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Critical companionship: part 1

Titchen A (2003) Critical companionship: part 1. *Nursing Standard.* 18, 9, 33-40.
Date of acceptance: August 18 2003.

Summary

This article is the first of two presenting critical companionship as a metaphor and framework for learning from healthcare experiences. Critical companionship is a helping relationship in which an experienced facilitator (often, but not necessarily, a colleague) accompanies another on an experiential learning journey, using methods of 'high challenge' and 'high support' in a trusting relationship. The overall purpose of critical companionship is to enable others to practise in ways that are person centred and evidence based. Critical companionship is effective in a variety of one-to-one or group learning contexts, such as practice development projects, organisational change, practitioner research, work-based learning, clinical supervision and action learning. In this article, the development and testing of the critical companionship framework, through action research, are briefly described. The framework is then presented and illustrated with exemplars of critical companionship expertise in an acute medical ward. Part 2 highlights how the framework was used in a practice development programme with NHS trusts for older people's services, to help nurses to become critical companions.

CRITICAL COMPANIONSHIP is a metaphor and conceptual framework for holistic, person-centred, helping relationships in a healthcare context, in which an experienced facilitator accompanies a co-learner on an experiential learning journey (Titchen 2000). It is a relationship built on trust and Johns' (1997) high challenge/high support. Companion and co-learner are together for the duration of their journey, with a mutual parting at the end. To establish, sustain and close such a relationship, the critical companion uses the same practical know-how that he or she would use to make patient care person centred. Person-centred facilitation requires knowing co-learners as professionals and people, helping them to go where they want to go and meeting their needs, as they see them. This requires the companion's use of self, that is, personal qualities, professional behaviour and skills, and the ability to blend different kinds of knowledge and skills with use of self, through professional artistry. Such artistry is akin to that used in person-centred health care.

Critical companionship brings together head, heart, body and spirit to achieve its overall purpose of enabling person-centred, evidence-based practice – whether this is clinical, educational, practice development or research practice. Thus, it combines the expressive, intuitive processes of relationships and creativity with rational processes of analysis, critique and evaluation of practice and its knowledge/evidence base (Titchen 2000). Role modelling and spelling out these processes enable practitioners to become reflective practitioners, practice developers or 'practitioner-researchers' and to develop professional artistry (Titchen 2000). The companion helps practitioners to (Hardy *et al* (in press), Titchen and McGinley 2003):

- Analyse knowledge/evidence of all types.
- Check out the rigour and/or usefulness of this knowledge/evidence for the particular patient and situation.
- Blend them to act effectively.
- Expose critique for public scrutiny and critical review.
- Overcome internal and external obstacles to person-centred, evidence-based practice.
- Create new knowledge in and from practice.

Critical companionship values all types of

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Key words

- Clinical supervision
- Education: experiential learning
- Facilitation: reflective practice
- Practice development

These key words are based on the subject headings from the British Nursing Index. This article has been subject to double-blind review.

knowledge/evidence used in practice equally, including professional craft knowledge generated from practice and life experiences, knowledge that patients develop through their lives and experiences of illness and local policy and research knowledge/evidence (Titchen 2000).

Critical companionship is challenging as it requires a vast range of qualities, knowledge and skills. This article presents findings from my larger study (Titchen 2000). It explains the practical know-how of critical companionship, in addition to how an expert practitioner can be helped to become a critical companion during everyday work.

Experiential learning literature

There is much theoretical literature on facilitating experiential learning in a variety of fields, including management, education and action research. Theoretical perspectives in the latter two fields have informed the development of the critical companionship metaphor and framework (Titchen 2000). Examples are: critical social science (Mezirow 1981); humanism (Rogers 1983); and pragmatism (reflective practice) (Schon 1987). Facilitation has also been examined by nursing theorists (Burrows 1997, Cross 1996) and practitioners bringing a scholarly approach to description of their practice (Dewing 2001, Palmer *et al* 1994). However, little research into the nature of facilitation has been undertaken in nursing and it is primarily in the context of clinical supervision, for example, Johns 1997 and Jones 1998. Nevertheless, there are a small number of studies that have explored the nature of facilitation in everyday nursing practice (MacLeod 1990, Schaefer 1991, Titchen and Binnie 1995) and in practice development contexts (Hardy *et al* [in press], Street 1992).

