Health Humanities

Paul Crawford
Professor of Health Humanities, University of Nottingham, UK

Brian Brown
Professor of Health Communication, De Montfort University, UK

Charley Baker
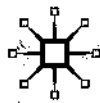*Lecturer in Mental Health, University of Nottingham, UK*

Victoria Tischler
*Senior Lecturer in Psychology, University of the Arts, London,
London College of Fashion, UK*

and

Brian Abrams
Associate Professor, Montclair State University, USA

For Jamie, Ruby and Owen

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Practice Based Evidence: Delivering Humanities into Healthcare

The title of this chapter could imply several things. First, it could cover the way evidence is derived from practice. Certainly, we will consider this later as this process is uniquely suited to the kinds of humanities interventions which are applied in healthcare contexts. Second, it could cover the kinds of evidence that may be needed in order to place humanities-based activities on the healthcare agenda and drive their inclusion in healthcare practice. Yes, this too will be among our considerations. But the relationship between the humanities, the idea of evidence and healthcare itself, is a lot more complicated than that. There are different cultures of what counts as evidence, conflicting ideas about how best to conduct human inquiry and tensions between the world of research and the world of practitioners. Therefore in this chapter one of our central tasks will be to explore what these cultures are and how they have evolved along different trajectories, as well as offering some ideas for their rapprochement to the benefit of scholars and practitioners as well as patients and informal carers.

Perhaps the best way to start is to consider the idea of evidence based practice. This has been an underlying principle of healthcare in many parts of the world for a generation now and has driven a whole range of debates about how best to evaluate healthcare interventions, how to fund research and how to educate and develop practitioners and researchers. It is with these powerful notions of evidence based practice and evidence based medicine that alternative ideas have had to compete to be taken seriously.

Therefore an appropriate way to begin our story is with the concept of evidence based practice itself, before we consider what its alternative – practice based evidence – might look like. This will enable us to consider the final part of the title, namely how best humanities interventions might be promoted and delivered in sometimes conservative healthcare environments and organisations.

An early definition of evidence based practice by Sackett et al. (1996, p. 71) still commands considerable assent amongst practitioners and researchers. It is 'the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients, based on the skills which allow the doctor (sic) to evaluate both personal experience and external evidence in a systematic and objective manner'.

In evidence based practice, a hierarchy of evidence tends to be set up, ranging from the highly trustworthy through to the least certain. This hierarchy, which is apt to be promoted on both sides of the Atlantic, tends to place randomised controlled trials – experiments, in other words – at the top of the list. Here, for example, is the kind of typology of evidence presented by the UK's Department of Health (1996). In descending order of credibility it includes:

I. Strong evidence from at least one systematic review of multiple well-designed randomised controlled trials.
II. Strong evidence from at least one properly designed randomised controlled trial of appropriate size.
III. Evidence from well-designed trials such as non-randomised trials, cohort studies, time series or matched case-controlled studies.
IV. Evidence from well-designed non-experimental studies from more than one centre or research group.
V. Opinions of respected authorities, based on clinical evidence, descriptive studies or reports of expert committees.

Thus, in this view the only thing better than a randomised controlled trial is a large number of these which are so similar that their data (or perhaps some statistical measure of effect size) can be added together in a meta-analysis or systematic review. This then is the evidence on which practitioners are encouraged to base their work.

As we have noted elsewhere (Brown et al., 2003), the arguments in favour of evidence based practice are commonsensically persuasive on scientific, humanitarian and politico-economic grounds. The spectacle of expensive and ineffective interventions falling to the astute gaze of perspicacious researchers is an attractive one. In principle, it seems to be endorsed as a service philosophy amongst many healthcare staff.

