the actions I had initiated. The propositional knowledge and professional craft knowledge I had used were further validated through the results of the clinical tests carried out by the urologist.

Titchen: *How do you know that the knowledge/blend had the impact you intended, in terms of being person-centred?*

McGinley: *First, Kate and Sean's level of anxiety was visibly reduced. Second, Joseph's residual urine volumes decreased and he gradually began to improve. Third, Kate and Sean actively began to seek information/advice from me and when they were upset or even angry about something they would phone me and share it with me and trust me to act on their behalf. Fourth, Joseph actually began to attempt to speak to me and even to touch me when I visited him.*

INSIGHTS INTO THEORETICAL PRINCIPLES

Theoretical principles can be derived by putting together the analytical frameworks (Figs 2 and 3) that have already been examined. These are shown as Fig 4. This is a dynamic, transformative model that shows how the skilled companion blends different types of knowledge in giving evidence-based, person-centred care. An image that might help to understand this blending is to look at Fig 4 as a kaleidoscope. With each patient, the practitioner turns the kaleidoscope to transform the pattern of the crystals — they are the same crystals, but their form and balance have been rearranged. So it seems to be with the practitioner — he/she is drawing on different aspects of the different types of knowledge and creating something new each time. It is not just one pattern or one blend that the person-centred practitioner offers, but an endless number of variations and diversity. But there is always one constancy at the point of balance: the place of stillness, at the centre of the model — the patient/client-practitioner relationship. All this is professional artistry.

CONCLUSION

This paper has described a search for new knowledge by McGinley, a practitioner, and her critical companions. They searched for the subjective within McGinley's person-centred practice and transformed the subjective, using analytic tools developed through research and critique into a contextualised, potentially transferable form. This form is a new dynamic model of skilled companionship as a strategy for blending self and professional knowledge through professional artistry. It has been made explicit how mature, self-aware, sensitive and skilled practitioners can deliver evidence-based, yet unique, personalised patient care that the patient wants and needs. They do this by blending self and professional knowledge through an inextricable twining of propositional, professional craft and personal knowledge. This may be accomplished through professional artistry, and can be facilitated through critical companionship strategies within any experiential learning context, such as clinical supervision and action learning.

Critical companionship parallels skilled companionship through parallel relationships, types of knowledge, knowledge-creation processes and professional artistry. Through setting up a person-centred facilitation relationship with the skilled companion, the critical companion role models the parallel ontology and epistemology of expert skilled companions who are investigating their own practice. Thus the critical companion, articulates the cognitive, metacognitive (thinking about thinking), intuition and artistry involved and nurtures their development in the other. Graceful care is particularly important to support skilled companions on what is often a lonely, challenging and sometimes painful research journey.

Through the extra facilitation domain, the critical companion enables the skilled companion to become a practitioner researcher and a transformer of her/his own practice and context. In so doing, the skilled companion becomes aware of the blending of different types of knowledge that occurs through professional artistry when person-centred evidence-based care is given. In this way, the mystery and artistry of practice is not only revealed, it is also critiqued and transformed into knowledge that others can access and use in their own practice.

Critical companionship also has the potential, ultimately, to benefit patients and their carers. This may be through:

- The role-modelling of person-centredness to practitioners (this includes being able to access patients' knowledge of self, illness and life experiences, concerns, issues, dreams, and practitioners using that

knowledge in tandem with their own different types of knowledge, in both caring for patients and in setting up co-research relationships with them — if patients so wish)
- Helping practitioners to access their patients' and their carers' experiences of the care they give using rigorous, ethical research methods that take full account of the vulnerability of patients and carers
- Finding out whether practitioners are providing the care which patients themselves see as demonstrating nursing expertise (RCN, 2003), for example:
  - providing them with access to information
  - demonstrating ability to help them change their current situation or problem
  - showing a non-judgemental listening ear.
- Critically reviewing, evaluating and critiquing care with their patients and with peers locally and nationally (RCN, 2003)
- Creating new knowledge about evidence-based, person-centred care that will be shared and tested by other practitioners through further critique in ever-widening ripples (Titchen and Higgs, 2001b)
- Using this new knowledge to improve their care practices
- Using rigorous research and evaluation practices to find out whether the improved practices are experienced as such by patients and whether they are receiving care that meets their needs, as they see them.

•This paper is based on, and further develops, the work of Titchen and McGinley (in press, see references)

†Figures 1-4 ©Angie Titchen

KEY POINTS

- The provision of evidence-based, person-centred care results from a creative blending of different types of professional knowledge (both hidden and explicit), with the self we bring to professional practice. This blending is brought about through professional artistry
- Critical companionship is a strategy for working with practitioners who want to investigate, evaluate and develop such care within their own practice
- Critical companionship works by critical companions helping practitioners to understand their practice ontology (their ways of being a professional) and practice epistemology (their professional knowledge and ways of acquiring, using and creating it). With this understanding, they can then learn how to gather, analyse and interpret robust evidence from their practice and disseminate theoretical principles (gained from their practical principles) that are potentially transferable to other practitioners
- An example is given which shows two critical companions helping a practitioner to become more aware of her practice ontology and epistemology, so that she is eventually able to collaborate in the development of a new conceptual framework which shows how self is blended with professional knowledge in unique ways for each patient and situation.

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