Box 1. Critical companionship expertise in action (Titchen 2000)

The scene: Alison Binnie, a senior sister and critical companion, and Harriet, a staff nurse in her first year of qualified practice, are sitting in the staff room of a busy, acute medical ward. At Harriet's recent staff development review, she and Alison negotiated a critical companionship relationship. The aim is to help Harriet learn from her practice, in practice. Alison is working in the same nursing team as Harriet and has been looking after Mazie, Harriet's patient, while Harriet has been off duty. Today, they are drinking tea while critiquing Harriet's care plan for Mazie.

AB: What does 'current experience' [a heading in the patient-centred assessment used in the ward] mean to you?

H: What is happening to them that brought them into hospital.

AB: It is more about the internal focus, that is, where the person is at now – from their point of view, rather than what is happening externally to them... What would you put in 'current experience' for Mazie?

H: I'll have to go and ask her.

AB: You've told me a lot already.

H: It always comes back to her husband and her son's death.

AB: She thinks her illness is related to their deaths.

H: Yes.

AB: So it's no good saying to this woman 'your heart problem is due to a blocked artery', when she thinks that it is related to her tragedy.

A review of the above nursing studies on the nature of facilitation identified two practical facilitation strategies (Titchen 2000):

- Role modelling and sharing expertise.
- Helping nurses to reflect on their practice.

It also revealed the difficulties that nurses had in facilitating learning and giving constructive feedback to colleagues on everyday performance. Apart from Johns' work (1993, 1994, 1997), these studies do not offer practical detail on how nurses can be helped over time to develop person-centred and evidence-based practice. It is in this neglected field that I and my colleagues have undertaken a series of studies developing and testing critical companionship.

Creating critical companionship

I created the term 'critical companionship' in 1998 and developed its conceptual framework in my doctoral research (Titchen 2000, 2001). I used action research (Brown and McIntyre 1981, Kemmis and McTaggart 1988) to help Alison Binnie, a sister in an acute medical ward, help the staff nurses who worked with her to become patient centred, rather than task focused. An interpretation of their facilitation resulted in the critical companionship framework, broadly located in a critical social science perspective with underpinning humanistic, phenomenological and spiritual perspectives. Although the framework is new, some of the practical know-how is likely to be recognised. What the research achieved was to put the know-how together in a new way, with newly described relationships between the elements of know-how.

The study findings indicated that critical companionship had a direct and positive effect on the development of person-centred care. This was strengthened by collaborative research (Binnie and Titchen 1999) that showed that critical companionship was effective in helping practitioners to overcome internal and external obstacles by transforming their workplace culture, roles, relationships and ways of interdisciplinary team working, so that they could become more patient centred. There was also evidence that patients found the new nursing practices healing, meeting their own perceived needs.

Testing of the framework has continued in nursing clinical supervision and emancipatory practice development work (Titchen *et al* 1999). Most notably, the latter has happened in an action research project to study expertise and its development in a wide variety of nursing fields (Hardy *et al* [in press]) and in the promotion of evidence-based practice (Titchen and McGinley 2003). It has also been used by other professions in educational and action research contexts (Goodfellow *et al* 2001, Higgs and Jones 2000, Winter and Munn-Giddings 2001). The framework continues to stand up with this further rigorous scrutiny and evaluation. A recent

concept analysis of facilitation suggests that critical companionship is an exemplar of holistic facilitation (Harvey *et al* 2002).

Before presenting the framework, the story in Box 1 is intended to give an idea of critical companionship in clinical practice. Apart from Alison Binnie, all names are pseudonyms.

Although critical companionship as illustrated in Box 1 may seem simple, the work Alison is doing is sophisticated. It reveals how she:

- Knows what matters in this situation for Mazie and for the care the nurse can offer.
- Knows that Harriet is not aware of what really matters here.
- Problematises Harriet's understanding of the situation by gently pointing out, without putting Harriet down, where there is a problem she perhaps had not perceived, and helps her to think through the situation and come to a new insight herself.
- Role models how a patient-centred nurse would think when he/she had discovered this patient's feelings about her illness, and considered the implications of this information for the patient's care.
- Articulates her professional craft knowledge (gained through professional experience).
- Uses careful timing: she only offers her interpretation and its meaning for Mazie's care after she has helped Harriet to reflect on and interpret Mazie's experience.

