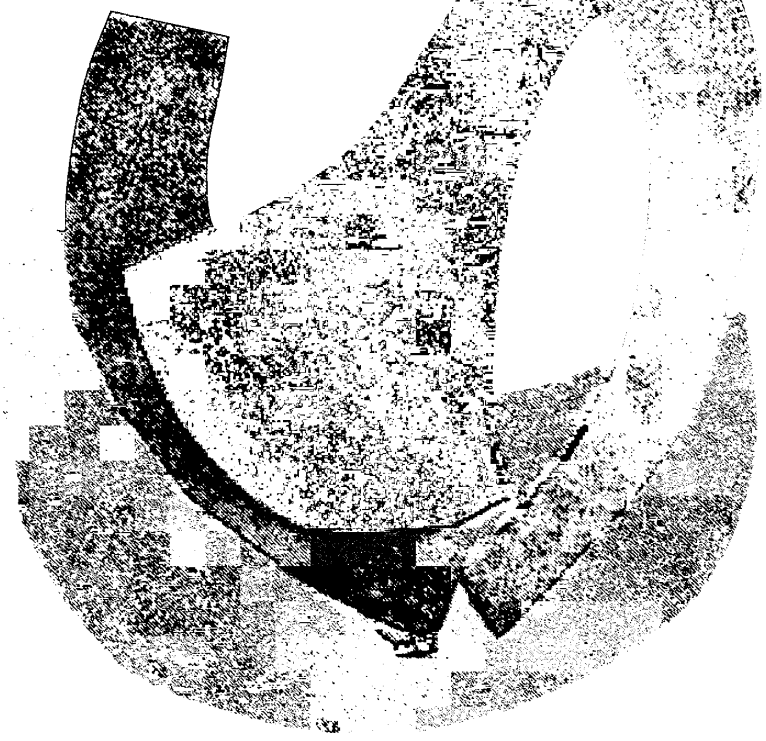
King's Fund

The Arts in Health Care: Learning from Experience

Edited by Duncan Haldane and Susan Loppert



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In association with Lulham Art Publications,
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Foreword

I am delighted to write an introduction to this publication of proceedings on the meeting on Arts in Health Care at the Roehampton Institute in September 1997. It is now increasingly recognised that the use of the arts can have a wide range of benefits for people who are ill, and their carers. Conferences like this allow debate and discussion and the sharing of ideas and projects.

There are several ways in which the arts can help. Perhaps the most obvious relates to the quality of life of individual people who are unwell. Music, dance and the visual arts can contribute enormously to well-being and give new dimension to people's lives. The effect on the people working in the health care establishments involved can also be profound and beneficial. We do need to ensure, however, that projects are evaluated so that future investment can be in areas that produce the best results.

One area of special interest is that of the arts in community development. Such projects as theatre and dance in the local environment fit well with the concepts of Health Action Zones and Health Living Centres. Improving the quality of life for those who are disadvantaged and increasing their self-esteem are a key part of the Government's programme to deal with social exclusion. Yet another dimension is that of the arts in professional development and education. The need for nurses, doctors, physiotherapists, dieticians, pharmacists and many others to be able to understand and empathise with patients and put the patient's point of view first seems obvious. The use of literature and theatre can help professionals understand more clearly the problems which patients have, and make them more sympathetic in dealing with them.

Finally, let me once again congratulate the organisers on the success of the conference, and I hope that this publication will bring its discussions to a wider audience.

The Baroness Hayman
Under-Secretary of State for Health

Introduction

Duncan Haldane

Dear nurse of arts
Henry V, 5,ii,35

This group of papers arose from a major international conference held at the Roehampton Institute, London, from 11 to 13 September 1997. It was probably the largest ever international gathering in the United Kingdom to examine the various uses of the arts in a health care context in so many different forms.

Roehampton Institute is a federation of four colleges of higher education, each with its own history and ethos. It has an established reputation for the study and application of public art in contexts such as hospitals, and this conference at Froebel College was therefore very much a part of its pioneering work.

The range and subject matter of the papers speak for themselves. There is little doubt that they stand as a significant contribution in their own right, and should help to develop debate about the important issues they address.

The idea for a gathering of this kind developed from my appointment as a Senior Research Fellow in the Art Department at the Institute as well as other work I had undertaken in the visual arts. My brief was to augment research in the links between the arts and health, and ways in which people with disabilities may enjoy the arts. A recurring question, particularly at a time of economic strictures, was the justification for expenditure by health care authorities on specific arts-related projects, and how these might be realistically evaluated. There is, of course, much room for argument as to whether such projects can properly be evaluated in any meaningful sense. However, all the speakers were selected both for their current research interests and for their experience of evaluating individual projects.

Until there are clinical trials which examine the impact of the arts in various fields of medicine, such as mental health or care of the elderly, we are forced back to more subjective means of evaluation. Although there are plenty of anecdotal accounts of such impact, I would still urge anyone planning an arts project in a health care building to require the beneficiary to carry out some simple self-evaluation. This could consist, at its most basic level, of agreeing objectives and monitoring the benefits. A critical examination of work in progress is likely to be of value to those working in such an environment, if nothing else, but would also help to set standards and might assist in validating any subsequent proposals.

Other aims of the conference were to assess the wider benefits of using the arts in health care; to look at some of the latest ideas in hospital design, both nationally and internationally; to explore the benefits of using artists-in-residence; to investigate the demands and requirements of site-specific art; and to examine ways in which patients and staff can, or indeed should, be involved in the selection of works of art and other arts activities. The scope was, therefore, both ambitious and innovative.

Inevitably, as the conference progressed, other strands began to emerge. While the use of the arts as a form of therapy was not intended as a topic, this clearly is a substantial area of work and one which deserves closer examination by those engaged in this important field of treatment. Community arts activities are another branch of study which the conference did not address. Delegates did, however, benefit from the presence of certain practitioners in community arts.

In addition, there are many continuing and long-established projects throughout the United Kingdom (and abroad) which are not represented by the contributions in this volume. However, we hope and intend that these various articles will be of widespread value and interest to those already working in this growing movement or planning to do so.

I should like to thank all those who chaired the different sessions of the conference, namely Sue MacGregor, broadcaster and presenter of BBC Radio 4's *Today* programme and an Honorary MRCP; Dr Aileen Adams, an anaesthetist and former President of the History of Medicine at the Royal Society of Medicine; Professor Richard Smith, the Editor of the *BMJ*; and Mr James Scott, consultant orthopaedic surgeon and founder

and chairman of the Chelsea and Westminster Hospital Arts Project. All of them gave of their valuable time to play a significant role in the proceedings. I should also like to pay tribute to Baroness Jay, the former Minister of State for Health, for her gracious welcome to delegates at the King's Fund reception and her expressed commitment to this subject. Thanks are also due to her successor, Baroness Hayman, for so kindly contributing a Foreword.

Deserving of warm thanks are my co-editor Susan Loppert and John Plant, who chairs the King's Fund Art in Hospitals Forum, for all their assistance in bringing this project together. It was an opportunity to explore in greater depth a fascinating topic, as well as benefit from their different experience.

Thanks are also due to the Roehampton Institute, without which these proceedings would not have seen the light of day. I am grateful to all my colleagues there who were unfailingly helpful. Lastly, I am very happy to acknowledge the generous support of the King's Fund, which believed in the worth of the occasion and was also prepared to support the production of this volume of papers.

Duncan Haldane has worked extensively in the field of art and disability. He is an art historian and is also Director of the John S. Cohen Foundation.

Any views expressed in this volume are those of the authors and not necessarily those of the King's Fund.

a history of art in British hospitals

DR HUGH BARON

Art has been placed in hospitals since as early as the 14th century. The concept is thus far from new, as will be shown in this review of the use of art in British hospitals.

Art in hospitals has taken up much of my non-biomedical energies for many years because, to me, it is axiomatic that hospitals, like all public buildings, should be beautiful, and that works of art have a special value to patients, staff and visitors. In this historical review I want to try to question what has happened in Britain, and examine who the patrons were and what their motives were. Why were certain artists chosen and what were they attempting to do? Was it really worthwhile?

Throughout the Middle Ages, hospitals had their own chapels and patients were exposed to images of the deity so that they could pray for their recovery, pray for the patrons of the hospital, or pray for immortality

and forgiveness of sins. This was, for instance, the case in the 12th century Eastgate Hospital in Canterbury as well as Lincoln Hospital; the role of art in medieval hospitals in Britain and other European hospitals is well documented.

In the 15th century kings and rulers moved their charitable work from the building of cathedrals to that of hospitals in order to achieve good works on this earth and help them to the next. The best examples are in Italy, with the great hospital in Milan planned by Francesco Sforza and the hospital in Siena of Santa Maria della Scala, which became known internationally.

In 1517, Henry VII built his Savoy Hospital in London after the model of the Santa Maria Nuova Hospital in Florence[1]. All that now remains of it is the Chapel of the Savoy, but we know that the hospital had a 320-foot nave and we can assume that the art was of royal quality. The roof had wooden pendants with angels on corbels holding emblazoned shields carved by Humphrey Coke (whose work is in Corpus Christi College and Christ Church, Oxford) and the great east window had the usual hospital subject for the dying, the *Last Judgement*, made by Bernard Flower, the glazier of King's College Chapel, Cambridge.

There were more than 100 beds, each with a counterpane and curtains in Tudor colours of white and green with a red rose in the centre. The lay staff wore blue gowns with a red Tudor rose on the breast, on the right for men and on the left for women.

The hospital no longer exists and we therefore do not know whether the Savoy Chapel had murals, but we can still see paintings of the late 15th century in the Hospital of St Wulstan in Worcester. In a room thought to be where patients were taken when dying are ten panels, including scenes of *St Erasmus on a Windlass being Disembowelled by Order of the Emperor Diocletian* (thus the patron saint of gastrointestinal disorders) and on the wall opposite is *St Michael Weighing Souls* to decide their destiny, Heaven or Hell[2].

17th and 18th century London

Bethlem

On top of the gates of Robert Hooke's Bethlem Hospital at Moorfields in east London (1675–6) were two life-sized stone figures by Caius Gabriel Cibber, the left known as *Melancholy Madness* and the right as *Raving Madness*. Both were clearly visible to every passer-by, visitor or patient coming for admission, and stated quite plainly the nature of the hospital and its work[3]. Possibly, they were there also to elicit alms. Bethlem Royal is now at Beckenham in south London and has a museum containing these two masterpieces of English sculpture, as well as its own art programme.

