informa
healthcare

ORIGINAL ARTICLE

The humanization of healthcare: A value framework for qualitative research

LES TODRES Prof., KATHLEEN T. GALVIN Prof. & IMMY HOLLOWAY Prof.

Centre for Qualitative Research, Bournemouth University, UK

Abstract

Qualitative research, through its illumination of people's perspectives and experiences, has contributed a particular kind of useful evidence for caring practices. Until now however, it has found its location in healthcare without making the powerful impact on humanizing practice that is its key strength. Our paper develops a conceptual framework for humanizing care, and through examples illustrates an emerging agenda that moves qualitative research into its next and overdue phase: to enter policy-making; curricula in professional education; and to be meaningfully translated into practice in ways that place people as human beings at the centre of care. This paper provides eight philosophically informed dimensions of humanization, which together, form a framework that constitutes a comprehensive value base for considering both the potentially humanizing and dehumanizing elements in caring systems and interactions. In each case, we show, with reference to published studies, how qualitative research findings are already consistent with the humanizing focus articulated in our conceptual framework. We finally describe a reciprocal relationship in which the humanizing value framework guides a dedicated focus for qualitative research, and in which qualitative research in its turn, supports the humanising emphasis because of its intrinsic features.

Key words: *Humanization, qualitative research, phenomenology, philosophy of care*

Introduction

Research into health and healthcare has achieved substantial advancement in knowledge and improvements in care, through its focus on interventions, treatment and cure. Todres, Galvin and Dahlberg (2007) note how increasing specialization alongside technological advances and research have improved health and well-being. Alternatively, there is increasing evidence in the media and from qualitative research in particular, that the human dimensions of care can be obscured by a sometimes-necessary technological and specialized focus. Charon (2006) speaks of the "vexing failures of medicine—with its relentless positivism, its damaging reductionism, its appeal to the sciences and not to the humanities in the academy, and its wholesale refusal to take into account the human dimensions of illness and healing" (p. 193). It is within this context that the recently established Global Institute for Research in Humanizing Care Contexts has produced a document that notes that the attempt to humanize healthcare requires a dedicated research focus (Morse, 2007).

In this paper, we wish to explore the productive mutual relationship between a humanizing value framework for health care and the practice of qualitative research. We aim to show (a) that a conceptual framework for humanizing health care may provide a dedicated focus for guiding both research and practice; and (b) that the nature of qualitative research is able to offer distinctive support to a humanizing emphasis for care. The paper is thus philosophical in emphasis even though it draws on examples from qualitative research in order to illustrate the concepts developed.

In developing our humanizing framework, we have been most influenced by the existential-phenomenological tradition, and sociological perspectives that have illuminated phenomena such as human agency, anomie and alienation. Our perspectives on "what it

means to be human," have been centrally informed by the phenomenological tradition beginning with Husserl's (1936) notion of the lifeworld. His exposition of basic dimensions of the lifeworld such as embodiment, temporality and spatiality helped us think through what is irreducibly human. Further Heidegger's contemplations about human freedom, being with others and the authentic "ownness" of self (Heidegger, 1962) as well as Merleau Ponty's (1964) ideas about body subject and body object also helped us to develop some core dimensions that could be applied to health social care.

First, we develop a conceptual framework that articulates what we mean by the term "humanization" as a value base for guiding care. This provides eight philosophically informed dimensions of humanization, which together, form a framework that constitutes a comprehensive value base for considering both the potentially humanizing and dehumanizing elements in caring systems and interactions. In each case, we show, with reference to a number of published studies, how qualitative research findings are already consistent with the humanizing focus articulated in our conceptual framework.

Such a framework is particularly useful when mapping a significant and meaningful focus for a qualitative research programme. We would like to contribute to this development by considering the potential for qualitative research to address such a dedicated focus. As such, the value framework may serve as an important foundation for guiding qualitative research programmes. We will also argue, however, that there is something about qualitative research that is particularly conducive for supporting more humanizing emphasis in practices of care. We thus describe a reciprocal relationship between the value framework and qualitative research. This framework also reveals a possible new important emphasis in the history of qualitative research whereby care is not just guided by its traditional emic focus, but that the emic focus has now got to a historical stage of achievement in which important general ethical and humanizing themes from the findings of qualitative studies may guide care more generally.