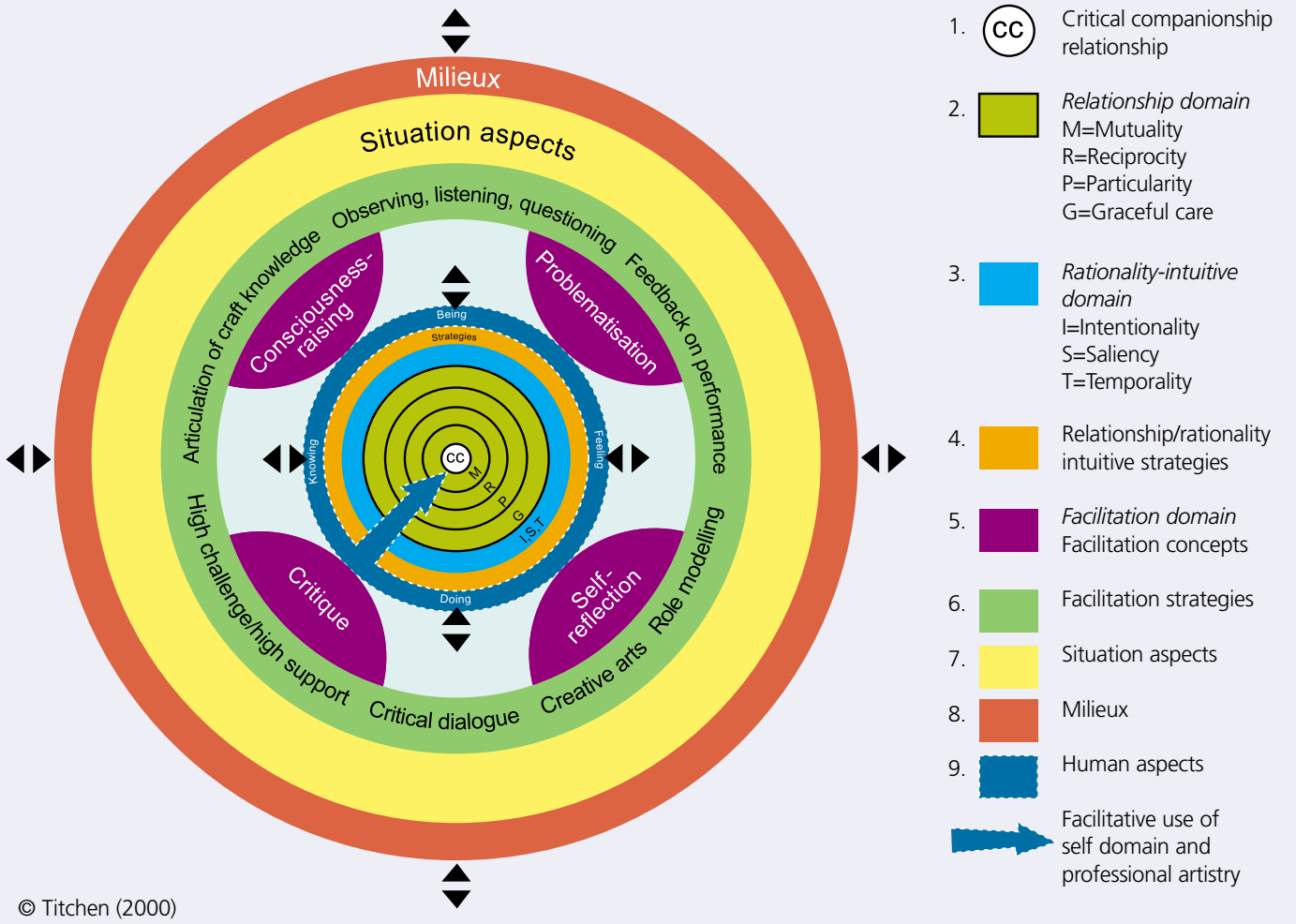
That Alison is able to do all this in a busy ward means she must know the practitioner (Harriet), have awareness of her own qualities and of the environment and make facilitative use of herself.

The framework

The conceptual framework of critical companionship is laid out in a series of overlapping circles (Figure 1), which represent various practical know-how domains. A domain in this framework is a collection of different kinds of knowledge that have a conceptual connection in some way. These connections (and conceptual relationships between the domains) have not been described before in the literature.

1. The relationship between the critical companion and the practitioner or co-learner.
2. Relationship domain, with four processes:
   - Mutuality – working with/partnership working.
   - Reciprocity – reciprocal closeness, giving and receiving.