Chelsea

Charles II created the Royal Hospital at Chelsea in direct imitation of Louis XIV's Invalides in Paris. The great hall has appropriate royal portraits and the 450 pensioners still pray in Wren's simple chapel (1682–7) with its *Resurrection* by Sebastiano and Marco Ricci of 1710–15. The grandees had stalls with cushions and hassocks, the staff had box pews and hassocks, but the pensioners' benches had to wait until 1834 even for backs to be installed. Perhaps the most sumptuous room in Chelsea Hospital is the council chamber with its fine ceiling, carvings, panellings, furniture and state portraits. This room was more to impress members of the council and grandees than for the benefit of patients; these were prevented from coming to see it by a guard in the form of a light horseman (an inpatient, yeoman class) posted in a watchman's seat at the foot of the staircase as 'sentinel to ensure that there be no Noise and that no Beggars lay about the doors'.

Greenwich

At the end of the 17th century, King William and Queen Mary built the Royal Naval Hospital at Greenwich, just south of the River Thames. On this occasion James Thornhill beat the Italians and obtained the commission for the ceiling of the Painted Hall (1708–12), a grandiose allegory, *The Protestant Succession*. The Hall was reserved for formal ceremonies and dinners and the pensioners ate as a rule in the basement below.

St Bartholomew's

Francis Bird's statue (1703) of Henry VIII stands in the centre of the 1702 gatehouse of St Bartholomew's Hospital (in West Smithfield), below two reclining cripples (by Edmond Stone, 1701), clearly inspired by the Bethlem figures.

When, in 1734, the painter and engraver William Hogarth was told that the governors were negotiating with Jacopo Amigoni to decorate the staircase of Gibbs' Great Hall, he was determined to emulate his father-in-law, Sir James Thornhill, and uphold the reputation of the English history painter over the foreigner and secure for himself a more dignified status than that of the designer of popular prints[4]. He offered to paint the staircase *gratis* to ensure that he obtained the commission and when this offer was accepted by the Barts' renter (estate clerk), Hogarth rewarded him with a portrait of his son 'in acknowledgement for his services'. Hogarth became a governor, and the murals were probably painted in lieu of the usual £50–100 donation.

The two paintings are oil on canvas, each 16 by 20 feet, and emphasise charity and compassion. *The Pool of Bethesda* (1735–6) shows the healing of people afflicted with a dozen different diseases, as well as poignant scenes such as a poor mother and child pushed aside by an attendant who has taken money to allow a rich, beautiful woman, perhaps with a venereal disease, to receive treatment: 'my object, dramatic and my aim to draw tears from the spectator'.

Hogarth's other painting is *The Good Samaritan* (1737) and below it are three rococo grisaille panels, one of which shows the vision of Rahere (Henry I's jongleur) being told by St Bartholomew to found a hospital in Smithfield. Again, these paintings were not for the patients but to impress the governors, grandees and visitors coming up the staircase to the Great Hall, where monarchs and donors are commemorated by portraits and lists of donations.

The Foundling Hospital

At the time that Hogarth was painting at St Bartholomew's (1739), Thomas Coram created nearby the world's first secular associational philanthropical corporation, the Foundling Hospital in Lamb's Conduit

Fields, Bloomsbury. Hogarth was again determined to prove that he could paint as well as any foreigner and he gave the Foundation a superb framed 'State' portrait of Coram (1740). Later, he painted a shield over the main door and designed the coat of arms, the heading for the subscription roll, and even the uniforms for the boys and girls. He and his fellow-governor, the Flemish sculptor Michael Rysbrack, persuaded 15 of their artist friends to ornament the hospital 'without any expense to the Charity'.

Although the hospital was demolished in 1926, the offices were rebuilt in 1937 in Brunswick Square and contain the original staircase, a picture gallery and the magnificent Court Room with a perfectly preserved decorative scheme of plasterwork, furniture, sculpture and paintings, all linked iconographically by Hogarth, who gave one of the four large history paintings, *Moses Brought before Pharaoh's Daughter*. These artists were made governors and became a *de facto* national school of painting. Hogarth's plan was that visitors would be attracted to the hospital to see both the foundling children and the wide range of paintings, bringing donations to the charity and commissions to the artists, who soon turned themselves into the Royal Academy of Arts (1768).

As in Brunelleschi's foundling hospital in Florence, the art was not for the foundlings, but at least London mothers did not have to push their newborn through a secret turnstile; instead, they had to mount the great staircase to the Court Room to plead with the governors to receive their babies and were no doubt suitably overawed by the works of art as, too, were potential donors watching this charitable ceremony. Hogarth also helped the London Hospital by donating a head-piece of the *Last Judgement* for broadsheets, reports, appeals, instructions and certificates of attendance. He even advised Bethlem Hospital on their paintings.

Thus, 18th century paintings in hospitals have 'a propaganda function of stressing the authority, charity or moral rectitude of hospital work'[5]. But the Foundling Hospital further laid down two important principles. First, they refused to apply any of the charitable contributions for decorative purposes, and relied on the generosity of artists and donors. Next, they insisted that works of art were to be seen and enjoyed by the needy; thus the full-length portraits were removed to the girls' dining room in 1756 and only smaller works put into offices. Thirdly, they looked after their

paintings – 'Resolved that all the Pictures which are or shall be put up in this Hospital for the Preservation thereof shall be lined with Boards' (1746). Finally, they appreciated that all works of art need conservation, and appointed Benjamin West as Honorary Curator.

Guy's

Thomas Guy had been Governor of St Thomas' Hospital from 1704. Noting that it and most other hospitals would not admit incurables, he built and endowed what is now Guy's Hospital across the street. On the courtyard facade sculptor John Bacon carved *Asklepios and Hygeia*, semi-recumbent patients, a pelican standing by a woman holding a swaddled child, blood-letting, a child holding a leech, a tourniquet and a scarificator. His 1779 monument of Thomas Guy in the chapel shows the would-be saintly Guy in contemporary dress grasping with his left hand the outstretched arm of a half-naked patient; Guy's right hand points to the ever-open welcoming doors of his hospital, to which stretcher-bearers carry another patient.

St Thomas'

The original St Thomas' in Borough High Street in Southwark had five statues by Thomas Cartwright. Edward VI (1682) has been re-sited outside the new hospital, together with a baroque Edward VI (Scheemakers 1737) and Lord Mayor Robert Clayton (Grinling Gibbons 1701–2). The four other Cartwright figures, two male and two female cripples, are in the new entrance hall.

19th and early 20th century hospitals in England

Guy's and Bart's both had beautiful old chapels, and in the 19th century other London teaching hospitals such as St Thomas', Middlesex and Great Ormond Street built lavishly decorated chapels, often with biblical scenes of healing, such as *Moses in the Wilderness Holding the Brazen Serpent* (Guy's 1858).

The Victorians conceived the idea that the lives of patients in hospitals and institutions should be made fuller and happier by pictures, plants and decorations, and there are ample illustrations and photographs of the wards of general hospitals and of mental hospitals (both private and

public asylums) showing that these concepts, discussed at length in books on hospital architecture[6], met widespread acceptance. One particular decorative feature was the use of tile paintings, especially in children's wards. Many of these have been researched, rediscovered and rescued by John Greene[7] and many of them re-sited in hospitals, for example the new Charing Cross and St Thomas'.

One of the governors at the Middlesex Hospital, and later its vice-president, was Sir Edmund Davies, a South African financier and patron of contemporary artists. He gave one collection to the South African National Gallery, Cape Town, and another to the Luxembourg Palace in Paris. In 1910 he commissioned from Frederick Cayley Robinson four vast (16 by 10 feet) oils for the front hall, with two scenes of *Orphans* (1915) flanking the central doors to the board room (which Davies panelled) and two scenes depicting *Doctors;* on the west wall he painted an *Ancient Temple of Healing* (1916) and on the east (1920) *Wounded Soldiers* in the hospital uniform of the First World War. When the Middlesex was demolished in 1930, the panels were taken down, and re-sited in 1935 in recesses in the front hall of the new hospital[8]. (This was the hospital where I spent almost 15 years.) Two further commissions for murals for hospitals in London were unsuccessful[9].

Fifty years of dismissal

After the 1910 Middlesex commission, little or no art was placed in hospitals in Europe due to changes in architectural fashion. One of the wisest of presidents of the Royal College of Physicians, Sir Robert Hutchison, advised doctors about this time, 'Don't be faddy ... beware of the stunts of the moment ... avitaminosis ... focal sepsis ... disturbance of endocrine balance ...'[10]. The architectural fad was exemplified by Auguste Perrier: 'Decoration always hides an error in construction' and by his pupil Le Corbusier: 'A house is a machine for living in ... it is the wall which is the work of art'[11].

Another element in the dismissal of art from architecture may have been the then fashionable dogma that Romanesque and Gothic cathedrals and Greek temples and their sculptures were all white, a belief reinforced for

both teachers and students by the beautiful black and white photographs of these structures appearing in illustrated textbooks. In fact, all these buildings and sculptures were beautifully coloured but the myths of the 1920s persisted until the 1960s, and for many decades hospitals, wards and patients had to suffer environments in which colour and decoration were taboo.

North America

The great hospitals of North America did not share this architectural fad. For example, the successive buildings of the Mayo Clinic in Rochester, Minnesota, have incorporated artwork and the 1928 Plummer Building there has magnificent bronze entrance doors showing the *Occupations of the People of Minnesota*. The grandeur and visible costliness of the clinic, comparable with that of a theatre, opera house or picture palace, to some extent reassured prospective patients about its high-quality medical care.

The Mayo Clinic has continued to be beautiful throughout the century, whether one enters from the splendid car park and proceeds along the multicolour subways with their restful waiting area and pictures (and with a view to the outside gardens and the Barbara Hepworth sculpture), or whether one enters the main lobby with Agam's rotating multicoloured *Welcome*. On each floor there are large tapestries of *The Seasons*, the clinic walls are studded with paintings and prints, and the ceilings and play areas are provided with mobiles.

The New Deal murals[12] were based on a long tradition dating from the 18th century of monumental murals in state capitals, museums, courthouses and clubs that culminated in the early 1930s with the Regionalists such as Thomas Hart Benton, and the arrival of the socially conscious Mexican muralists Diego Rivera, José Orozco and David Siqueiros; however, neither group painted in hospitals in the USA.