A value framework for humanizing healthcare

In this section, we first consider what we mean when we use the term "humanization". We then offer eight dimensions, which articulate the essential constituents of humanization in relation to caring. Each dimension is heuristically expressed as a continuum stretching from the term that characterizes humanization in a positive sense; through to the term that characterizes the barrier to such a possibility. Even

though each of the dimensions is expressed as an assertion that has an opposite for the sake of clarity, we are not suggesting any dualism here. In other words, we are not suggesting that one is either "in a humanizing or dehumanizing moment" but rather that these bipolar terms suggest possibilities along a spectrum that have to be considered in context. Thus, we should like to emphasize that each dimension expresses a spectrum of possibilities that constitute "ideal" types. We are not suggesting these ideal types as absolute values but rather as touchstones for awareness when considering the complexity of lived situations. As such, we do not wish to over emphasize the negative value of what we have called dehumanizing practices, there may be appropriate times when these are necessary for effective care. For example, in an intensive care situation patients fully accept the necessity for professionals to focus exclusively on the technological definitions of their current bodily functioning at particular phases of their treatment (Todres, Fulbrook & Albarran, 2000).

What do we mean by the term humanization?

To be concerned with humanization is to uphold a particular view or value of what it means to be human, and furthermore to find ways to act on this concern. Thus, we need to articulate the essential constituents of what it is to be human as a value base. A consideration of all the constituents taken together can then form a useful standard from which to judge the humanization of care. The judgement would include two levels: the extent to which care addresses all eight dimensions, and the extent to which care can be located somewhere along the continuum of each dimension's positive humanizing characteristic in relation to its more negative dehumanizing feature. Therefore, the following dimensions are not separate but imply one another; for sake of clarity, we highlight these nuances as important because they can be differentially empha-

Table I. Conceptual framework of the dimensions of humanisation.

Forms of humanization	Forms of dehumanization
Insiderness	Objectification
Agency	Passivity
Uniqueness	Homogenization
Togetherness	Isolation
Sense-making	Loss of meaning
Personal journey	Loss of personal journey
Sense of place	Dislocation
Embodiment	Reductionist body

This table is just to help the reader imagine each dimension along a spectrum of possibility rather than indicating an either/or category in each case.

sized or be de-emphasized in particular circumstances (Table I).

Dimensions of humanization/dehumanization

Each of the eight dimensions of humanization and dehumanization expresses a spectrum of possibilities. In each case, the positive humanizing value is first articulated, followed by how it may be obscured by a dehumanizing emphasis. Dehumanization occurs when any one or more of the humanizing dimensions are *obscured to a significant degree*. We should like to note here that the dimensions of humanization and dehumanization are not absolutes but rather a matter of emphasis. For instance we acknowledge that forms of assessment and other health care practices, which are problem solving in a technically helpful way, are important. However, it is when these technical problem strategies overshadow the humanizing dimension we refer to, that there is a *potential* for dehumanization. Each of the eight dimensions clearly overlap in some respects, but each emphasizes something special as captured in the name of the dimension in each case. Such distinctiveness is also indicated by the choice of example from the qualitative research literature. We searched the qualitative literature for everyday examples that would illustrate something distinctive about the specific dimension. There are numerous examples in the literature that could be used, so we "handpicked" examples that we thought would provide some understanding of how the dimension could be relevant to practice and situations.

Insiderness/objectification

What makes each of us intimately human is that we carry a view of living life from the inside. To be human is to live in a personal world that carries a sense of how things are for the person. Only individuals themselves can be the authorities of how this inward sense is for them. Such subjectivity is central to human beings' sense of themselves. Our sense of feeling, mood and emotion is the lens by which our worlds are coloured. This provides important human textures for valuing the qualities of things. If such a dimension is neglected then something important is missing when responding to human need.

In *objectification,* people are made into objects by focusing excessively on how they fit into a diagnostic system, part of a statistical picture or any other strategy by which they are labelled and dealt with that does not fully take account of their insiderness. There is a whole psychology of how we separate ourselves from one another through dissociation by emphasizing the distance between insider and outsider. For example, when nurses or doctors break bad news to a patient, and sit at the computer, they may focus the conversation on how the individuals fit with the statistics of their condition, the diagnostic category and other categories rather than attending to the meaning the bad news has for the person. Along our spectrum, this is an everyday example of how an objectifying interaction may happen. An extreme example of objectification is Arendt's reference to the use of 'office-speak' by Nazi executioners when dealing with human beings in concentration camps while putting aside the work of the office before a family dinner (Arendt, 1963).