Figure 1. Critical companionship framework (Titchen 2000)



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- Particularity – knowing the practitioner/co-learner.
- Graceful care – using all aspects of self.

These processes stand in a 'prerequisite relationship' with each other, working with (mutuality) being the most dependent. For effective mutuality, then, all the other processes in the relationship domain must be used and well developed by the critical companion.

3. Rationality-intuitive domain, with three processes:
   - Intentionality – acting deliberately.
   - Saliency – knowing what matters and acting on it.
   - Temporality – attending to time, timeliness, anticipating and pacing.

These are practical tools to help use of the relationship and facilitation processes. They are, therefore, prerequisites for the relationship and facilitation processes. For example, to get to know the co-learner (particularity), deliberate strategies (intentionality) must be used to find out about him or her and the situation being examined. However, they are not prerequisites for each other, which is why they are set out in the same ring.

4. Strategies to put the relationship and rationality-intuitive processes into action.
5. Facilitation domain, with four processes:
   - Consciousness-raising – bringing hidden or taken-for-granted knowledge to the surface.
   - Problematisation – raising awareness of problems in situations that are perceived as being problem-free.
   - Self-reflection – facilitating critical investigation of own self and practice.
   - Critique – developing new knowledge and critically reviewing it through debate.

These processes do not have prerequisite relationships with each other.

6. Strategies to put the facilitation processes into action.
7. The situation – the focus of the critical companionship or the broad aspects of the situation under examination.
8. The milieux or opportunities for reflection that can be seized or created by the critical companion (for example, as Alison created during busy practice to have a conversation with Harriet). Black arrows indicate the antennae through which critical companions sense what is happening, internally and around them.
9. Facilitative use of self domain: the blue arrow shows how the critical companion takes him/herself into the relationship with the co-learner, that is, his or her own being, knowing, doing and feeling. The dotted lines around the arrow indicate how the companion 'picks up' the necessary elements of practical know-how in the relationship, rationality-intuitive and facilitation domains, and blends it together into a unique mix for working with each practitioner and 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 2001).

The next three sections contain definitions of the processes, a selection of the strategies that put the domain processes into practice and stories to illustrate their use in promoting person-centred care. I show where the processes are supported by the research literature on the facilitation of experiential learning and which ones are newly described.

Relationship domain

Mutuality (Johns 1993, 1994, 1997, Schaefer 1991) – the critical companion and practitioner work together in a partnership that is carefully negotiated. Critical companions are alert to the practitioner's readiness to learn, making use of opportunities for shared experiences. They build on the practitioner's starting point and offer their knowledge and experience as a resource for the practitioner to draw on in solving problems and helping him or her to learn from practice. Strategies are:

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

Reciprocity (Johns 1994, Schaefer 1991, Street 1992) – mutual, collaborative, educational and empowering exchange of feelings, thoughts, knowledge, interpretations and actions. Companion and practitioner recognise that they receive gifts of care, concern, satisfaction and wisdom from each other. Strategies are:

- Negotiating.
- Receiving.
- Learning.

Particularity (new finding) – getting to know and understand the unique details and experience of the practitioner, in the context of the specific learning situation and of the practitioner's life (as far as he or she wishes to disclose). Once the companion knows 'where the person is at', he or she can take this as the starting point from which to help the practitioner learn from his or her own 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 are:

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- Observing the practitioner's situation and responses, facilitating and listening to the practitioner's stories and self-reflection, picking up on cues and clues.
- Blending knowledge of the practitioner with the companion's self-knowledge, professional craft knowledge (know-how built up through professional practice) and facilitation theory and research, to design and evaluate unique learning experiences for a particular practitioner in a particular situation, at a particular time.

Graceful care (Johns 1993, Schaefer 1991, Smith 1992) – support given to the co-learner by the critical companion through his or her presence, touch and use of body language (including posture, speed of movement and tone of voice) (Box 2). This enables the companion to express who he or she is as a person and his or her response to the practitioner. This makes the practitioner feel personally valued, which promotes his or her emotional, psychological and intellectual growth. The spiritual dimension is articulated here in terms of a symbolic or metaphysical giving of grace without any religious or doctrinal overtones. Strategies are:

- Being genuine and expressing self as a person.
- Being generous with self, knowledge and time.
- Having a kind intention (for example, when giving constructive criticism).
- 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 or inappropriate emotions.
- Using humour to provide support.
- Valuing the practitioner as a person and his or her unique professional contribution.