The dominance of the large scale randomised controlled clinical trial as a way of finding out what works in healthcare has been challenged on a number of counts. For example, as Warner and Spandler (2012) point out, smaller scale, qualitative studies may be better to meet the everyday concerns of service providers and users. However, given the minatory power of hierarchies like Sackett et al.'s, research like this tends to carry less weight in the development of health policy and clinical guidelines. In the UK, bodies such as the Cochrane Collaboration and the National Institute of Clinical Excellence attempt to direct practice in terms of the highly valued evidence. There are, therefore, significant tensions among policymakers, practitioners and service users as far as the merits of different types of 'evidence' are concerned.

'But it's a bit more complicated': Limitations of the Evidence Based Practice Model

The traditional view, that the best scientific evidence should inform practice, is what Bracken (2007) has called the 'technological paradigm'. This is dominant in a variety of fields, including healthcare and especially in mental health. Put crudely, the 'technological paradigm' assumes that we can identify a set of interventions and study them as they are applied to particular patient groups. Moreover, it is assumed that we can study them relatively independently of context, relationships and values. It is as if we were able to say 'here's a storytelling initiative for people with postnatal depression', 'here's a visual arts intervention with nursing students', or 'here's an art therapy group for people with schizophrenia' and so on. Now let's see if people who've been through this intervention are doing any better than similar people who haven't. That looks sensible enough at first glance. But let us unpack some of the stages in this process. First of all, it's hard to cleanly define groups of people like this. Especially in mental health, grouping people on the basis of symptoms or

diagnoses may not make much sense as the boundaries between categories and the way in which people are assigned to them are often ambiguous (Kinghorn, 2011; Whooley, 2010). In addition, people often have complex multiple health problems and needs. Disorders (if we can call them that) rarely occur in isolation and often show high degrees of co-morbidity such that people may have multiple mental and physical health problems at once (Cunningham et al., 2013) and may relate to a whole range of other psychosocial aspects of the situation like coping resources, physical activity and social relationships (Di Benedetto et al., 2014). So in practice it is often difficult to be precise about what is wrong with people and what exactly it is that the intervention is addressing.

Let us suppose, however, that we can define a group of people for whom an intervention works. For example, if we found that poetry therapy improves resilience and reduces anxiety in people with cancer, as Tegner et al. (2009) did, does this mean that it's a good thing to roll out to everyone with cancer? Well, most people reading this would feel that it is a good idea at a personal level, but let us consider the reasoning process behind this. It would involve grouping people together on the basis of their diagnosis as 'cancer patients' and offering them interventions that seem to have the best results for the majority – the 'best average'. As a number of authors point out (Bola and Mosher, 2002; Warner and Spandler, 2012) this often comes about at the expense of individualised, flexible and tailor made support. As we have suggested above, the similarity of clients on the basis of a diagnostic category may be uncertain. In Warner and Spandler's case they remark that lumping together people who self-injure and people who make suicide attempts is often done, but may be problematic. In addition, the suitability of, and patients' response to, an intervention may be contoured by a variety of wider social inequalities related to social class, age, gender, sexuality and ethnicity, although these are often strongly correlated with long-term health problems (Rogers and Pilgrim, 2003).

Practice Based Evidence: Doing Justice to the Richness of Practice

To foreground the alternate view, that much can be learned in practice itself, a number of authors have proposed a countervailing concept, that of 'practice based evidence', which is said to offer

a bottom-up means of gathering evidence from the experience of everyday practice, drawing on the expertise of practitioners and service users to inform recommendations for future practice and, ultimately, policy (Lucock et al., 2003; Margison et al., 2000; Warner and Spandler, 2012).

Warner and Spandler (2012) argue that research should try to incorporate service users' own values and aspirations and thereby provide more holistic and contextual understandings of clinical practice. The focus on meaning which they advocate tends more often to be found in qualitative approaches to research. Accordingly, Warner and Spandler propose that we should conceptualise research so as to combine aspects which include cognitive, emotional *and* more nuanced behavioural data. In this way, they say, research can elicit information which is meaningful to practitioners and service users and produce evidence which is also robust enough for policymakers and those who commission services.