Another example of everyday objectification is shown by a qualitative study. Holloway, Sofaer and Walker (2007) examined the experiences and needs of people who suffered from chronic low back pain through interviews. Stigmatization by "the system" and health professionals as well as by significant others, emerged as a key theme from the narratives of participants. To be labelled as members of a group that were not only expensive to the system but also seen as "malingers" deeply affected the perception of self and self-esteem and the behaviour of the patients. The study demonstrated that pain management programmes need to take into account the feelings of participants to make them feel valued and accepted. It illustrates how labelling is one form of objectification.

Agency/passivity

To be human is to experience oneself as making choices and being generally held accountable for one's actions. This constitutes a sense of agency in which we do not experience ourselves as merely passive or totally determined but have the possibility of freedom to be and act within certain limits. A sense of agency appears to be very closely linked to the human sense of dignity. When this is taken away, one's sense of personhood is diminished.

In *passivity,* there is excessive emphasis on attitudes and practices that render the person passive in relation to their condition and treatment. Traditionally the medical model has emphasized a view of the person and the body as passively subjected to internal and external forces. The increasing emphasis on the user involvement movement in health and social care is a reaction to this view. Through excessive passivity, one is stripped of human dignity to varying degrees and this can be dehumanizing. For example, people with anorexia nervosa often rebel against the lack of dignity when an over concern with nutrition and weight gain infantilizes them in such a way, that they are excessively watched

and a sense of personal dignity becomes difficult to sustain.

What follows is an example of a study where practices have rendered individuals passive in relation to their condition and treatment. Johansson and Ekebergh (2006) described how women who were recovering from myocardial infarct, experienced well-being through being facilitated to influence and take responsibility for their own bodies after a period of acute care, which was characterized by insecurity and felt "pushed out" by their care situation. They were passively dependent on health care professionals and their knowledge, but need to regain control of their own health. A humanizing care is actively facilitating participation in their health process. The study illustrates how everyday care can be humanized by enhancing agency through increased patient participation.

Uniqueness/homogenization

To be human is to actualize a self that is unique; such uniqueness can never be reduced to a list of general attributes and characteristics. We are always more than the sum of the parts. No matter how much we are part of larger influences and contexts, there is something unique in space and time about this particular person in this particular moment that characterizes their particular individuality.

In *homogenization,* there is excessive focus on how the uniqueness of the person is de-emphasized in favour of how they fit into a particular group. In their concern to please, patients agree to looking at themselves or accepting practices in which their own uniqueness is de-emphasized so there is a kind of self-fulfilling prophecy. When this happens, uniqueness is no longer considered by self or other.

In order to "fit in", one may adopt the role of a "good patient" acting according to expectations, not complaining and complying with treatment. For example, there is long standing evidence that "unpopular" patients are labelled and placed into categories and experience worse treatment (Stockwell, 1984). There is also evidence of the tyranny of institutional authority: individuals develop a sick role (Parsons, 1951), become accepting, and submit to the authority of expert knowledge. This role reduces the creativity and imagination of the options that may be open to the sick person. In an early study, Rosenhan (1973)) for instance, wished to show the extent of de-personalization and labelling in institutions. His study illustrated how "pseudo-patients actions", while under cover in psychiatric hospitals, were interpreted as pathological behaviour because of context; the "fake" patients were not recognized.

The following qualitative study is an example of loss of unique identity and everyday practices that emphasize how individuals fit into a particular diagnosis or homogeneous group. Phenomenographic research by Widäng, Fridlund and Mårtensson (2008) showed that patients feared that they were seen as "the disease", "helpless", and "an individual suffering from cancer" rather than a person with other identities, such as for instance, 'professional woman". The study illustrated that "maintaining the self" and retaining personal identity as a unique individual is necessary for people during illness. In interaction with their carers, the participants found it important to keep their dignity by means of retaining "the self" as a unique individual. This implied having some control over the situation related to what they themselves saw as important. This study illustrates the importance of a sense of personal uniqueness for well-being.

Togetherness/isolation

To be human is to be in community: our uniqueness exists in relation to others, and there is always an ongoing dialogue or "play" between what we have in common, and how we organize and make sense of this in very personal and unique ways. Togetherness and uniqueness imply one another and make meaningful the central human experiences of both aloneness and intimacy. In different ways and in different times, privacy, human connectedness and intimacy can be important. This dimension of togetherness makes possible the experience of empathy in which we can appreciate the suffering and struggles of "the other" who is also actively engaged in a personal world like ourselves with its own vicissitudes. Either commonality or uniqueness can be overemphasized and this has implications for care.