In 1933 President Roosevelt was persuaded to support a scheme for murals in public buildings. The Public Works of Art Project at the Treasury was funded by Harry Hopkins' Civil Works Administration (CWA) to provide work relief for 4,000 destitute artists. In 1934 the

Treasury Department's section of painting and sculpture was funded by 1 per cent of the appropriation for new government buildings.

CWA was succeeded in 1935 by the Works Progress Administration, the Federal Arts Project and the Treasury Relief Art Project to pay for mural projects in old and new government buildings. These four projects sponsored over 4,000 murals, 200 of which were in New York City, and many of these were in hospitals[13]. Some were semi-abstract, some didactic like William Palmer's panels of *The History of Medicine* (Queen's Hospital, 1938), and many were in children's hospitals, such as Abraham Champanier's *Alice in Wonderland in NYC* (Gouverneur Hospital, 1940)[15].

This 1 per cent for art system exists today in many states of the USA and also in Europe and, as a principle, was accepted in New York in 1965; from 1982 five of the newest city hospitals received municipal funds for the arts, including Woodhull in Brooklyn and Bellevue Hospital. Of the great voluntary hospitals in the city, New York Hospital has a major art programme which includes not only thousands of paintings but also four 'art carts', one for photographs, one for paintings and two for art for children; these are taken round by volunteer 'picture ladies' so that patients can choose and change the pictures in their rooms.

Several other organisations have tried to humanise public buildings in the USA. Thus the New York State psychiatric centre on Ward's Island has had its institutional gloom alleviated by two contrasting aesthetic philosophies. Artists Representing Environmental Art (AREA) champion large-scale, on-site works of art, whereas the Margaret Gate Institute humanises institutions, especially hospitals, by the use of light and colour.

Hospitals' Audiences Incorporated improves access to the arts for disabled people by placing art in institutions and also by taking people who are institutionalised to the arts. Many of the bigger new hospitals throughout the USA and Canada, whether state, city, private or federal, have planned artwork in the early stages of building these new hospitals, and have appointed curators and committees to preserve, conserve and acquire new art for them.

None of the New Deal hospital murals had any political content, but Rivera introduced revolutionary motifs (now obliterated) into the Rockefeller Center, New York. However, when he returned to Mexico he painted not only giant murals of the history of cardiology for the National Institute in Mexico City, but also blatant political propaganda in a hospital (De la Ruz) with *The People's Demand for Better Health* (1953), which contrasted modern, scientific and technologically advanced treatment for the rich with the primitive medicine available for the poor.

In Canada I have been impressed by the ready acceptance and finance of art in hospitals: in Ontario I admired McMaster in Hamilton[16], the old and new Victoria hospitals in London, and the General and Sinai hospitals in Toronto. In British Columbia I enjoyed its University Hospital in Vancouver, and in Alberta I was overwhelmed by the art in the new Mackenzie Health Sciences Centre[17].

Worldwide

Other notable new art-improved hospitals are the Parramatta Hospital, Westmead Centre, near Sydney in New South Wales (1975–9), and the University Hospitals in Jerusalem, with a large Lipchitz sculpture at the Scopus campus and *The Twelve Tribes of Israel* windows by Marc Chagall in the synagogue of the Ein Kerem campus. In Marburg, Germany, we know from the 1598 Elseimer painting that St Elizabeth visited the sick in hospital there; today's magnificent new University Hospital had 1 per cent for art and used it wisely[18]. The Academisch Ziekenhuis at the University of Amsterdam cost £230 million in 1974 with half a million of it for the arts: the didactic theme of post-war movements in the arts in The Netherlands puts each movement, from Zero to Neo-Expressionism, in a separate unit and there are about 5,000 pictures with a full-time curator[19].

The London scene

The half century of decorative blight in English hospitals was ended by Sheridan Russell, formerly head almoner at the National Hospital for Nervous Diseases, Queen Square, in London. In 1947 he borrowed from Vera Cuningham one of her paintings for the hall of his department and

with stealth, against all opposition from the hospital administration, borrowed more paintings from artists, friends and galleries and the Contemporary Art Society.

In 1959 Paintings in Hospitals was founded, which now has 1,500 contemporary British paintings which it lends by rotation to hospitals throughout the UK, with satellite schemes in the west of England, Northern Ireland and Scotland.

Some of the London teaching hospitals have used endowment funds for art programmes in recent years. Eugene Rosenberg, architect of the new St Thomas', was one of the first late-20th century British architects actively to want works of art in his buildings[20]. St Thomas' now has an extensive collection of contemporary prints; it commissioned Robyn Denny's *St Thomas' Enamels* and borrowed from the Tate Gallery their stainless steel construction (1972–3) of Naum Gabo's 1929–37 design, *Torsion*. This rotating water sculpture spurts jets from the outer edges of diagonal ribs, and looks superb against the background of Big Ben and the Houses of Parliament; it has recently been restored, and is wonderful.

Similarly, the new Charing Cross Hospital (1968–72) has a whole range of art: a large *Reclining Figure* by Henry Moore (a friend of the architect Ralph Tubbs), similarly on loan from the Tate, is in an ornamental pool in front of the hospital.

In the 1960s the Metropolitan Regional Hospital Boards (later succeeded by regional health authorities), responsible for hospital building in the Home Counties, rarely included works of art in their new hospitals. However, the occasional Department of Health & Social Security (DHSS) scheme did encourage art; for example, in 1967 the architect A J Noakes commissioned from potter Phillippa Threlfall a 60-foot long mural on a concrete screen wall of the day-nursery playground of the new Greenwich Hospital. The organisation Shape specialises in providing art for disabled people and has commissioned works in London hospitals such as Bethnal Green, the Royal Marsden and the South Western.

The King's Fund/Greater London Association of the Arts Council scheme

There have been two determined efforts this century to commission murals for London hospitals. The 1911–12 scheme involving D S McColl, Charles Aitken, Roger Fry, Vanessa Bell, Wyndham Lewis, Frederick Etchells and Duncan Grant failed[9]: the other survives.

For 15 years I was a student and doctor at the Middlesex and knew that a hospital did not need to be gloomy and ugly. I was aware that various hospitals in London and elsewhere in England already had their own schemes, but there was a need for a central initiative to brighten with pictures the other dreary buildings of the NHS. In 1979 I approached Sir Patrick Nairne, then Permanent Secretary of the DHSS, and Sir Francis Avery Jones, then Deputy Chairman of the King Edward's Hospital Fund for London.

The following year the King's Fund agreed to finance, jointly with the Greater London Association of the Arts Council (GLAA), a scheme to commission young artists to paint murals in Greater London. My initiative coincided with a change in policy of the Arts Council to finance art in public places and with artists themselves wanting to work again in community environments such as hospitals; this included, for example, Peter Senior and his Manchester Arts Project[21].

St Charles'

At the time I was a consultant at St Charles' Hospital, North Kensington, a typical 1881 workhouse infirmary for the sick poor. I arranged to form a beautification committee there; this was in 1978. In 1980 we were the first to put in a request to the new King's Fund scheme which led to the 1981 Michael Ginsborg abstract murals in the entrance foyer, another in 1984 in the front hall, and figurative murals by Judith Francis in the Visitors' Suite[22]. The whole hospital was then visually refurbished over the next 12 years with a Munsell system colour scheme for the main corridors, replacement of NHS lettering everywhere by Times Roman, murals by Stephen Selwyn in the outpatient corridor, X-ray department and the stairs to the children's wards, a tapestry and re-

hung stained glass for the chapel, murals from the Foundation for Hospital Art, Atlanta, Georgia, and installation of Tam Giles' *Spiral Fountain* of 1990. The new mental health units were opened in 1985 with their own separate arts committee.

In the last 18 years the King's Fund scheme has commissioned, in collaboration first with the GLAA and now with the Public Art Development Trust (which will be described later by Michaela Crimmin), works of art in dozens of hospitals, including Western, Royal Brompton, Colindale, Newham, Central Middlesex, Charing Cross, Graham Park, Hillingdon, Homerton, the Royal London, Maudsley, Northwick Park, Queen Mary's Roehampton, Royal Free, St George's, St Helier's, St Stephen's, St Thomas' and Westminster.

St Mary's and the Hammersmith

After years of nagging I eventually persuaded my other two hospitals to found committees to encourage the arts, St Mary's in 1985, its medical school in 1990, and in 1986 Hammersmith Hospital, the Royal Postgraduate Medical School and the Medical Research Council (MRC) Unit formed a single committee[23]. Both the St Mary's and Hammersmith committees commissioned new works of art for the new wings and tried to improve the visual environment of the old buildings.

At St Mary's there are now paintings by Bridget Riley in corridors on two of the floors. At Hammersmith we were keen on water sculptures by William Pye in a roof garden which we constructed in a round courtyard upon the top where surgical patients could see it. It is a matter of getting your window-sills low enough to enable a patient in a bed to look out and see what is there. People can sit in the garden there, and it is also visible to those walking in the corridor behind. Hammersmith Hospital, like most of the hospitals I have ever worked in, was originally a slum workhouse where the women worked at sewing and the men had to break granite stones for street paving as a condition of their stay. A large rock remaining from that period has been incorporated by Jeremy Shrecker to produce a Zen-like water garden as commemoration of that aspect.

The forecourt of the Hammersmith Hospital was redecorated and then the Art Committee, which I chair, commissioned this cycle of life to honour the obstetric department, particularly Lord Winston's IVF, and it is covered with inscriptions of sperm over chromosome mitochondria and so on by Sarah Tombs (1993). In the entrance of St Mary's Medical School we have two murals facing each other. On the right are two great men of St Mary's, Alexander Fleming who (like Rodney Porter) won the Nobel Prize, and Professor Waller, who discovered the ECG. An entirely different technique was used by Jacqueline Visby for the opposite mural, which celebrates the social life of the students and depicts rugby, rowing and other sports.

Most recently there have been major developments at the Chelsea and Westminster Hospital which opened in 1993; here, contemporary works by artists such as Allen Jones, Patrick Heron and Maggi Hambling combine with the glorious *Resurrection* by Veronese from the late 16th century. In addition, there is a mural which was done for St Stephen's by Faye Carey which is a *trompe l'oeil*: there is the pretence that you are looking out of the window through the curtains into your garden. Adapted and enlarged, it is now housed in the dining room.