This chimes in with a feeling on the part of many practitioners in a variety of healthcare disciplines that there is more to what goes on in their work than what evidence based practice can capture. Meanings, feelings, culture, dreams, relationships and reflections are often hard to apprehend via the medium of randomised controlled trials. Consequently, there are for example pleas for the rubric of nursing to extend beyond evidence based practice to include information literacy, the humanities, ethics and the social sciences (Jutel, 2008). Especially in mental health nursing, the arts have often been employed as diversional and therapeutic interventions, and for both therapy and education – as we quoted earlier, 'art offers a showing of human experience in unique ways' (Biley and Galvin, 2007, p. 806) to promote and enact shared understanding of people's experiences. Many of these issues can only be crudely characterised in ways which would make sense within a clinical trial. It is often not an easy task to unpack what is happening within an arts or humanities intervention and in what way it has most impact.

There are similar problems with the idea of practice based evidence. As Fox (2003) points out, there is a great deal of social science research into 'practice', in healthcare as well as a variety of other fields – social services, education, youth work and so on – which provides a great deal of data on how services are delivered. In some cases this provides valuable recommendations for improving services.

However, very often academic researchers do not take the time to push these ideas through into practice. It is as if research has ended as soon as the report is written to the funders, the paper has been accepted for publication, seminars have been given and participants and stakeholders have all gone home.

Wood et al. (1998) found that practitioners felt that disembodied research findings were not convincing, but wanted instead to see these findings contextualised in terms of their own professional experience. Wood et al. argued that in order for adoption to occur it was necessary that practitioners 'bought in' to the proposed changes, and for research to take into account locally-situated practices through which practitioners engage with the research. 'Research findings' do not necessarily represent 'truth' about reality, as one 'reified moment' in the ongoing saga of 'practice' (Wood et al., 1998, p. 1735).

The Question of Evidence and the Humanities: Difficulties of Evaluation Perspective and the Politics of Knowledge

In terms of unfolding an evidence based rationale for humanities interventions, this too is fraught with difficulty when we consider what humanities-based interventions and their originators say about themselves. This is relatively rarely phrased in terms of outcome measures and key performance indicators. To take an example, let us look at how we might conceptualise the effects of an intervention based on fairy tales or folktales (Sommer et al., 2012). Folklorist Maria Tatar (1999) has explored what she sees to be the value of fairy tales at both individual and community levels. She notes 'their widespread and enduring popularity' and claims that they perform 'a significant social function...' (p. xi). She continues that our enduring fascination in stories like these is part of a desire 'to develop maps' to enable people to cope with complex personal, familial and social frustrations encountered in everyday life (p. xi). A fellow folklorist, Jack Zipes (2006) of the University of Minnesota, propounds the idea that fairy tales are a 'metaphorical mode of communication' which people use to understand both themselves and the social world around them (p. 95). These kinds of claims are not unusual amongst students of folklore and fairy tales. The difficulty in formally

evaluating these assertions is not particularly crucial since their truth lies in their persuasiveness and their ability to generate insightful ways of looking at folklore – what function is it performing for the people concerned and what sense do they make of it? The question of how we might evaluate these sorts of claims and what we might do about testing them becomes more critical when we consider the growing popularity of narratives and stories in psychotherapy and counselling. As a narrative counsellor, Barclay (2007) also indicated that stories serve a similar function. He noted that 'in the context of cultural myths, stories soothe people with the analogies that they provide, normalizing, through metaphor, the vicissitudes of life's travails' (p. 1). Brown and Augusta-Scott (2007) propose that stories and their re-telling serve an epistemological function – that is, they are concerned with the nature of knowledge. In their view, it is more or less impossible to know the world directly – indeed this is fundamental to the approach as much narrative psychotherapy adopts a social constructionist view of the world. Instead we turn to 'lived experiences' and alternative stories or 'alternative story possibilities' (p. xii). Indeed, Speedy (2000) suggests that work with stories 'would acknowledge the multi-storied possibilities available' (p. 419). And Tatar (1999) notes that where stories are concerned, 'few fairy tales dictate a single, univocal, uncontested meaning; most are so elastic as to accommodate a wide variety of interpretations, and they derive their meaning through a process of engaged negotiation on the part of the reader' (p. xiv). Thus stories offer multiple opportunities for individual interpretations which can allow clients (and maybe practitioners too) to examine their own difficulties through this process of mutually negotiated meaning.