In *isolation,* we feel ourselves separated from our sense of belonging with others. Our everyday social connections are disrupted and we can feel lonely. What we have in common with others recedes from view and we can feel like strangers. In isolation, we feel alienation from others to varying degrees. It is inevitable that illness brings a sense of separation from taken for granted feelings of belonging with our intimate social world and significant others. Isolation however can then either be mitigated or exacerbated by different health care systems and practices. For example, any institutional bias with its sometimes-necessary rules, safety procedures and concern for the efficient running of the system can take away a sense of belonging. In such circumstances, a person can feel dehumanized and cut off by the creation of an alternative culture that is alien to a sense of

everyday belonging. There are many practices whereby the social needs of communities with particular conditions are attended to, for example, social networking websites, special support groups and any ways in which a person can be treated within their everyday social networks.

What follows is an example of a study where practices emphasize an institutional culture that separates persons from their sense of familiar belonging. Williams and Irurita (2004), following a grounded theory study, describe a range of practices that led to isolation. Participants identified feeling devalued by activities such as lack of eye contact, standing at the end of the patients bed rather than beside them, serious or blank expressions, lack of touch, not having social conversation with the person, not remembering their personal details. In a further example, Del Barrio et al. (2004) have described how nurses can optimize positive experiences for liver transplant patients in intensive care by facilitating the presence of family members in the ICU at their bedside, as this qualitative study showed that the only social support patients wanted and needed was from their immediate family. These qualitative studies illustrate how a sense of human belonging can become vulnerable in institutional contexts and the need to support such belonging in practical ways.

Sense-making/loss of meaning

To be human is to care for the meaning of things, events and experiences for personal life. Such sense making involves an impetus or motivation to bring things together, to find significance and to make wholes out of parts. Within this context, we are story makers and storytellers. The search for narrative truth is often experienced as more humanly significant or felt to be more meaningful than the search for statistical truth. Sense making looks for *Gestalt* and patterns that connect. When such sense making is taken away from us in varying degrees, we can experience a sense of dislocation and meaninglessness. This can feel like being part of a machine or a "cog in the wheel". In finding patterns that connect for our lives we are acknowledging a certain seamlessness to living in which life cannot be essentially compartmentalized into the private and the public, concerns of body and concerns of mind, health care from social care, from economic care; human needs are holistic and transcend such differentiated discreet categories.

In *loss of meaning*, human beings become numbers and statistics. When we are counted as a statistic, our treatment often does not make sense to us, because what is important statistically does not necessarily connect with individual human experience. For example within the UK, "a postcode lottery" has developed in which political and geographical considerations determine differential treatments. Apart from the general issue about lack of equity, in the present context, we wish to draw out the theme of "not making sense" from the patients' perspective. It does not make sense to people with cancer living in one part of the country that they cannot get the same treatment as another person living in a different part of the country. Statistical realities can produce inequalities because they are usually based on a utilitarian philosophy and are designed for large-scale representation and standardisation. When human beings are forced to fit into the standardised framework they often feel that it makes logical sense, but do not always experience practices of standardization as systems of *care*. Within this context there is also insufficient appreciation of how different systems of care, and the agencies within them, contribute to the fragmentation of "sense making" by the agencies and practitioners themselves feeling disconnected. Charmaz (2006) used a grounded theory approach to examine ordinary everyday pursuits of people with chronic illness. The purpose of this was to explore how people use past and present involvement in activity to form implicit and explicit meanings of their health, well-being and emerging selves. The study described how a sample of people with chronic illnesses, such as diabetes, multiple sclerosis and heart and circulatory disease, measured their everyday pursuits and involvements as indicators of their health and adopted these measures as markers of who they are and who they are becoming. The research illuminates how people were able to make sense of their health and well-being by taking their focus beyond their symptoms to looking at how they are doing within their larger lifeworld contexts.

Personal journey/loss of personal journey

To be human is to be on a journey. We live forward from the past; how we are in any moment which needs to be understood in the context of a before and a next. We move through time meaningfully and do not exist in a vacuum; to be human is to be connected to a sense of continuity. In addition, the future faces us as an unknown that offers the possibility of novelty and something different. To be human is to be connected to the familiarity of the past as well as to move into the unfamiliarity of the future. One can be oppressed by the past repeating itself and stultified by the familiarity of merely "more of the same". Alternatively, individuals can be dislocated and shocked by the unfamiliarity of events that excessively wrench them away from the familiar.

This engagement with temporality thus needs to be understood when considering a more humanized form of care; how the meaningfulness of a person's personal journey can either be supported or lost.