Rationality-intuitive domain

The processes of this domain are prerequisites for those of the relationship and facilitation domains:

Intentionality (discernible in studies by Johns (1994), MacLeod (1990), Schaefer (1991) and Street (1992), but not explicitly described) – consciousness, self-awareness and thoughtfulness of critical companions as they deliberately use all the critical companionship strategies.

Saliency (new finding) – the ability to know, consciously and intuitively, what is important, of concern and of significance, from the critical companion's and practitioner's perspectives. Using significant cues and clues to plan learning strategies to address what matters (Box 3).

Temporality (discernible in studies by Johns (1994), MacLeod (1990), Schaefer (1991) and Street (1992), but not explicitly described) – time, timing and pacing. The critical companion should understand the need to attend to what has happened in the past, what is happening in the present and what could develop in the future. He or she should make time for this work, and act (or hold back) in timely ways at the right pace for the practitioner, anticipating his or her needs. Strategies are:

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

Facilitation domain

The four processes can be discerned in Street's (1992) and Johns' (1994) works:

Consciousness-raising – bringing into the practitioner's consciousness the knowledge embedded in daily practice, and recognition of the nature of this knowledge. This includes a practitioner's intuitions and behaviour and the effect they have while practising as a clinician and as a critical companion.

Problematisation – helping the practitioner to become aware of, and to critique, the tacit understandings that have grown up around repetitive, routine practice, pointing out areas that might need attention but are not perceived by the practitioner as problems. Where practitioners do see a problem but cannot find a solution, the critical companion helps them to see things from a different perspective.

Box 2. Examples of graceful care (Titchen 2000)

Staff nurses experienced Alison's graceful care in the following ways:
Moira: Alison is approachable and non-threatening because her manner is cheerful and she never seems to be down... She is really reliable, you know what to expect... She makes time for me... and makes me feel that I have something positive to offer... and I found that really encouraging.
Harriet: She seems to be listening to the meaning of my questions, not just for the sake of it, but really empathising with me. She really cares if you are having major problems with patients.
Janice: She gives you good feedback, always honest. It never puts you down.

Box 3. Drawing salient information into a cluster (Titchen 2000)

AB: When Harriet told me the situation... I asked in a non-critical voice: 'How long has Daisy been in?' So I was planting or bringing to the surface information and putting it together in Harriet's mind, in a way, so the information was then in front of her. I was making her think: Daisy has been in for a week – has she got a district nurse? [yes she has] – two bits of information there. Then she's almost there herself, thinking: 'Well, I haven't actually spoken to her myself'. So I didn't need to say 'you should have phoned the district nurse' because by the time I had drawn up the relevant bits of information in a cluster, she was able to make the judgement.
AT: You helped her lay the significant information out and bring it together and she could then see, looking at the picture, what she should have done.
AB: That's right. I think I try to do that quite a bit with people... You draw up salient points for them, out of what might be a bit of a fog, and once the salient things stand out, things suddenly make sense to them.

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Table 1. Facilitation matrix with examples of AT as critical companion to Alison and nurses in Part 2