The Homerton is another new hospital where the art was planned holistically to include the architecture, signage and symbols. One of the many fine works installed there is a wooden structure which represents books.

Gardens, too, feature in this resurgence of art as therapy. St Bernard mentions a quotation from the *Song of Songs* that refers to invalid eyes, ears and nostrils drinking like colours of songs and perfumes. Accordingly, many old and new hospitals have concentrated rightly on gardens. One at the Dorchester Hospital in Dorset contains a waterfall by Hamish Horsley in local Portland stone. The Prince of Wales visited this garden and pointed out that the sound of running water can sometimes be healing in itself.

Another new hospital with a major commitment to the use of art is St Mary's on the Isle of Wight. This is sited in a particularly attractive setting.

Some national and international initiatives

The DHSS was responsible for the standards of hospital buildings throughout England and Wales, even though it rarely built hospitals itself, and its advice to planners was contained in a series of Health Building Notes covering all aspects of design and construction. In 1988 the DHSS revised Health Building Note 1, which gives general guidance. I was able to persuade them at the time to emphasise in this Note that hospital buildings should be 'beautiful as well as functional ... attractive visually, both internally and externally, in all aspects of design ... works of art enhance ... health buildings: their provision should be incorporated into the architect's brief and the scheme budget'[24].

More and more hospitals in England set up arts projects and arts committees throughout the 1970s and 1980s. I therefore conceived and established, in 1989, British Health Care Arts (BHCA) as a national organisation to develop the arts in health buildings; its credo was that art in hospitals should be appropriate to engage an audience and should celebrate the locality. It worked with health authorities and NHS trusts to introduce art and craft works into hospitals, and advised the Department of Health and its NHS Management Executive and Estates on demonstration projects in ten outpatient and six accident and emergency departments throughout the country.

The Director of the BHCA, Malcolm Miles, and I as Chairman tried to spread the arts message nationally and internationally[25] and for three years we awarded the Astra prize for the best art in hospitals, especially in mental hospitals, and produced publications and exhibitions. In Dunfermline in Scotland there is the Queen Margaret Hospital, which had some lovely new stained glass by Shona McGuiness installed in 1993, depicting the old and new. At the Florence Day Hospital in Glasgow, *Men in the War* won the Astra arts prize for mental hospitals in 1994.

BHCA was subsequently re-structured as a new organisation, Healthcare Arts. In England, Healthcare Arts operates under the auspices of Capital Solutions at the General Infirmary in Leeds, with a satellite office in London; Healthcare Arts in Dundee covers Scotland and Northern Ireland.

The many hospital art schemes in the USA have been encouraged to form a Society of Healthcare Arts Administrators (now the Society for Arts in Healthcare) which holds an annual conference to further these ideas and to educate, research and publicise in this field.

Art and anti-art

In this field there is both action and reaction. Until fairly recently the stimulus for beautiful hospitals came from influential individuals, rulers, administrators or chancellors, as it had in the Renaissance. More recently, it has come from architects or artists, doctors or health care workers, and sometimes from outside the hospital from a local authority or pressure group, and we at British Healthcare Arts have received active support from the Department of Health and many regional and district health authorities. Thus in 1991 Stephen Dorrell, then Parliamentary Under-Secretary of State for Health, emphasised that 'asking patients to wait on hard seats in a corridor with a draught is unacceptable. It is a bad tradition in this country that in the public services we can live in squalor'[26].

There is also intense opposition to art in hospitals. Part of the reason for this is class. From the 15th (Beaune) to the 17th (Toledo) centuries new hospitals took both the rich and the poor, with the intention that sumptuous embellishment would inspire charitable activity. Although the 18th century reformers also wanted the poor to receive health care, they were to be segregated from the rich: there was to be no lavishness. Thus in France: 'Hospitals should be built solidly but simply. Buildings destined for the poor should convey something of poverty ... too much beauty in a house will curtail the interest of the charitable ... the poor must be lodged with the poor. Much cleanliness and convenience, but no splendour'[27]. 'Hospitals must not be made too comfortable as the poor would ... then be too fond of having recourse to them'.

Certainly in Scotland, whether from thrift or Calvinism, hospitals were even grimmer. Indeed, I do not know of any art placed in Scottish hospitals until the last quarter of this century. W E Henley, a patient of Lister in the Edinburgh Royal Infirmary, made the point:

A tragic meanness seems to environ
These corridors and stairs of stone and iron
Cold, naked, clean – half-workhouse and half-jail[28]

Florence Nightingale had no doubt where the problem lay: 'The weary Treasury is the root of all evil'. But it is not just a question of money: as fast as art is praised and installed, the forces of anti-art marshal themselves against it.

Whether commissioned or donated, art may still be rejected. Thus Jefferson Medical College commissioned from Thomas Eakins in 1899 a portrait of their Dean, Dr James Holland, but rejected it because the subject looked 'too tired and careworn', a quality which today we would expect in a successful Dean. In 1952 Ancoats Hospital commissioned L S Lowry to paint the outpatients' hall, but later gave the picture to the local art gallery rather than continue to hang this consummate '[rendering of an] acute sense of isolation assailing each of the patients assembled in this gloomy interior'[29].

Too many of today's hospitals, like some universities, colleges and local authorities, sell off their works of art. Large sums of money have been raised in this way: for example, £95,000 for a Batoni[30] and £51,000 for three paintings by Ernest Norman and one by his wife[31].

In 1989 a health authority sought donations from the public to buy 40 paintings for its hospitals 'at a time when there was a nationwide drive to bring art into hospitals'. With the NHS reforms, however, the successor health authority in 1993 sold the lot: ' ... the paintings were probably bought to enhance the environment, but now the view is that the money could be better spent ... I would rather look at photographs of things that are going on now, patients and staff would, too'[32].

When new ministers first arrive in their departments (or new ambassadors move into their embassies), they are determined to make their mark and create a forceful impression among the staff: 'Who chose these pictures?' 'Your predecessor, Minister.' 'Get rid of them.' So, too, health service reforms bring forth new chiefs, some of whom wish to

create beautiful hospitals, while others immediately tear out the works of art in order to prove that the new NHS is friendly to its customers, a claim it strives to confirm with decorator chic. Or unremovable murals can simply be painted over with whitewash.

When neither sale, nor removal nor obliteration is practical the art can be degraded, as were Epstein's 18 sculptures carved in 1907 on the BMA building in the Strand. Southern Rhodesia acquired the building in 1935 and tried to remove the statues, but finding that impossible, mutilated them permanently in 1937[33]. Elsewhere, at a university hospital, a door was built in the middle of a wall-painting, and in another, a mural of *Bathers* in a nurses' swimming pool worried the general manager who feared for its effect on the parents of 17-year-old girls considering training there. He asked for smaller, lighter genitals, but was not satisfied with them and ordered the mural to be whitewashed over[34].

One famous mental hospital, Springfield, opened in 1841 and acquired a collection of hundreds of pictures and prints to decorate its walls, many given by famous London dealers such as Agnew's and Colnaghi[35]. In 1948 came the NHS: the chairman of the new hospital management committee got rid of the padded cells, opened the locked wards and had every picture in the hospital removed and burnt in batches until none was left.

Envoi

For over 650 years it has been accepted, first in Europe and now worldwide, that hospitals can and should be made beautiful buildings. Installing art is valuable and I do not agree with those in authority who prevent or halt beautification of their hospitals and who remove, degrade, destroy or sell off their works of art.

In the cathedral of St John the Divine, still rising amid the squalor of Upper West Side, New York, an inscription with the words of Camus captures the dilemma of trying to allot resources to both patients and to art: 'In this world there is beauty and there are the humiliated and we must strive, hard as it is, not to be unfaithful either to the one or to the other'.

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needs of clients & patients in hospital buildings

ANN NOBLE

Recently I spent several hours on a bus journey while the passenger next to me recounted in great detail his several stays in hospital. Although apparently not life-threatening or medically very serious, they were obviously important to him. When I asked him why this was so, his response was, 'Well, being in hospital makes you think, and you have plenty of time to do so'.

Patients go to hospitals for diagnosis, for treatment and for nursing care. They may be cured, they may die, or they may have to learn to live with pain, disability or uncertainty. Inevitably, therefore, hospitals are places which encompass more than the provision of medical and nursing facilities: they are places where people address the fundamental issues of sickness and health, suffering and well-being, life and death. In more secular societies, perhaps this is the only place where many of us come to address these issues.

Therefore, in order to set a context for this conference, it seems right to focus on patients and some of their needs, to look at the ways in which hospitals meet or fail to meet these needs, to consider the complex ways in which hospitals work, and to look at how hospital buildings affect all of these things.

Any sense of wholeness in the treatment of patients can only be achieved by the integration of their spiritual, psychological, social and cultural needs with their requirements for medical and nursing attention.

One of a series of historical prints and engravings displayed in the colonnades of the Hotel Dieu Hospital in Paris, a 16th-century view of the building, illustrates the varied and complex functions of a hospital. It shows care of the patients carried out by the religious nursing sisters whose service is dedicated to God. The altar at the end of the ward provides a focus both for their work and for the patients in their suffering, their will to recover or their acceptance of death. On the right, the patients are served food, and on the left the priest offers spiritual comfort with the sacrament. The sisters at the front of the installation wrap the dead for burial and, in the centre, Louis XII, the royal patron of the hospital, prays, interceding for their souls.

Religion-based hospitals such as the Hotel Dieu were very clear about their purpose, and the form and content of their buildings generally expressed this. The image projected by more recent hospital buildings is less clear and often confusing; some look like laboratories, some like offices, some like shopping malls and some like airports. The relationship to the human scale can be very daunting and, from the outside, their promise of meeting patients' needs seems unlikely.

The predominant emotion experienced by patients in hospital is fear. It is fundamental in meeting patients' needs that their fears should be recognised and alleviated. All patients in hospital are frightened and apprehensive, frightened of pain, of the unknown, of being out of control of their own lives, of not being able to retain their personal dignity, of being forgotten by staff, of not knowing what is happening, and of dying. This is so fundamental that all hospital briefs need to address this as a top priority.

The second example comes from a comparative study of different ward designs within St Thomas' Hospital in London. St Thomas' Hospital was built between 1868 and 1878 with a series of pavilions stretching towards the River Thames. During the war much of the hospital was damaged and subsequent rebuilding included two new ward blocks, one completed in the 1960s and one in the mid-1970s.