Loss of personal journey can happen when health care practices do not pay sufficient attention to the history and future possibility of a person's life. This manifests in an excessive emphasis on *how* the person is, not *who* the person is. For example in "snap shot" medical consultation individuals are separated from their normal social context and treated as cases rather than persons with a history and biography. In health care delivery systems, there is sometimes little room for considerations of continuity, or of how a person's sense of continuity is maintained. The focus is very much on the present. The trajectory of technological advances as well as demands on practitioners' time mean that a snap shot approach to health care conditions needs to be complemented, with a more biographical approach, which appreciates a person's history and importance of continuity: an increased emphasis on *whom* the person is. The feeling of knowing who they are helps people know and feel how their care is linked to their history. A dehumanizing practice also occurs where individuals are oppressed by sameness, routine and repetitious activity. A practitioner will keep on interacting with the patient in the same way and this reduces possibilities by experiencing oneself as being "more of the same". Medved and Brockmier (2008) interviewed adults who had suffered brain injury to explore how people experienced themselves and their sense of self following significant neuro-trauma and disability. The researchers discovered that during the course of the narrative interviews with their participants, the autobiographical accounts asserted a sense of sameness and continuity for the participants even when they suffered memory impairment. The stories told evoked a sense of continuous self and an unbroken connection between pre injury and post injury self. This study underlines how people are able to attend to the tasks of achieving a sense of personal continuity even in the face of profound changes in everyday life for disabled patients.

Sense of place/dislocation

To be human is to come from a particular place; such a habitat is not just a physical environment measured in quantitative terms but a place where the feeling of at-homeness becomes meaningful. Such a sense of place is not just a collection of colours, textures and objects but rather gathers around that which constitutes the kind of belonging that provides a degree of security, comfort, familiarity, continuity and unreflective ease. When wrenched away from such a sense of place and locality, one can feel dislocated and one can be made a stranger.

In *dislocation,* a form of dehumanization occurs where a sense of place is lost or obscured and a sense of strangeness arises. In this circumstance people are challenged to find a sense of place in a new and unknown culture where norms and routines are alien to them, and where spatial re-orientation must take place if they are to fit in, similar to "the stranger" who has a sense of dislocation when first experiencing a new place as described in the essay by Schutz (1944).

Insufficient attention is paid to the quality of space in our health care environments. Attention is needed for an architecture of space that can be conducive to privacy, dignity, homeliness and hopefulness. Furthermore, spaces are not just created by the physical environment but by what happens within them and the practices that occur there that make the space hospitable to the richness of human life. The overspecialization of space needs to be tempered by an attentiveness of how to bring forms of life that are fully human to the space. A study by Reed-Danahay (2001) shows how location can be important for a sense of well-being. She carried out an ethnographic study in a residential unit for people with Alzheimer's in the USA using the concepts of place and non-place from Augé and Bourdieu. Analysis showed that some residents experienced greater confusion partly due to the bureaucratic "office-like" and "unhomely" setting in which they lived. In other words, their confusion could not just simply be explained by the neurophysiology of Alzheimer's disease on its own, as if it occurred without a living context. Reed-Danahay thus argues that the biomedical model of Alzheimer patients pathologizes their behaviour and underestimates the human dimensions of living in qualitatively different environments.

In contrast, the following study considers the positive impact that an environment can have, in terms of both its architecture and the practices and routines that take place there. Arman, Rannheim, Rehnsfeldt and Wode (2008) used a phenomenological approach to explore the perspectives of 16 patients who had experienced anthroposophic care at a specialist facility in Sweden. The patients felt that they had encountered an environment that was like a "retreat". The absence of computers, telephones and radio created a "peaceful oasis" that was homely. This study illuminates how well-being cannot be considered separate from the atmosphere and "rhythms" created by the built environment and the ways in which this space "speaks". This anthroposophic hospital referred to in Sweden is a good

example of how a more humanized form of care is supported at many levels including the architectural level. These studies underline how a sense of place is crucial for a more humanizing emphasis when considering healthcare practices.

Embodiment/reductionist view of the body

To be human means to live within the fragile limits of human embodiment. Our insiderness reveals the human body as tiredness, pain, hunger, loss of function, excitement, vitality and other experiences of the human body's being-in-the-world. When un-preoccupied with the vicissitudes of bodily attention, embodiment supports us in moving out into the world, attentive to people, places and tasks in life. Alternatively, one's attention can be dominated by bodily messages that announce "dis-ease" and are a reminder of the limits of our everyday possibilities and potentials. Consistent with this dimension, a humanizing perspective will view well-being as a positive quality that makes life worthwhile and not just as an absence of illness, with the body viewed as merely an object to fix. A model of causality that is deterministic and linear can be de-humanizing in that it underestimates human spirit, purpose and meaning.