Scientific research in the era of post-Enlightenment modernity, and the kind of work which is highly valued in the evidence based practice movement, has this kind of search for truth as its goal. Through observation and reasoning and progressive refinement of theory, knowledge will approximate ever more closely to 'truth' (Popper, 1982). In this framework, the aim of research is to observe, analyse and understand aspects of the world in causal, material terms. Consequently, the mutual negotiation of meaning and the analysis of experience which we have described here are unlikely to satisfy the requirements of a form of inquiry that demands the evaluation of knowledge claims in this way. Moreover, as the academy has

evolved in the latter part of the 20th century a variety of other voices have demanded that peoples, groups and kinds of experience that have hitherto been marginalised should be heard.

For example, Ramazanoglu has argued (1992, p. 209) that a specifically feminist approach to methodology has arisen as a result of power struggles over what it means to 'know' and what counts as valid research. The feminist commitment to resisting patriarchy has been accompanied by a suspicion of grand narratives (Holmwood, 1995, p. 416) and instead entertains a preference for research which is local, engaged with women's concerns and which values experience (Gelsthorpe, 1992, p. 214; Oakley, 1998, p. 708).

Within feminism, as with other critical forms of inquiry, many writers have drawn attention to the differences in power between the researcher and the researched. Research often involves relatively privileged people looking at those who are more marginalised. The participants in research are often those whose gender, ethnicity or sexuality places them in a marginalised or minority position. Alternatively, their status as patients, offenders, clients of social services, or pupils in schools means that they are disadvantaged in terms of expertise and social power. Other writers have explored the relationship between the person doing the research and the person on whom the research is being done from a variety of theoretical perspectives.

Research has often involved those who are in powerful positions eliciting information from and scrutinising those with less power. Elite groups do research on people in poverty, criminologists do research on offenders, and doctors and medical researchers corral patients into clinical trials. Elite groups themselves – senior managers, politicians and the like – are often far less intensively investigated and have more control over how they are presented. These power relationships in research have been a focus of concern especially for feminist scholars. Landmark publications in this area include Stanley and Wise (1983) and their feminist exposé of power relationships in research or Oakley's (e.g. 1991) ground breaking studies of childbirth in which she examined the role of relationships in research and the way that rather than simply discovering new truths about the human condition this was often a two-way transaction in which the women in the study had many questions for the researcher.

In the 1990s there was a good deal of interest in the potential of postmodernism in the social sciences to open up opportunities

for hitherto marginalised voices to be heard. Moreover, there were attempts to problematise the roles of the actors involved. For example, Stronach and MacLure (1997) argued that the concept of a 'researcher' is a construction achieved in opposition to definitions of practitioner or a research participant (1997, p. 100).

Practice Based Research: New Approaches, New Validities

In the 1990s spirit of postmodernism a number of authors argued for new approaches to make sense of the research process. Rather than the well-worn notion of validity (whether you are measuring what you think you're measuring) there was some discussion of a novel construct, that of 'transgressive validity' in research, as outlined by Lather (1993, p. 676; DeLuca, 2011). In this view, the 'validity' of research is to do with its ability to transgress, challenge or subvert existing conceptions of the topic area. Lather's application of transgressive validity to social science research sought to de-centre traditional ideas and 'reframe validity as multiple, partial, endlessly deferred' (1993, p. 675). In this conception of the human inquiry process the transgressive mode of working fundamentally problematises the traditional ideas of truth derived from positivism and instead seeks to reconceptualise 'the very criteria of validity' through critical questioning of culturally biased assumptions (Moss, 1996, p. 26).