In 1976, acutely ill patients were being nursed in three differently designed wards, the earliest being the pavilions of Nightingale open wards built more than a hundred years previously, old-fashioned and waiting to be replaced, and the most recent a bright and cheerful tower block with a mixture of single, four- and six-bedded rooms with a good provision of bathrooms and other ancillary spaces. Since patients, staff and hospital policies were very similar in each, an ideal opportunity was available to study the effect of different ward designs on patients and staff. The surprise finding was that the overall level of satisfaction of patients, nurses and doctors was significantly higher in the older wards.

Again, the reasons for this were complex, but much of the explanation lay in immeasurable, intangible requirements that were met in the large older open wards but not in the new ones. Patients could see nurses at all times, could see when other patients had gone to use the bathrooms, could see what was going on and decide how much contact they wanted with other patients, and could offer each other comfort and support. Nurses could see patients as well as their colleagues as they moved about their tasks. Observation, control and management were effortless. Patients could see when nurses were busy and nurses could see when patients needed attention or junior nurses needed support.

In the new wards, patients could not normally see a nurse, but had to call for one; this meant that some of them were too worried to do so and others called non-stop. Patients could not see whether WCs or bathrooms were in use without leaving their bedrooms and walking to them. When those with limited mobility found the toilets occupied, they were unhappy even though there was a generous provision of sanitary facilities on the ward. Patients could not see, and so did not know, what was going on in the world outside their bedroom. In addition, they were placed in intimate social contact with other patients in their room and

had, therefore, less privacy than in the large wards. Staff felt less in control and could not see what was going on without walking and opening doors. They found it harder to know when help was needed or to prevent problems such as patients falling down. The amenities were excellent, the decor good and the space generous, but a lot of important elements had been lost.

The experience of interviewers conducting interviews with patients was also informative. On large open wards this was very straightforward, but in the four- and six-bedded rooms it was less easy since patients were inhibited by the presence of other patients who could hear every word; and for patients in single rooms, three times as long had to be allowed for each interview because they so valued company and the opportunity to talk.

Having shown how complicated the working of hospitals can be, I want to return to the question of how hospitals can provide a healthy and health-promoting environment for patients. Making beautiful buildings, which are visually well proportioned and lift the spirits, is a good start. Definitions of beauty can vary but few people find their spirits lifted in a corridor with low ceilings and fluorescent lights but they might be when passing through arcades with curved, painted ceilings with views of trees and gardens.

There is a consensus, both historically and empirically, that certain elements are essential for providing a therapeutic environment. The importance attached to the introduction of sunshine and fresh air is illustrated in the design of the Pioneer Health Centre at Peckham, South London, in 1936, and in the provision of solaria at Soder Hospital in Stockholm. Balconies and verandas for patients were a common feature in the past and, in hospitals where these are now used for storing unwanted equipment, patients often choose to sit out in the sunshine amid the grime and clutter.

Another essential element is to offer patients the opportunity to look out of a window at something attractive. One patient interview survey was dominated by the patients' interest in the progress of a pregnant mare, the birth of her foal and its subsequent progress in the field next to the hospital.

But there was also increasing criticism that art was being placed everywhere one turned, using the environment itself as an extended gallery. Many community murals became symbols of urban decay and many abstract sculptures became indicators that the squares in which they were placed were *not* actually owned by forward-thinking magnates.

In addition, artists who were not being approached in a professional way understandably began once more to retreat to the white sanctuary of a gallery, as their public sculptures rusted or were physically abused. They had also been asked to solve every conceivable problem along the way (and still are). Would they make sculpture in public so that people could see the process? Would they do related workshops for eight-year-olds? Would they link up with the community? Would they help with marketing and sponsorship drives? Would they solve architectural problems which no one else could? Would they make a work which provided an identity for a place? The expectations became, and often still are, ridiculous.

Public Art Development Trust

In the wake of some extraordinary public art projects in the USA and Europe, Public Art Development Trust (PADT) was set up to find a place for art in the cultural fabric of everyday life. The organisation was established by Lesley Greene in 1983, with a grant from the Gulbenkian Foundation, to act as an intermediary and facilitator between artists, people and organisations wanting to commission artwork. PADT is a limited company and registered charity. The Trust works with national, regional and local bodies in the public and private sectors to develop strategies which make art an indispensable part of the public realm. To this end, the Trust initiates projects and enables artists to expand the role and form of public art.

PADT continues to operate in three specific areas:

- *research and development:* placing the Trust's work within the context of contemporary art practice and pursuing new situations for public art
- *commissions of new work:* enabling innovative commissions of art and acting as advocate for both artist and public/private partners

– *information and education:* expanding the ways that art is experienced and encouraging the public to broaden their understanding of art.

We work with a wide range of agencies but the Art in Hospitals programme has always been a fundamental part of the organisation and is of paramount importance. From the very beginning we worked with the King's Fund. To date, the scheme operates exclusively in London's NHS hospitals, although the Art in Hospitals Forum, to which it has been closely linked, includes participants from hospitals outside London.

The scheme works with visual artists, although if an appointed artist wishes to work in complementary media, or in collaboration with artists using other forms (such as music), this would be acceptable.

The Art in Hospitals scheme has been continuously funded since 1985 by the King's Fund, with additional support from London Arts Board (the regional channel for Arts Council funding).

The King's Fund seeks to promote good practice and innovation in all aspects of health care. The grant given in support of arts and health work in most recent years represents around 5 per cent of the Main Grants programme funds of some £2 million. This work fits with the King's Fund's priorities and objectives. In the words of Robert J Maxwell, the Fund's former Secretary and Chief Executive:

> *Part of the quaintness of the King's Fund, but also part of its strength, is that it displays a range of characteristics which sit oddly together. It is an establishment body that tries to think radically and listen to people whose voices are often ignored, yet ought to be heard. It seeks a balance between professional expertise, the individual patient and the public interest. It attempts to work with those in power and say things that they sometimes do not wish to hear.*

Current Art in Hospitals Scheme

With the appointment of a new director – Sandra Percival – at PADT, the Art in Hospitals programme slightly shifted focus. We wanted to pursue an earlier project – Hannah Collins' *Shelf-situation-shrine* –

So how do we cope with fear? Patients need to have complete confidence that they are receiving the right treatment, and are in the care of good, knowledgeable staff. For all patients this is crucial and for some it is sufficient. Patients need to have complete confidence that the system works as it should: for example, that medical records and test results are available at the right time for the people making decisions about them, and that information pertaining to them is passed among staff. Too frequently, patients not only fail to receive this reassurance but have definite evidence that the system is not working.

Not knowing what to expect, or what is expected of you, or what is going on, is frightening. One of the advantages of large open wards is that patients know what is going on. They know where the nurses are. Much information is available without having to ask. Other patients and domestic staff are prime sources of information. Many patients feel less diffident about asking them rather than the 'busy' nurses and doctors. In fact, in one study it was found that the introduction of carpets on a ward, while enhancing its comfort and appearance, unwittingly eliminated conversations between cleaning staff and patients because of the noise of the vacuum cleaners; this was regretted by both sides, because of the loss of information for the patients and a reduction in job satisfaction for the domestic staff.

Fear of pain is difficult to assuage and the best that can be offered is an environment where it is possible to talk about this to staff. Sometimes the experiences of other patients can help. The ways of dealing with or reacting to pain are factors that can differ dramatically between patients from different cultures, some offering a stiff upper lip and concealing it, while others give full vocal expression. To control pain, some people look only to external interventions but others seek to increase tolerance from within themselves.

In hospitals founded by the early Christian orders there was an essential recognition of, and provision for, both the physical and spiritual needs of patients. The fear of dying, or learning to accept incurable and painful conditions, is rarely addressed by cultures which do not have a strong religious foundation. There are a large number of hospitals with religious

symbols on the walls and some of the older ones still have proper chapels incorporated into the building itself, but most recent hospitals have minimal provision, often just a room off a corridor with the word 'Chapel' on the door.

The hospice movement is a response to the failure of mainstream hospitals to meet the needs of terminally ill people and their families and there are many wider lessons that can be learned from them. The fear, and for some, the likelihood, of dying are very real and ever-present in all hospitals; yet requirements which are fundamental to the design of hospices – such as surroundings which are reassuring, and inspiring, with views and sunshine – are either totally absent from modern hospitals or are regarded as no more than optional extras.

The value of and the need to provide a therapeutic environment in hospitals are surely axiomatic but the best way of achieving them is less clear. One reason for this is the complexity of interactions between patients, staff and the building. The effect of the carpet on valuable conversations quoted above offered one example; since I believe that anyone seeking to satisfy patients' needs should have an understanding of the complexity of these interactions, let me offer two more examples by way of illustration.

The first example, which was reported at a seminar on ward design, relates to a geriatric ward in a large hospital which was in serious need of maintenance and very grim. One day the ceiling began to collapse, so the patients and staff were moved to the only other suitable accommodation elsewhere in the building which was a recently completed, but not yet occupied, unit for young people with chronic disabilities. The result was dramatic. An incontinence rate of over 90 per cent dropped almost to zero and a number of patients who had never been expected to return to their homes recovered enough to do so. All sorts of explanations have been offered: the improved environment; the more domestic nature of the ward; a carpet on the floor; easy access to bathrooms; aids to facilitate mobility; the high increase in staff morale; families and doctors responding differently to the patients in the improved surroundings; or simply the disruption caused by the change. Most likely it was a combination of them all.

A survey carried out by Roger Ulrich attempted to measure things that would usually be considered intangible.[1] The question this should pose for people who fund and build hospitals is not 'Has Professor Ulrich shown it to be so?' but 'Why, when everyone agrees that a room with a view is more desirable than one without, does this require scientific justification before it is provided?' The therapeutic value of sites with views and space, away from the noise and dirt of cities, has long been recognised.

The final element of a therapeutic environment is the value of access to gardens, plants and flowers; to be able to enjoy them and the benefits derived from contact with nature and things that grow. Gardens come in all shapes and sizes. St Mary's Hospital on the Isle of Wight, the Scuola di San Marco Hospital in Venice and the walled garden of the Hospitum of the Capuchins in Athens (circa 1771) offer examples of different hospital gardens.

It seems extraordinary that it is necessary to draw attention to such things as desirable components of a therapeutic environment, but it is not unusual to find hospitals on sites which could offer good views for patients, but where the rooms face inwards towards internal atria in which real or artificial plants are used to simulate a garden. It would be good if the all-too-frequent request in a design brief for something bright, cheerful and domestic were replaced by an instruction to provide sunlight, fresh air, rooms with desirable views and access to gardens for all patients.