Strategy	Facilitation process			
	Consciousness-raising	**Problematisation**	**Self-reflection**	**Critique**
Articulation of craft knowledge	I* deliberately shared with Alison my professional craft knowledge about facilitating nurses' reflection in the midst of practice (knowledge I acquired through my own experience of being a critical companion).	By doing so, Alison began to see how simply responding to the nurses' requests for advice is not facilitating their reflection on practice.	I helped Alison to think about other situations where she had missed opportunities for facilitating nurses' critical, creative and independent thinking about practice.	We discussed how nurses and other healthcare professionals are socialised into didactic clinical teaching, rather than facilitating learning from experience.
Observing, listening and questioning	While I was observing Alison, I asked her to tell me what her intentions and rationale were, at specific points, when she was helping Dave to learn from a problem about his patient. I also asked what were her intuitions, the options open to her and why she made the decisions she did.	My questions enabled Alison to see that, by pointing out to him where he had gone wrong, she had decreased the opportunity for him to evaluate his own performance.	Answering my questions gave Alison insights into how she has been socialised, as a nurse, into focusing on a quick solution. Helping Dave to do the problem solving meant that she had to hold back.	This insight gave us an opportunity to theorise about why there is a tendency to respond to nurses' requests for advice in a traditional way, rather than helping them to find their own solutions.
Feedback on performance	On another occasion, giving Alison my observation notes showed her how she merely assumed nurses would learn from role modelling, without telling them what she was trying to do.	I pointed out that it was clear from her behaviour and body language that the nurse had not understood what Alison was trying to do during the bedside handover.	Alison began to realise that she could make opportunities to tell the nurses what she was trying to do.	We theorised that the potential of role modelling could be more fully realised if expert nurses articulated the knowledge behind their actions to less experienced nurses.
High challenge, high support	After pointing out what was good in her interaction with Yvonne, I challenged (with graceful care), her claim that Yvonne had learned something from this exchange, asking her for evidence to support this.	This challenge was taken non-defensively by Alison. She began to see that she often assumes that because she has told the nurse something, the nurse will have grasped it.	Alison began to form an action plan to check out her assumptions – she would devise ways of evaluating the effectiveness of her critical companionship strategies.	We formulated learning outcome criteria that could be fulfilled if a nurse was learning to become more patient-centred and a more critical, creative and independent thinker.
Critical dialogue	Our theorising about socialisation and learning outcome criteria raised Alison's awareness of the complexity of becoming a critical companion using an opportunistic approach.	Previously, she, like many of her colleagues, had felt that helping others to learn in the midst of practice would be easier than the more formal approaches.	She theorised that she was not transferring what she knew about helping someone to learn in a staff development interview, to the clinical setting, because no-one had ever done it with her in practice.	We critiqued the idea that formal theories, such as Heron's (1989) six category interventions could not just be applied to critical companionship. Nurses had to create new knowledge about how to use that theory in the 'hot action' of nursing.

Table 1. Facilitation matrix with examples of AT as critical companion to Alison and nurses in Part 2 (continued)

Strategy	Facilitation process			
	Consciousness-raising	**Problematisation**	**Self-reflection**	**Critique**
Role modelling	By articulating what I was trying to do in our interactions, I attempted to maximise the potential of role modelling in facilitating reflective practice.	For example, I pointed out how I put the significant things about a problematic situation in a cluster, when giving feedback to Alison. I do not say 'there is a problem here'. This enabled Alison to see the problem of which she had been oblivious.	Alison reflected that nurses are not usually helped to evaluate their own practice in this way and decided to try out the strategy of putting significant things in a cluster, so the nurse could work it out for him or herself.	We critiqued the unquestioned assumption that nurses learn through role modelling and examined ways of helping others to be more aware of the potential for combining it with an articulation of professional craft knowledge.
Drawing out creative imagination	At the beginning of the practice development project (described in Part 2), I helped the senior nurses to visualise their development as critical companions as if it were a landscape. They then painted their journeys on flipchart paper.	Sharing their paintings helped them to examine previously held assumptions about learning from experience. They began to see that culture change would be necessary to overcome obstacles that they had not seen before.	This form of reflection about the future helped the senior nurses to evaluate where they were now in terms of their skills for the culture change ahead. These understandings helped them to develop action plans.	At the end of the project, some of the critical companions identified key themes and shared meanings of their experiences of the project. They created a painting to show their composite journey and produced a poster for a national conference.
Professional artistry in the facilitative use of self (in this example, blending relationship, rationality-intuitive and facilitation processes with use of self)	When challenging Alison about her above interaction with Yvonne, I was aware of making the tone of my voice not sound critical, more the tone of a colleague who is genuinely engaged, interested and wanting to help her to learn.	I tried to show by my posture that I was not setting myself up as an expert with theoretical expertise, standing in judgement over Alison's actions.	By using silence, humour and empathetic understanding, I helped Alison to recognise her weaknesses but not to beat herself up about them.	By expressing my passion for facilitating learning from actual practice, and my awareness that I needed to place my passion and knowledge under critical review, I facilitated lively, critical debate between myself and Alison.

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*'I' refers to AT throughout

If practitioners are unaware of inconsistencies or contradictions in their practice, the companion gently points them out.

Self-reflection – a cyclical process in which practitioners critically reflect on and evaluate their experiences, thinking and intuitions in a particular situation. The critical companion helps them to describe the important features of their actions, behaviours, what happened and their thoughts and feelings. The companion encourages practitioners to focus on positive feelings and deal with negative ones. He or she also supports the analysis by making practitioners aware of their thinking and reasoning processes. New knowledge is linked with that they already know. Practitioners are then helped to draw conclusions about these experiences, to use theory to deepen understanding, and then use their conclusions to inform action plans.