In this way, says Fox (2003), we can imagine and implement 'practice-oriented research that is constitutive of difference, challenges power and constraint and encourages resistance and new possibilities' (p. 89). Among a number of newer approaches to thinking about research, the idea of transgressive validity is helpful in prompting a critical stance towards validity, evidence and validity criteria. In a similar vein, as Ledwith (2007) says of emancipatory action research, there is more to the business of being critical than simply enabling participation. Whilst it is valuable for researchers to enable meaningful participation on the part of the people they are researching, and promote collaboration, a more fully emancipatory approach goes a step further than simple participatory research and may involve the participants in the research helping to define problems, identify research questions and implement research activities, as well

as trying to find ways of using the research to bring about social change. In this way, research aims to be empowering and transformatory. For example, White and Robson's (2011) account of work in arts and health in schools in the north-east of England describes how sustained programmes of participatory arts activity and shared creativity can contribute to bottom-up expressions of public health. They can at the same time help identify and address the specific local health needs of a community. This kind of action work, involving creative activity, research and ambitions towards effective social change, combines personal experience and facilitating people's engagement with their own health needs, and also creates 'commitment to a communal will for a shared experience' (White and Robson, 2011, p. 54).

This species of activity, integrating action and intervention with research and an agenda for change, may well rely at a basic level on dialogue, dialectic, interpretive and hermeneutic modes of inquiry which may yield very different ideas about reality depending on whose perspective is considered. Indeed, as veteran action researcher Michelle Fine (e.g. Stoudt et al., 2012) has frequently argued, objectivity may well turn out to be not so much about truth, but to represent the standpoint of a dominant group. Hence, democratising methods and involving people in helping to define reality can itself serve to provide interpretive evidence for validity arguments themselves. Indeed, in examining the role of the creative arts in humane medicine, McLean (2014) highlights how people who have often not had a voice in the past can be surprised that practitioners and researchers are suddenly taking an interest in their point of view.

A further example of how participation and practice can change the agenda, perspective and debates comes from Matarasso (2012), who examines the role of the arts in older adults and the part they might play in successful ageing. Art among the elderly can be considerably more than the pleasant diversion it is usually thought to be. It can be a fundamental means of negotiating one's place and purpose in society. In Matarasso's work there is hardly any mention of the usual agenda of infirmity and disability but rather a focus on creative engagement and flourishing. Indeed, it is only in retirement that some of Matarasso's informants had finally been able to fulfil long-cherished creative ambitions.

The commitment to changing the terms of debate or changing the world is one facet of the notion of transgressive validity we

mentioned earlier. Much of what one might do in this variety of research owes a good deal of its shape and form to the principles of 'emancipatory' action research outlined by Carr and Kemmis (1986) nearly 30 years ago. However, the idea of transgressive validity foregrounds a principle of difference rather than convergence on a shared rationality. As originally conceived, the idea of transgressive research is a reflexive one. As Stronach and MacLure (1997) comment, in the spirit of transgressive validity, this concept itself would necessarily be subject to transgression.

Despite this awareness of reflexive possibilities, the transgressive spirit in research does not necessarily lead to stasis or navel gazing. The concept of 'transgressive research' and the transgressive approach attempt to interrogate the evidence for hegemonic imbalances in order to discover the political underpinnings of experience and practice. For example, Furman (2006) discusses the role of poetry in exploring the experience of illness and hospitalisation. As he says:

> Successful expressive poems are based on empirical data that are sensory and evocative in nature. Imagistic language allows the reader to enter a work and develop his or her own personal relationship with it; the images are transformed into knowledge pertaining to both the poem and the reader. (Furman, 2006, p. 561)

Furman's poems relate to a period of hospitalisation with troubling symptoms of respiratory distress and imagistically and evocatively record the sights and sounds, anticipation of one's own death and interaction with staff and loved ones. Moreover, as the poetry evolves it comes to resonate with other much earlier forms of poetic storytelling from different cultures such as the so-called 'tanka' or the repetitive 'pantoum' form.