To finish on a more optimistic note I should like to show off two health buildings which made a conscious attempt to meet the needs of patients and staff at many levels. The first is the Fairfield Centre in Charlton, South London, which opened in 1996. This is a health centre which combines a large GP practice with a number of community health services. The building sits in a garden and most of the rooms look out on to it. There is a pond near the entrance, which can be enjoyed from within the waiting area and throws patterns of light on the walls. The whole building is calm, light and airy. According to patients, they now dress differently to come to the 'new' building, and behave differently inside it. The combination of the building and the way it is managed has generated a feeling of community ownership which people enjoy. New

services have developed and a therapy garden is planned. A point of particular interest to this conference is that a number of artworks for the centre were commissioned from Roehampton Institute art students as part of their course. The collaboration of doctors, architects and artists proved both stimulating and productive.

The second building is the Sathya Sai Institute of Higher Medical Sciences in India, which opened in 1991. A tertiary hospital specialising in cardiology, urology and neurology, it is located in rural central India, near Bangalore. It has been built to provide free health care by Sri Sathya Sai Baba, a holy man whose Whitefield ashram is nearby. The architects and design team were English, and Keith Critchlow, who led the design team, was selected because of his knowledge of sacred architecture and geometry. The hospital is based on the concept of treating mind, body and spirit and the form of the building expresses this underlying concept. Its curved shape expresses welcome and protection for patients, and at the same time offers views from the wards across gardens to the domes and colonnades of the hospital. Symbols of faith and inspiration, which help patients understand the goal of life, are incorporated in the design. Perhaps it is easier to achieve such things in a country like India, where people have a particularly clear understanding of their own culture, than in other countries.

Despite the emphasis that is placed on meeting patient needs, designs for health buildings which consciously try to take account of these at all levels are still the exception rather than the rule and if things are to change, we need to understand why this is so. I suggest three possible causes. One is the nature of the client who specifies what is required of a building. For health buildings there is rarely a single client with a clear philosophy about the nature of the building under commission, but a committee with an assortment of concerns. A second is the widely held belief that if something is good or desirable it must cost more than something that is mundane, a belief which is unsupported by fact. Third, despite the abundance of lip service paid to the desirability of providing therapeutically beneficial environments, this is not always backed by strong convictions and sound understanding.

As a start, we can attempt to change matters by raising understanding of the issues and opportunities by people in general and by the commissioners of new hospitals in particular.

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the King's Fund /Public Art Development Trust Art in Hospitals scheme – recent work

MICHAELA CRIMMIN

Artists have played a part in the environment since time began and continue to do so now in many different cultures. But in Britain and in the western world generally, during this century, artists were pretty much absent from the public domain for a number of reasons, one factor being current trends in architecture. My intention is to talk about art and how artists can have a role outside a gallery or a museum.

In the late 1970s and 1980s there was a resurgence of interest in how artists might contribute to the urban and rural environment. Artists did make an impact – often with huge success: islands astonishingly wrapped in pink polypropylene by Christo; a sort of visible/literally invisible man in an American campus landscape by Jonathan Borofsky; Bruce Nauman stridently wrapping a building, the Vietnam War Memorial in Washington, where, by the time you reach the end of its sloping wall inscribed with all the names of the American lives lost, you know something more about the price paid in war.

undertaken for Colindale Hospital, which was rooted in the notion that patients are largely discouraged from hanging objects of real and personal value in their environment, and therefore Hannah Collins introduced the idea of a false museum. This was to be a museum full of photographed collections of objects and photographs taken directly from the private collections of staff and patients; these were borrowed for inclusion in the artwork and then returned to their owners. I visited 35 homes and discussed with the participants what they might contribute; objects varied from collections of bizarre key-rings to a miner's lamp, to a sewing-box filled with mementoes and artefacts.

The museum-shrine, intended for long-stay patients and staff, consists of seven colour transparencies mounted in light-boxes, which were installed at the end of 1995. I subsequently wished to borrow two of the pieces for an exhibition elsewhere but the hospital was strongly opposed to this, not wanting any of the work moved, even for a couple of months, which is presumably a compliment to the suitability of its present home.

In May 1994 PADT submitted an application to the King's Fund for a further three-year Art in Hospitals programme supported by evidence which had been gathered by them in the previous year through an extensive questionnaire survey on the role of art within London hospitals. The results showed a wide range of benefits recognised by those hospitals which had already taken part in artists' projects, and also revealed a growing interest from many other hospitals who sought to involve artists in various aspects of their activities.

There was clearly a need for the Art in Hospitals programme to continue. Of the 42 hospitals which responded, 35 (83 per cent) were actively interested in establishing or continuing with an artwork programme. The survey suggested a variety of possibilities, most particularly the commissioning of new artworks, artists working in residence, portable works, and publications.

The notion of portable works generated the most interest, being supported by over 75 per cent of the hospitals, and PADT therefore incorporated this into the development of the programme. There were many comments about the potential for using art more positively as an

educational tool for the benefit of staff and patients, to increase appreciation of art, engender creative awareness and even to inspire creativity. Involvement in an art programme was seen as a potential for empowerment of staff and rehabilitation of patients.

PADT therefore proposed some key initiatives to the King's Fund. The major focus of the application was to develop an art programme which encouraged artists and hospitals to enter into an extended dialogue in order to ensure that artwork developed from the social context as well as the physical environment of the hospital. A related intention was to facilitate artwork which could be reproduced, in order to extend the benefits to other hospitals. PADT also aimed to raise awareness of the experiences and benefits of involving artists in hospitals through a publication and through the Art in Hospitals Forum. The publication would relate specifically to PADT's art programme, be produced by PADT, and be distributed to a wide audience. It would illustrate work produced by artists for the scheme and include texts to amplify the work.

PADT proposed a continued involvement with the Art in Hospitals Forum, which was then in its fourth year. The Forum provides opportunities to meet and share information for hospital staff involved or interested in the arts in hospitals, as well as voluntary members of hospital art committees. The intention for the grant period was to extend the advocacy, training and educational role of the Forum. Following discussions, it was agreed to work on new projects in the art programme, on a publication and on the Forum, rather than spread the resources too sparingly and be unable to deliver or ensure demonstrable results.

The final budget approved by the King's Fund Grants Committee included a fee to PADT for the management of three artists' projects, the artists' fees, expenses and the production costs of their works, the production costs of the publication, a fee to the King's Fund co-ordinator, and a sum for Forum meetings and its related art commissions for host hospitals.

PADT recognised that there was scope for the scheme to become more innovative because of the growing number of individuals and organisations that could now offer the kind of advice that it had been

called upon to provide since its inception. After more than ten years in the field, PADT's familiarity with the use of art in different types of hospital setting meant it was well placed to develop new dimensions of the scheme.

The art programme

The art programme comprised three 'multiples' projects which PADT had initiated and wished to implement whereby three different artists would work in three separate hospitals which had not previously been involved in the scheme, each of them making work which could be have limited editions. A further project was developed with two artists working collaboratively on a touring art scheme.

The artists participating in the multiples project were: Catherine Yass at Springfield Psychiatric Hospital in South London; Zarina Bhimji at Charing Cross Hospital in West London and Tania Kovats, initially working with the Royal London Hospital in Whitechapel. This therefore fulfilled the objective of involving hospitals with diverse medical specialities.

Catherine Yass

Each artist was asked to help choose and then address a specific location. Catherine Yass immediately opted for a psychiatric institution and Springfield Hospital in Tooting Bec, south London, was chosen.

Catherine Yass is 34 years old, studied at the Slade and Goldsmiths, and also in Berlin. Her work is photographic and has been exhibited in Britain and abroad since 1984. It demonstrates a response to a particular place, and features people as a way of interpreting situations in a more general way. She was exemplary in her dealings with Springfield Hospital, and the quality of the relationship was reciprocated.

For an extended period prior to determining the form and content of the artwork, the artist was very closely engaged with people at different levels of the hospital structure as well as exploring other aspects of the institution; in particular, she was attracted to the archives, which were used to make a historical link in her work, and the architecture of the

Victorian buildings. The result was 14 light-boxes – six portraits of staff and patients, and eight photographs of the hospital architecture itself.

The dynamics between institutional and personal identity are central to Yass's work. She made a conscious decision to exclude the sitter (the artist is known for her portraits) in favour of what was originally intended merely as a backdrop in the eight architectural images. The background claims a higher significance than that which we would normally expect to find in the foreground; in so doing, Yass turned her own photographic practice inside-out, shifting our gaze away from the lens-pinned specimen to the immediate environment. Architectural interiors have a subliminal impact on the individual; none more so than the corridor, a transitory zone with a beginning and an end. It presents a picture embedded deep within the human psyche: it is the stuff of dreams and nightmares.

Catherine took the architecture as a means of evoking our responses – shifting our thought from interior and specific details to reflections on what is comforting, and not comforting, about these places.

It is the subtle shifts in our perceptions of nuances within architectural space that the artist explores through these interiors. At a momentary glance they might be set within a school, prison, hotel, laboratory, factory or government building; some appear comforting while others hold a certain dread. We are stuck in the middle, somewhere between entrance and exit. Their recesses, polished floors, oddly shaped windows and an incongruous mixture of arches, arouse emotional responses based in our own subjective memory. The idea of the photograph-as-record is undermined; what was there to start with and what is shown are very different things. The work comprises a series of large-scale light-boxes which potentially form an installation within the 'real' corridors at Springfield.

Yass employed a process of layering together a positive and negative colour film within the same image, with further enhancement through printing. The result is ghostly; the images are filled with a peculiar resonance as the positive and negative, the Yin and Yang, meet in symphysis across the surface, lending them a semi-X-ray quality or suggesting architectural dissection. Strong light sources appear solid blue,

objects are blurred, light reflecting off a wall appears as a shadow, a queer light emanating from a translucent plastic door gives the impression of a massive electrical surge.

The second part of the work superimposes people on these spaces. Yass humanises them, but does not attempt to differentiate between staff and patients. The insurmountable divisions that ostensibly separate 'us' from 'them' begin to crack as we acknowledge that mental illness could befall anyone at any time.