Critique – 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 light of their newly gained insights, understandings and interpretations of practice. Refined understandings are then used to develop new knowledge about how to change the

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Box 5. Professional artistry in practice (Titchen 2000)

Harriet: It was excellent to work alongside Alison as she gives such concise, clear details of what she was saying and what she was doing and how she was doing things... I was asking Alison whether she was touching Peter or not because you don't want to invade somebody's body space and make them feel uncomfortable, but then you don't want to just leave them if they are wanting you to touch them – reassuring them... So perhaps next time we have a bereaved relative, my confidence is going to be better. I think I will be able to draw on that experience...

AT: What else did you learn from that experience?

Harriet: ...knowing how to act – just be yourself... just getting to grips with the fact that more often than not, you don't say anything, but just sit with them. Alison always says you just have to be there to listen, just let them do the talking. So learning to listen. To take them away and chat.

Seven months later, Harriet told me about her work with Bob, who was facing an imminent heart transplant. She had sat beside him and listened attentively and almost silently to his fears of dying. She said that she felt more confident and less fearful about dealing with distressed or difficult relatives and using the skills that Alison had demonstrated to her. 'Six months ago, I wouldn't have sat so long with Bob... I would have shied away and left it for someone else to do. I would have identified his need to talk about his heart transplant, but would not have had any discussion about it.' Bob told her later that he had found her presence very helpful. From observations of Harriet working with Bob and comparing them with her work six months previously, it appeared that Harriet had become more person centred in her practice.

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situation in the practitioner's own sphere of work, in social, cultural, historical and political constraints. Strategies are:

- Articulating craft knowledge.
- Observing, listening and questioning.
- Feedback on performance.
- High challenge/high support.
- Critical dialogue.
- Role modelling.
- Drawing out creative imagination and expression using creative arts.

Facilitation matrix in action The facilitation matrix shown in Table 1 can be used by critical companions to examine their own practice. It shows how the strategies (on the left) put the facilitation processes into action. The example focuses primarily on how I helped Alison, as her critical companion, to become a critical companion to staff nurses in the ward. As well as showing the facilitation processes in action, the relationship and rationality-intuitive strategies can be seen blended in with the facilitation strategies.

Although the four facilitation processes are shown separately in the matrix for clarity, in reality they often overlap. For example, problematising practice also raises a person's consciousness of a particular aspect, issue, area and so on. In addition, the four processes are not a continuum (that is, they do not stand in a prerequisite relationship with each other), however, the reality is that the first three processes tend to provide material for the practitioner and critical companion to critique. If the matrix is used to examine a particular facilitation experience, whether your own or your observation of an experienced facilitator, it is unlikely that it would be possible to fill in all the boxes for that one particular experience. New critical companions often find that problematisation and critique are the more difficult processes to develop.

Facilitative use of self and professional artistry

The facilitative use of self (Table 1) is hinted at in Schaefer's (1991) and Johns' (1994) studies. However, professional artistry in facilitating experiential learning, the key finding in this research (Titchen 2000) has not been described in the literature before. It is through professional artistry that the domains of critical companionship and the different types of knowledge/evidence discussed earlier, interplay, balance and are blended with each other and with the companion as a person. This artistry, which parallels the artistry of person-centred care, appears to enable effective person-centred, evidence-based facilitation that is unique for each practitioner. I have found from my experience of helping practitioners to develop critical companionship that they often seem to miss this idea of professional artistry – perhaps because it is the most demanding aspect of critical companionship and takes years to refine. Building on further research (Titchen and Higgs 2001), the time is ripe for further investigation of this area in the fields of facilitation, clinical practice, research and practice development.

The story in Box 5 shows the effectiveness of Alison's professional artistry in helping Harriet, over time, to become more person centred and clinically effective.

Conclusion

The aim of this article has been to show the complexity and sophistication of critical companionship processes and strategies and their impact on practitioners and patients. The practical application and development of critical companionship in service environments are explored in Part 2 of this article published next week. This next article shows how critical companionship is not a prescriptive model for facilitating experiential learning. It demonstrates that the metaphor and framework provide inspiration and practical principles for individuals to develop their own unique forms of critical companionship

Acknowledgements

I would like to thank all the practitioners who have helped me to develop and test critical companionship and Eleanor Bird for her help writing this article.