In *a reductionist view of the body,* there is an overemphasis upon signs and symptoms and the body as separate from its broader contexts. There is an excessive emphasis on tissue, organ, hormones, electrolytes and a neglect of a more relational view of the body in its broader meaningful context such as psychological, environmental, social, and spiritual matrices. A reductionist causality regarding the body can be dehumanizing in that it can neglect the implications of "being a person in there". A view of biomedical causality that stresses a microanalysis of internal structures can be an overly narrow perspective when describing the complexity of meaningful relationships of living in which the body participates; this oversimplification can reduce ones' more complex sense of embodiment. Conversely, when a person's embodiment is considered within its broadest meaningful relationships, their options for healing resources may be broader, and they may feel more in accord with the complexities of living. The emerging field of "mind body-medicine", although expressed in an excessively dualistic way, is an acknowledgement of the need to consider broader causal contexts in a more comprehensive view of illness and well-being. Likewise, the increasing attention to environmental and complementary medicine similarly expresses an awareness of a broader and alternative framework of intelligibility for wellness. An example of a dehumanizing inter-

action that is informed by a reductionist view of the body is when a professional disbelieves a patient's symptoms because the evidence for their back pain does not "show up" in physical tests.

An empirical study from Canada demonstrates one of the ways in which less reductionistic views of the body can become important in supporting more humanizing forms of care. Kontos and Naglie (2007) used performance-based presentations to help health professionals become more aware of the danger of depersonalisation when patients cannot communicate in verbal ways. Here, a view of the moving body as a realm of significant meaning becomes an important resource for humanizing practices. Based on findings from focus groups with older people with Alzheimer's, they demonstrated how patients' bodily expressions could be understood in more meaningful ways. They showed how, in spite of increasing dementia, patients retained a sense of "embodied selfhood" and how their bodies meaningfully communicated "states of self" without words. By facilitating increased understanding of how patients communicated in bodily ways, professionals could then learn how to respond in interactive ways that confirmed the "personhood" of the individual, even when they could no longer verbally express themselves fully. This is one example, where an understanding of non-reductionist views of the body becomes important as a humanizing resource.

The reciprocal relationship between the humanizing value framework and qualitative research

The eight dimensions offer a framework for distinguishing both the range of humanizing issues that could be fruitfully researched, as well as an evaluative basis from which humanizing and dehumanizing elements can be judged along a spectrum of possibilities.

The range of research programmes would thus include qualitative studies on all features of humanization relevant to the eight dimensions. Therefore, for example, one could imagine an interesting interdisciplinary programme that includes architects and human geographers whereby patients' experiences are analysed in order to support the design of built facilities that are conducive to a sense of well-being and "at homeness". Taking the framework as a whole with its eight dimensions also allows consideration of where research programmes may be particularly needed. For example, one may find that there are many meaningful studies in the area of increasing patients' agency but a lack of studies in another important area such as "sense making"

whereby new understandings of how patients make meaning of their illness and situations can inform professional consultations.

The framework also provides an evaluative basis from which humanizing and dehumanizing elements can be judged along a spectrum of possibilities. Each of the eight dimensions (such as agency/passivity) provides a particular nuance that expresses its potentially humanizing and dehumanizing elements in caring systems and interactions. In practice these extremes very seldom occur. However, it is useful to consider the direction of movement that may be appropriate in any concrete situation. For example, in an intensive care context, Todres et al. (2000) showed that a patient became aware how at a certain stage within the marginality of her situation, it became important for her to value the definition of her well-being in more objectified ways as given by feedback from the monitors around her. She describes a moment where she "felt fine" but realized from the activity of the professionals that her condition was critical. At this stage, she very quickly achieved a switch of perspective in which she fully valued and participated in the more objectified definitions of what was going on. At another stage however she indicated how she really needed the professionals around her to be more flexible in moving into a more humanizing emphasis, which validated and nurtured a sense of her "insiderness" and subjectivity. She became aware of how such flexibility is not often easily achieved. In providing this dimension of insiderness/objectification and research that illuminates such dilemmas, health care professionals might become more sensitive to the human complexities of care in concrete situations.

In conclusion, the framework is thus able to provide a helpful coherent value base for guiding a dedicated and coherent research programme.