In the case of Furman's work, the aim is to use poetic forms to produce something meaningful but in a way which runs counter 'to the standard validity of correspondence: a non-referential validity interested in how discourse does its work' (Lather, 1993, p. 675). In presenting experiences poetically this kind of approach recalls the famous social scientist Norman Denzin's (1997) advocacy of using alternative forms of data in order to evoke deep and compelling emotional responses on the part of the reader of research. Accordingly, the expressive and creative arts have the potential to expand

understanding, represent in new ways subtle ideas or notions that might be paradoxical or dialectic, and lend themselves to the conceptualisation of experiences and processes that are difficult to reduce.

Following the implications of this for our discussion of how research might be understood and evaluated, let us return briefly to Lather (1993) and DeLuca (2011) who outline some lesser appreciated but nonetheless useful aspects of the idea of validity which may be especially useful when the arts and humanities in health are under scrutiny:

1. The first of these validities is what Lather calls simulacra/ironic validity, which involves raising questions about the representation of validity. In this view the notion of truth itself is something that should be problematised. All validity evidence is at least one step removed from real experience, and through our language, which is always an incomplete and partial representation of reality, experience is placed in symbolic form which may therefore be communicable, but is somewhat different from what gave rise to it.
2. The second form of transgressive validity which Lather identifies is what she calls the paralogical form of validity, in which the need for logical resolution is avoided and the opportunity for incommensurable forms of evidence is allowed. This form of validity reminds us to resist the urge to clean up nature and resolve incongruent evidences from validity arguments. Here, the aim also is to embody 'a situated, partial, positioned, explicit tentativeness' (Lather, 1993, p. 685).
3. Thirdly, Lather considers rhizomatic validity. The idea of a rhizome in philosophy and the social sciences is borrowed from Deleuze and Guattari (1980) and describes theory and research that allow for multiple, non-hierarchical entry and exit points in data representation and interpretation. This they distinguish from the conventional tree like 'arborescent' representation of knowledge which charts causality along chronological lines and looks for the original source of 'things' and looks towards their pinnacle or conclusion. A rhizome on the other hand is concerned with ongoing connections between chains of meaning, organisations of power, and circumstances relative to the arts, sciences and social struggles.

4. Fourthly and finally, Lather's voluptuous validity encourages us to seek out ethics through practices of engagement and self-reflexivity (Lather, 1993, pp. 685–686). This kind of approach has often been identified with a feminine principle as distinct from the masculine principle of 'hard' data. It concerns the extent and nature of the researcher's engagement with the participants and their sensual world. Indeed, the enjoyment of things like music, drama, poetry or the visual arts are sensory, and often sensual, experiences. Under the heading of voluptuous validity we might also examine how validation practices and theories typically reflect a more powerful male perspective. Further, voluptuous validity reminds us of the need to examine validity processes and the kinds of evidence that relate to these from multiple perspectives including those of diverse genders, cultures and political positions.

Going back to our original concern about the nature of evidence in the health humanities and the kinds of ways in which evidence might inform and also be derived from practice, we hope it has become clear that this is not a simple issue. The reliance of much discourse about evidence based practice on randomised controlled trials places many of the interventions in the arts and humanities at a disadvantage because they are often not evaluated in this way, and unlike drug treatment, it is difficult to imagine an adequate placebo which could be given instead of the active treatment. On the other hand, there is the possibility of practice based evidence. This is a rich field and, as we have demonstrated in this volume, there is a wealth of experience. Yet thinking about the experience of practitioners, researchers and participants in practice is by no means straightforward. As feminist and postmodernist scholars have pointed out, whose reality we privilege and how we turn experience into research reports is fraught with difficulty. Practice – at least if it is performed sensitively and thoughtfully – does not yield a single reality that can be turned into 'evidence'.