The work, which involves the representation of people, is a response to Springfield's photographic tradition dating back to the 1840s, when a certain Dr Diamond carried out there, under the heading of 'scientific investigation', pioneering photographic research into mental health. Asylum inmates were ushered in front of the camera to have their portraits taken; then, by layering together several of the resulting negatives, Diamond printed a composite photograph, considered then to be a generic image of madness or the face of the archetypal 'lunatic'. The composites were filed away and categorised by type of illness such as 'mania', 'hysteria' and 'melancholia'.

Yass's portraits have been permanently installed in Springfield Hospital. The works are considered appropriate to their site, are technically well executed, and have been recognised for their importance in current developments in contemporary art. In both this and the next project described, there was an extraordinary commitment from the hospitals in facilitating access, assisting with technical matters, and in exchanging perceptions and ideas with the artists.

Chris Bumstead, the Director of Occupational Therapy at Springfield, who acted as the hospital co-ordinator on the project, said the experience and the work had enabled him and others 'to reflect upon the hospital and our relationship with it and the people we encounter here ... a raising of consciousness in people's personal interaction with the hospital and their perception of the purpose and atmosphere'. He said that for him 'the work of bringing art into hospitals is vital, not because of perceived needs to address otherwise impersonal spaces, but to encourage a degree of response and reflection by people who use those spaces'.

The eight architectural images have reached a very wide general public through their inclusion in the Arts Council's fourth British Art Show, touring to Manchester, Edinburgh and Cardiff. The Arts Council estimated that over a quarter of a million people saw the work during 1996.

Zarina Bhimji

The second artist working on the 'multiples' scheme was Zarina Bhimji at Charing Cross Hospital, making work which developed directly from her insight into hospital systems and practices. A young and already successful artist, she was artist-in-residence at the Victoria and Albert Museum in London in 1992 and Visiting Fellow of Darwin College, Cambridge, in the following year.

She was based first in the Renal Department of the hospital and then focused on the Pathology Museum. Preliminary work ranged from research into the ordering of hospital supplies to witnessing patients undergoing extensive surgery. She conducted many conversations with doctors, pathologists, staff and patients. In the text for an exhibition catalogue, Marina Warner wrote:

> *When Zarina Bhimji began going to Charing Cross Hospital as artist-in-residence, she was attracted by the ceremonies of flowers around the sick, and first thought of fulfilling her commission from Public Art Development Trust by exploring the reasons people bring bunches [of flowers] to their friends and loved ones in hospital, or make wreaths for the dead, or lay bouquets on the bier ... Nobody complains if you don't bring them flowers in hospital, and they express pleasure when you do. But failure to make the gesture can open a gap of disappointment; images then may register, perhaps even bridge such dislocations. Zarina Bhimji's image-making looks at these gaps and the way they can be tender, both in the sense of sore and in the sense of delicate, pleasurable, caressing.*

Zarina Bhimji's resulting work consisted of eight large colour images. Four of the photographs are installed on the ground floor of the hospital, two are in a teaching laboratory, partly as a tool to education, and two are in

the Anatomy Department as a counterpoint to routine day-to-day work being undertaken by staff.

In Zarina Bhimji's work there is always a concern to explore the dynamics between institutional and personal identity. Bhimji took a very different starting point from Catherine Yass. She was keen from the outset to work in a big, busy general hospital and said from the very beginning that she wanted to explore the mechanics and activities of the place before edging nearer to the human experience. These explorations ranged from witnessing extensive brain surgery to absorbing herself in hospital supply catalogues, and finally took her to the Pathology Museum where she spent many hours photographing displayed objects. Not unlike an art gallery, even to the point of having a curator, this museum and its exhibits triggered a connection with Zarina's concerns about personal identity: where is the person? where is the individual? It also introduced questions about classification, sensitivities, taboos and intrusion.

As with Catherine Yass's, the work again falls into two parts. Some of the images which resulted in the first part of the series, taken directly from the Pathology Museum, are frightening. Marina Warner wrote:

> *The residency at Charing Cross ... took Zarina Bhimji into a disturbing encounter with issues of mortality, authority and the violated individual when she discovered the Pathology Museum ... The 'museum' is an adjunct to a laboratory, and is still receiving specimens. The material it displays is shocking, unspeakable, made monstrous by mutilation and preservation. The body parts float, drained of blood – and drained of story, too: who were these people? Zarina Bhimji has photographed fragments, sometimes wounded; anonymous, unexplained, cut from the body and framed for inspection. In this medical archive, the clash between the privacy of persons and the investment of society in knowledge for the common good becomes visible.*

These images would not and could not be shown in the publicly accessible parts of a hospital for obvious reasons. However, they have reached a different public – through journals of photography and through an exhibition at the Photographers' Gallery in London. Two of the light boxes were shipped to New York to be included in a major exhibition at the Guggenheim Museum in 1996.

The second and related part of Zarina's work now rests in the busy part of the ground floor of the hospital. The artist uses flowers photographed on different materials – for me these images are about softness and texture in the great tradition of the still life. I asked Zarina about this work and she replied that people who work in operating theatres and on people have to be detached: so where is the institutional, where is the individual? The body is particularly vulnerable. She talked about rawness and, inevitably, about big institutions. Writing about the work, critic Tania Guha sees a dichotomy in Bhimji's work which 'creates an interplay between truth/untruth; public/private; reason/emotion; presence/absence; revulsion/seducton'.

Robin Illingworth, who was then Medical Director at the Charing Cross Hospital, and who had quite wonderfully facilitated access there for the artist, commented that the photographs are 'images of great beauty, modern versions, perhaps, of the complex symbolism of 17th-century Dutch still-life paintings. How have these artworks been received in the hospital? Neither staff nor patients enter hospitals for their art, but this does not mean that art cannot positively affect and engage those who are there. Art can indicate that medical science is not the only force within the hospital. Zarina's work addresses the experiences of patients and visitors; to staff it is an important reminder that our patients are people like ourselves'.

Tania Kovats

The third artist we worked with was Tania Kovats. She studied at the Royal College of Art, was the winner of the Barclays Young Artist Award, was a frequent exhibitor in Britain and in Europe, and was on the design team for the new Ikon Gallery in Birmingham.

Tania Kovats wanted to make work which related to issues around terminally ill people. Two hospitals were involved in preliminary research by the artist: St Pancras Hospital, looking at geriatric care, and the Mildmay Mission in Shoreditch, a hospice for AIDS and HIV patients; subsequently, she spent time at the Royal London Hospital in Whitechapel working with the Oncology Department and discussing approaches to the subject with medical staff.

The result is a series of eight botanical works using flowers, herbs and roots cast in resin. *Pink Perfection*, *Blue Heaven*, *My Love* and *Purple Gem* are among some of the overtly romantic titles Kovats has given these clinical resin slabs and cylinders. The titles sit uneasily with the base specimens that lie frozen within the hardened rose or green-tinted liquid. The titles are drawn from popular flower names yet on inspection, the specimen *Pink Perfection* is a misshapen root bulb, while others are seeds or Eastern herbal remedies. Kovats uses the timeless links between flowers and healing and their symbolic power within the emotional rituals of mourning and hope, death and life; hers, however, have been preserved in cast resin as bulbs and seeds never to bloom.

The resin slabs resemble medical slides under a microscope; the cylinders, Petri dishes full of agar jelly in which these embryonic life forms are set and suspended. Cutting through social taboos surrounding terminal illness, the works are rich in metaphor; they alternate between quiet pathos and an internal optimism, flitting between grotesque and beautiful, clinical and spiritual, body and mind.

Central to Kovats' work is an engagement with the public taboos that surround aspects of death and terminal illness. She explores the metaphors of illness, in particular with relation to AIDS and cancer, and questions why some of the myths generated around these diseases should hold such currency. Tania Guha, whom we asked to write about the programme, said that Kovats 'was struck by the positive outlook of staff and patients towards terminal illness and the way this outlook confounded social expectations ... [and like Zarina Bhimji] enthralled by the links between flowers and illness, for instance the tradition of bringing bouquets to those in hospital or scattering wreaths on coffins. Flowers often appear in 17th-century *vanitas* painting as a means of alluding to the inevitable life-and-death cycle to which we must all succumb'.

These works will be sited permanently in a London hospital.

A publication describing these three hospital art projects was produced by PADT. This comprises illustrations and text: an essay by Tania Guha which examines the artists' conceptual approaches, relating artistic practice to the history of medicine, and a short fictional story by Jeremy

Millar inspired by the artists' projects, reflecting upon the fragility of the individual and his/her relationship to the institution.

Art in Hospitals Forum

The King's Fund is also committed to the Art in Hospitals Forum, which was established as part of the scheme in 1990 on the initiative of Iden Wickings (then the King's Fund's adviser to the scheme), who thought it would 'give support to lonely creatures on a hostile planet'.

Under the direction of John Plant, previously Chief Executive of the Royal Brompton Hospital, the work of the Forum has continued to bring people together by providing a programme which has stimulated discussion and given access to a wide range of artworks in hospitals. This fulfils the objective of involving hospitals in issues as well as practice, and in extending information generally.

Three of the Forum's quarterly meetings are hosted by a different hospital each time, with the fourth meeting taking place each year at the King's Fund. The total membership of the Forum is about 130 and a core of 30 to 40 regularly attend meetings. The programme includes talks by artists and staff of the hospitals, tours and discussions, and includes a supper, which allows informal conversation. A grant of £2,000 is given to each of the hospitals which host a meeting to enable them to commission new artworks on condition that the hospital itself matches this figure. The size of the Forum network is steadily increasing and now includes representatives from the NHS Executive and some senior members of health authorities and trusts.

Mark Francis and Nicky Hirst

A new project was developed during 1997 when artists Mark Francis and Nicky Hirst were invited to collaborate on the creation of an artwork which will tour hospitals. The two artists have undertaken extensive research, particularly at King's Hospital in South London and the result consists of a series of ten images, mounted on aluminium. These will be installed for periods of six months at hospitals which have not previously benefited from the scheme. In addition, a book is being produced which will be an anthology of writing by artists and others on issues relating to

art and health care and about this work in particular, which will also be distributed to hospitals.

Following Phyllida Shaw's *Review of the Art in Hospitals Scheme* (published in August 1996), it was agreed that PADT's work and the Forum's operation should be run as separate entities, although there would naturally be considerable liaison and mutual interest.