Qualitative research: Offering distinctive support to a humanizing emphasis for care

The studies used here to illustrate each of the eight humanizing dimensions, give an indication of how qualitative research is particularly conducive for illuminating the complexity, depth and range of living situations relevant to more humanized forms of care. A humanizing emphasis requires a particular kind of "knowledge for care" and needs studies with certain epistemological and methodological characteristics. Such characteristics are intrinsic to qualitative research and include a focus on the insider perspective, description, evocative impact, rich unique contextualization rather than a premature
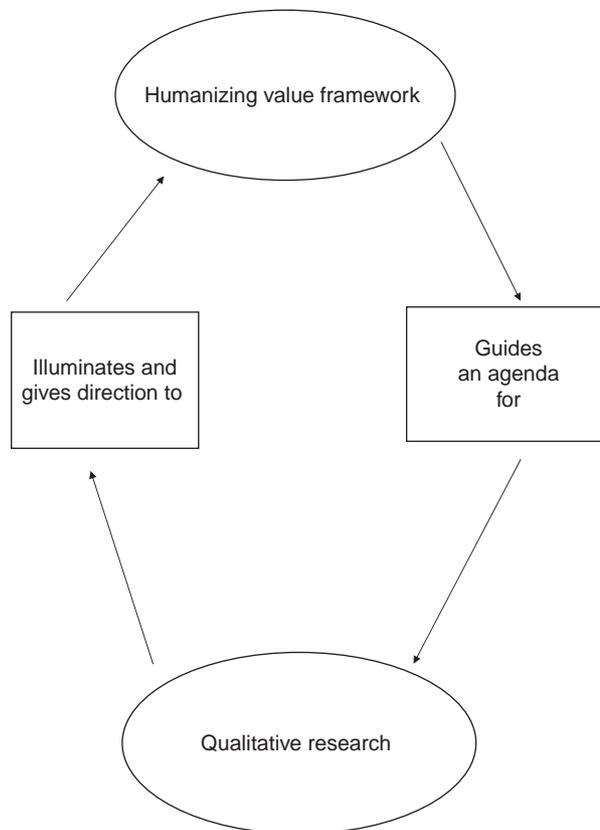

Figure 1. The reciprocal relationship between the humanizing value framework and qualitative research.

emphasis on abstraction, and discovery orientated, open ended enquiry.

We are thus describing a reciprocal relationship between a humanizing framework for care and qualitative research that can be expressed in the above diagram (Figure 1).

Conclusion

Is the humanization of healthcare a luxury? We do not think so. There is increasing evidence in the media, and in our culture at large, that everyday citizens are worried that the more personal dimensions of care are being neglected in favour of "bottom line" outcomes; the quality of the journey is just as important as the destination. So, it is not that humanization of healthcare is not important; clearly it is, as evidenced by recent policy documents that highlight professional compassion, dignity in care and greater patient choice (Department of Health, 2008, "*The Darzi Report*"). Although this policy document is within the British context, it is significant because it explicitly addresses the need to humanize healthcare. However, more than that, as a professional and academic community, we are lagging behind in articulating a coherent qualitative framework for

care. It is in this context that a dedicated focus for developing theoretical frameworks and research studies that support the humanization of care may be timely. If not, existing efforts and pockets of practice that attend to humanization may remain piecemeal as isolated practices without guidance from coherent theories and research programmes.

Do we need a different emphasis on what the distinctive contribution of qualitative research can be? We think so. During the various stages in the development of qualitative research, scholars have been particularly attracted to its core methodological and emic strengths (Morse, 2002). Recently Lincoln and Cannella (2004) have shifted this debate to the level of public policy discourse; they discuss the contribution of qualitative research as a way to uncover "oppressive, inequitable, and unjust social practices" (p. 5), and this can become one of its most distinctive contributions. In line with this, it could be that a different emphasis is needed when championing the value of qualitative research. Our particular emphasis concerns a movement from the methodological contributions of qualitative research to an emphasis on the implications of the findings of qualitative research as a systematic whole for humanizing caring practices. This is unashamedly an ethical pursuit for qualitative research, but we think that it is a pursuit to which qualitative research is particularly well suited. It can be argued that qualitative research is now at an interesting historical point. It is at a stage of development where findings can become more systematized within a value framework and which can serve as a rigorous and credible ground for guiding practice and policy. This achievement reflects how an emic methodological focus has opened up more general insights that have an intrinsically qualitatively human and ethical dimension. It is this qualitatively human and ethical dimension that may be a new phase in articulating the distinctive benefits of qualitative research findings. Moreover, it is in this context that we offer this conceptual framework for humanizing healthcare.