As a consequence, a good deal of what we learn about the role of the arts and humanities in health is in the form of knowledges that cleave most readily to interpretive, narrative or postmodern styles of inquiry. There are a great many precedents for trying to make sense of this – from feminism, postmodernism itself and a variety

of hermeneutic and interpretive styles of work. Thus any single analysis can only be presented as a 'tentative statement opening upon a limitless field of possible interpretations' (Churchill, 2000, p. 164). Savin-Baden and Fisher (2002) write of allowing researchers to 'acknowledge that trust and truth are fragile' while enabling them 'to engage with the messiness and complexity of data interpretation in ways that ... reflect the lives of ... participants' (p. 191). Now, most texts about research methods would claim that it is not appropriate to generalise or extrapolate findings from qualitative studies. However, this need not be seen as a blanket prohibition. Rather it is a call to modesty and tentativeness in our findings. As Kersten et al. (2010) propose, if we are sufficiently explicit about the circumstances of the study, the recruitment of participants, the methods used and the researcher's role, readers will be able to judge how relevant the knowledge in question is to their own (Sandelowski et al., 1997). Indeed, in some cases research and writing in the health humanities may yield 'knowledge claims that are so powerful and convincing in their own right they ... carry the validation with them, like a strong piece of art' (Kvale, 1996, p. 252).

Evaluating Research: How Do We Know It Will Work?

Martyn Hammersley (1992), in a volume entitled *What's Wrong with Ethnography?*, proposed that ethnographic work should be evaluated in terms of its *plausibility and credibility* – that is, are there sufficient data presented to support the credibility of the findings? Hammersley also proposes that we should consider the relevance of the study in the sense of offering valuable new information on the topic or making a contribution to the literature. He also notes the importance of the audience to which the account of research is addressed. What will be needed for a medical journal will differ from what might work in a presentation to an informal carers' group, for example.

There are many further contributions to the debate on how we can evaluate qualitative research. Finlay (2007) talks about clarity (does it make sense?), credibility (is it convincing?), contribution (is it adding to our knowledge?) and communicative resonance (does it draw readers in?). Madill et al. (2000) offer the notions of *internal coherence, deviant case analysis* and *reader evaluation*. By internal coherence they mean the extent to which a given analysis 'hangs together'

logically without contradictions. Deviant case analysis involves considering outliers and data that do not appear to fit the analytic scheme. Reader evaluation relates to the extent to which the study yields insight and understanding for the reader. Madill et al. recommend that we rely extensively on verbatim quotations from the data to enable readers to derive their own interpretations. As they go on, 'qualitative researchers have a responsibility to make their epistemological position clear, conduct their research in a manner consistent with that position, and present their findings in a way that allows them to be evaluated properly' (Madill et al., 2000, p. 17).

As the stock of knowledge about health humanities interventions grows, we need to consider how it might be possible to aggregate or compile the various studies or strands of information. In the last few years the technique of metasynthesis has been proposed as a means of bringing the diversity of qualitative research together. Rather like its cousins systematic review and meta-analysis, this initially involves identifying appropriate terms with which to search the available literature, but the mode of analysis is thematic rather than statistical.

Noblit and Hare (1988) suggest that there are three stages to conducting a metasynthesis:

1. The reciprocal stage – recognising recurring themes and ideas where the reviewer identifies what these recurrent themes are, which sources they are in and how often they occur.
2. The refutational stage – recognising themes and ideas that go against the common themes and ideas.
3. The line of argument – constructing a statement that can summarise and express what has been found.

For example, a metasynthesis examining studies of the experiences of living after a stroke found remarkably similar findings in the nine sources included (Salter et al., 2008). Salter et al.'s metasynthesis suggested firstly a sudden, overwhelming and fundamental life change for the stroke survivor. There is also a widely reported sense of loss, uncertainty and social isolation in conjunction with the process of transition and transformation. However, a further theme concerns the capability of the survivor for adaptation and reconciliation of identity, enabling them to move forward towards meaningful recovery.

In addition, the kinds of interpretive inquiries which take place in the health humanities may increasingly find themselves occurring in conjunction with other methods in complex evaluative programmes of research. The popularity of mixed methods approaches to evaluate complex interventions is growing, with many funding bodies (e.g. the UK Medical Research Council, 2008) recommending that randomised controlled trials should be supplemented by qualitative research. In connection with this, Daly et al. (2007) suggest a hierarchy for judging the value of qualitative research as a basis for action for practitioners or policy. Daly et al. would attach more weight to conceptually sophisticated studies that analyse all available data according to conceptual themes. Even so, there may be limitations as a result of a lack of diversity in the sample. More readily generalisable studies, they say, will be ones which use conceptual frameworks to derive an appropriately diversified sample as well as attempting to account for all data. The least likely studies to produce convincing, practically relevant evidence are single case studies. A study which is largely descriptive may provide interesting lists of quotations but in the absence of detailed conceptual analysis it may have little to contribute to the broader field of practice.

Daly et al. (2007) also contend that qualitative studies may have a variety of uses such as illuminating treatment issues – for instance exploring why some clients respond better to some interventions – and in formulating critique of current practice. It is often through detailed qualitative analysis that we become aware that standard practice may not be benefitting one or more groups of people. In the broader health field qualitative analysis may help us identify the variables and factors which may be critical in providing evidence for or against interventions and programmes and lay the foundations for evidence relevant to the creation of better health policy.

Summary and Conclusions

Finally, do we always need randomised controlled trials before we can deliver a humanities-based activity in healthcare? Surely the answer here is 'no' for the reasons we have described earlier. Do we need to question and interrogate the evidence for what we do? The answer to this is undeniably 'yes'. Surely we will need some assurance that what we do will be better than doing nothing, and we will

often need to demonstrate this to those who have their hands on the purse strings. The best answers about how to improve outcomes for patients will very likely arise from integrating a variety of suitable methods (Upshur et al., 2001). It is vital that different kinds of knowledge are valued, understood and most importantly integrated if we, as service users, investigators, practitioners or commissioners, are to reach towards a more complete picture of what may be going on when the humanities are applied in healthcare.

8
Creative Practice as Mutual Recovery

There is a clear opportunity for the emergent field of health humanities to move to a whole new level of impact, with contributions from anthropology, narrative and literature to linguistics, music and visual art, as well as the very many arts and humanities-based knowledges and practices that it was not possible to include in this slim manifesto volume. As we have indicated, creative practice is a major activity in societies worldwide, and arts and expressive therapies are well established in physical and mental health services. In terms of the latter, for example, research has already demonstrated the importance of arts for 'recovery orientated mental health services' (Spandler et al., 2007), how they provide ways of breaking down social barriers, of expressing and understanding experiences and emotions, and of helping to rebuild identities and communities (Brown and Kandirikirira, 2007; Devlin, 2009; Secker et al., 2007).

The creative practices in both the arts and humanities are set to become a mainstream mechanism for social connectedness and recovery for all involved in healthcare, that is, the healthcare workforce alongside patients and informal carers. Arguably, what is coming down the track is more radical and transformative than what has been achieved to date under a 'therapy' umbrella. Creative practice has documented potential for having a unique role to play not just in advancing mutual recovery but also in transforming future approaches to non-professional solutions for physical and mental health and well-being. The notion of 'mutual recovery' (Crawford et al., 2013b) was seeded many years ago when author