Declaration of interest: The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

References

Arendt, H. (1963). *Eichmann in Jerusalem: A report on the banality of evil*. London: Faber & Faber.

Arman, M., Rannheim, A., Rehnsfeldt., A., & Wode, K. (2008). Anthroposophic healthcare—different and homelike. *Scandinavian Journal of Caring Science*, 22, 357–366.

Charmaz, K. (2006). Measuring pursuits, marking self: Meaning construction in chronic illness. *International Journal of Qualitative Studies on Health and Well-being*, 1(1), 27–37.

Charon, R. (2006). The self-telling body. *Narrative Inquiry*, 16(1), 191–200.

Department of Health (2008). High quality care for all. Next stage review final report. Retrieved September 5, 2008, from http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825

Del Barrio, M., Lacunza, M. M., Armendariz, A. C., Margell, M. A., & Asiain, M. C. (2004). Liver transplant patients: their experience in the intensive care unit: A phenomenological study. *Journal of Clinical Nursing*, 13(8), 967–976.

Heidegger, M. (1962). *Being and Time*, trans. J. Macquarrie and E. Robinson. Oxford: Blackwell. (Original work published 1927.)

Holloway, I., Sofaer, B., & Walker, J. (2007). The stigmatisation of people with chronic back pain. *Disability and Rehabilitation*, 29(18), 1456–1464.

Husserl, E. (1970). *The crisis of European sciences and transcendental phenomenology. An introduction to phenomenological philosophy*, trans. D. Carr. Evanston: Northwestern University Press. (Original work published 1936.)

Johansson, A., & Ekebergh, M. (2006). The meaning of well-being and participation in the process of health and care—women's experiences following a myocardial infarction. *International Journal of Qualitative Studies on Health and Well-being*, 1(2), 100–108.

Kontos, P.C., & Naglie, G. (2007). Bridging theory and practice: Imagination, the body and person-centred dementia care. *Dementia*, 6(4), 549–569.

Lincoln, Y. S., & Cannella, G. S. (2004). Qualitative research, power and the radical right. *Qualitative Inquiry*, 10(2), 175–201.

Medved, M. I., & Brockmier, J. (2008). Continuity amid chaos: Neurotrauma, loss of memory, and sense of self. *Qualitative Health Research*, 18(4), 469–479.

Merleau-Ponty, M. (1964). *The Primacy of Perception*, James Edie (Ed.), Evanston, IL: Northwestern University Press.

Morse, J. M. (2007). Why humanized health care? Plenary address. Saiyud Niymviphat Lecture at the First Asian International Conference on Humanized Health Care, Khon Kaen, Thailand Dec. 3–5, 2007 (Proceedings pp. 74–81).

Morse, J. M. (2002). Qualitative health research: Challenges for the 21st Century. *Qualitative Health Research*, 12(1), 116–129.

Parsons, T. (1951). *The social system*. London: Routledge and Kegan Paul.

Rasmussen, D. M., & Elverdam, B. (2007). Cancer survivors' experience of time—time disruption and time appropriation. *Journal of Advanced Nursing*, 57(6), 614–622.

Reed-Danahay, D. (2001). "This is your home now": conceptualising location and dislocation in a dementia unit. *Qualitative Research*, 1(1), 47–63.

Rosenhan, D. L. (1973). On being sane in insane places. *Science*, 17(70), 250–258.

Schutz, A. (1944). The stranger: An essay in social psychology. *American Journal of Sociology*, 49(6), 499–507.

Stockwell, F. (1984). *The unpopular patient*. Beckenham: Croom Helm.

Todres, L., Galvin, K., & Dahlberg, K. (2007). Lifeworld-led health care: revisiting a humanizing philosophy that integrates emerging trends. Medicine. *Health Care and Philosophy*, 10(1), 53–63.

Todres, L., Fulbrok, P., & Albarran, J. (2000). On the receiving end: a hermeneutic phenomenological analysis of a patient's struggle to cope while going through intensive care. *Nursing in Critical Care*, *5*(6), 277–287.

Widäng, I., Fridlund, B., & Mårtenson, J. (2008). Women patients' perceptions of integrity within health care: A phenomenographic study. *Journal of Advanced Nursing*, *61*(5), 540–548.

Williams, A. M., & Irurita, V. F. (2004). Therapeutic and non-therapeutic interpersonal interactions: the patient's perspective. *Journal of Clinical Nursing*, *13*(7), 806–815.