PADT's programme will create the best of artistic practice in London's hospitals, setting precedents which move the field of art in hospitals into the 21st century with vision and caring. As in previous years, PADT will concentrate on key areas of activity, inviting artists to participate in a range of residencies, commissions of work, and interdisciplinary collaborations. The aim is to have a wide impact on a larger number of hospitals, health care workers and the general public. PADT will also develop one project which takes place outside hospitals in order to broaden the public's view of art and health.

Until 1998 Michaela Crimmin was Co-ordinator of the King's Fund/Public Art Development Trust Art in Hospitals scheme; she is Head of Arts at the Royal Society of Arts.

art in vienna's hospitals – decoration or challenge?

DR MICHAEL ERTL

My intention here is to give a general picture of the role of visual art, sculpture and architecture in Viennese community hospitals but the emphasis is not on art as therapy for there is already enough evidence that this is a very useful and efficacious form of medicine. Rather, I will examine the application of visual art in general in Viennese hospitals, how it might support the healing process and what difficulties can be expected. I will illustrate this with the example of Vienna's two or three leading hospitals, which are fairly representative.

Art, in the form of painting or crafts, helps the body and mind grow and, ultimately, heals them. Nevertheless, hospitals seem unable to fulfil this need of patients and I will list and try to explain some of the reasons why this unfortunate situation has occurred. I will also suggest aspects which could lead to a wider acceptance of the need for art in hospitals and a greater respect for it.

For a long time the Vienna General Hospital, the Allgemeine Krankenhaus (AKH), which includes the University of Vienna's medical school, has been planned, replanned and sometimes misplanned, as a result of which we now have an extremely tall building with high running costs. The political decision for construction of the new AKH was officially announced in 1957 (the first Viennese AKH dates back to the Hapsburg Emperor Joseph II, in 1784) and in 1994 it was finally inaugurated and opened to the public – nearly 40 years later and 30 years after building had begun.

The overall size of the hospital is 240,000 square metres: the main building consists of 11 floors on which two blocks, each of 13 floors housing patient rooms only, were built. It employs just over 1,500 doctors and 2,800 members of nursing staff, and there are 2,200 beds for patients. In 1994 the AKH counted more than 360,000 ambulant first-users to the facility, with more than 600,000 nursing days. This has continued to increase. On average, a patient at the AKH costs approximately 10,000 Austrian schillings, about £500 per day. The medical and institutional regard for the patients is undeniable and is emphasised in an official brochure. However, this brochure does not mention that there are a variety of extremely expensive and good quality works of art to be seen.

In the area above the entrance hall the presentation of the paintings is structured like an exhibition but elsewhere the paintings just seem to have been hung at random, which is not only unfortunate, but also diminishes their value. It suggests that the officials running the AKH are not seriously concerned with the effect of art on the healing process, or the interaction that patients may have with the art. This is confirmed by the AKH's history of handling the visual arts. Even though the planning phase of the hospital was extraordinarily long, the conception of using art there was introduced only after the architecture and the planning of the building itself had been completed. Therefore the art had to adapt to the building instead of the other way round.

Sixty million Austrian schillings (about £3 million) were available for the installation of art: this is a small sum, in comparison with the unbelievable amounts spent elsewhere. The architect, Ernst Kopper, a member of the team responsible for the art concept in 1983–4, said that a

structured design of the art was to provide a similar look in various areas to enable the viewer to understand and distinguish between them. The waiting rooms should also have been fitted with single paintings like those that characterised the chapel, hallways and patient rooms. The simple intention was to provide users (patients, staff and visitors) with easy recognition of the different areas and to facilitate their identification with the hospital. The general intention was to encourage them to feel at home there. So much for his quoted view.

The general idea was to emphasise the specific hospital situation and to concentrate on that theme within the artworks. However, all these concepts and ideas came to an abrupt halt because those responsible for the overall planning ignored the advice given. All that remained was that the artists were asked to provide pictures to fit a certain measurement in order to simplify their hanging.

I have already mentioned the lack of interest shown by those responsible for the art concept. Equally low was their interest in the art that was purchased. The jury in charge of acquisition consisted of people from different professions. There were not only doctors, but also art professors, artists and members of the hospital administration. With 20 members, this jury was definitely oversized, and this led to various individual decisions concerning what was to be bought. As a result, there is such an enormous variety of expensive paintings and sculpture in Vienna's largest hospital that it is not only confusing but also quite impossible to retain an impression of it for any length of time. As Kopper himself pointed out, we have to deal with an overwhelming number of paintings and objects that reach from north to south and show no consistency whatsoever, even though this was initially the intention. Those people who are less interested in art do not readily distinguish between the value and quality of the objects. In addition, the art loses a great deal of its potential for interaction with the user and the viewer, the patients themselves.

At the AKH, the 160 large-scale pictures are kept behind a special form of Plexiglas to safeguard them and the screws that secured it were sometimes put through the canvas of the pictures, front to back. The record is held by a picture that is secured by no fewer than 48 screws! How can patients be comforted, soothed or even possibly moved by

pictures that are apparently of so little interest to those who bought them? Such a bureaucratic attitude on the part of the hospital administration does not lend itself to the arousal of sensitive feelings.

The hospital where I work, the Donauspital (Danube Hospital) or Sozialmedizinisches Zentrum (Ost) (SMZ-Ost), has a more favourable approach. The management there took artists and their views into consideration from the initial planning stage and provided them with clear guidelines according to which they were to fulfil their work. Through the partnership of the building's architects, the planning officials asked the artists to establish a soothing art project. Some of the artists felt these obligations were too restrictive but the hospital ultimately received what it had requested.

Now, on entering the hospital, one is immediately confronted with art. The first piece is a fountain designed by the famous architect, Wilhelm Holzbauer. The roofing in front of the main entrance is 37 metres long and is covered by metal, four edged stakes painted in rainbow colours. According to the position of the sun and the amount of cloud, these stakes are reflected in three shallow fountains whose irregular levels catch the viewer's attention. The entrance hall and the waiting-room areas, including the cafeteria, offer oversized enamel pictures. The artist chose a quote by poet Arthur Schnitzler, who wrote at the end of the 19th century: 'It is wise in life to take all things fairly importantly, but none totally seriously'.

A team of artists designed a fourth patio, where there are colourful 3.4-metre long metal paper aeroplanes conducted into the patio by a blue hand of the same size. This is called *Monument of Peace*. The square leading to the psychiatric ward shows a bamboo ellipse. Within the same square, but slightly removed to the side, stands a windmill, which has absolutely no technical use. The surface of the square is not only covered with grass but also with various materials that allow both visual and tactile experiences – bricks, wood, sand, pieces of bark.

The long main hallway traversing the Donauspital provides space for various exhibitions by current artists which are organised in a similar

manner to art galleries. The pictures are on sale and artists are often available to talk to visitors.

There is a wall composition which consists of several layers of wire netting on which film negatives are fastened in strips; the colours create a generally positive and optimistic aspect. Furthermore, the viewer is offered a kinetic involvement while walking past the strips due to the arrangement of the material in several layers. Pictures are also placed permanently along the hallway, which is used as a gallery; using computer graphics, arteries and bronchioles are reproduced and coloured.

The Donauspital has abundant and diverse artistic material of a sophisticated nature at its disposal and, in addition, is praised repeatedly in the media as the prototype of a modern city-run hospital, whose value lies mainly in its state-of-the-art and high-tech medicine. When it was first opened, it possessed the most modern X-ray department in Central Europe; probably it still is. (Each X-ray can be called up from any department or station on a terminal, which eliminates the bother of transporting copies by hand).

The hospital is also extremely popular with the public, a fact that is confirmed by the soaring number of outpatients in its clinics. Is this due to high technology and top achievements in the field of medicine? Or do the people running the hospital as well as the philosophy of the place, plus the atmosphere and the artistic design and decor, also play an important role? At present there is still no empirical research that can shed light on these questions.

An extensive survey of patients was finished in July 1997 but evaluation of the data by a medical-sociological institute has not yet been completed. I would, however, like to make a few observations on the opportunities that visual art has or may have in a hospital setting and the difficulties that are to be expected in such a venture.

My observations are based mainly on findings in psychoanalysis along the lines of Sigmund Freud. I found stimulating ideas on these thoughts in a paper written by a colleague, August Ruhs, which is part of a volume

which another colleague of mine, Frau Eisenbach-Stangl, and I have jointly published: *The Unconscious in Organisations – on the Psychoanalysis of Social Systems*.

In the framework of a psychoanalytical theory of drives, art and culture represent privileged functions of the organisation of the unconscious. According to Freud, the study of drive always means shifting, limitation and canalisation. Every system that represents drive psychologically also represents a shifting and limiting factor. Art and culture are such a type of representation system of the activation of human drives which, in their whole, are experienced as behavioural categories. Art is included in the cultural system and here especially the visual arts play a significant role. In art, values of community and society are created and cultivated and the human being tries to express himself or herself in a sublime way, meaning artistically. The two constituents of artistic creativity are sublimation (object libido) and the idealisation (of the object).

Artists are constantly striving for originality in their creative work. In this way they separate themselves, at least temporarily, from the obligations of societal communication and conventions in order to fulfil both their own and society's requirements. This double function is by nature not without contradiction. To the extent that an artist is aware of a social commitment extending beyond private enjoyment of the object created by his or her creativity, the artist feels an obligation to reimburse society. However, in its organisational structure, this society consists of a so-called 'tenant community'. This community is composed of clients, promoters, custodians, collectors and consumers of art in a personal union and lacks a clear-cut opinion on the freedom of art and the availability of artistic creativity. This ambivalence means that the freedom of artistic creativity (as the basis of any creativity) is constantly guaranteed, but is also immediately limited (as you will see in the following examples). This ambivalence arises because the work on the sublimation of drives and of coveting is delegated to the artists. On the other hand, partly unconscious and sublimated things belong to this coveting, as they are also tendencies of the human soul which are frowned upon. It is inevitable that resistance to the expression of these proscribed tendencies must be activated in artistic form.

As a rule, the unconscious and sublimated drive activities represent taboos of society. For example, one subject that is taboo for artists in a hospital concerns death or serious physical or psychological trauma. In the whole Donauspital there is no single painting that deals with this subject in an open, confrontational way. The impression is given, as you will recall, that the artists have been commissioned to produce art that calms. If a society's tendency to repress certain subjects, events or wishes is strong enough, taboo areas are created and art, as it strives to cross limitations, is fond of breaking in here. On the other hand, these taboo areas are defended vehemently against the shaping of consciousness by artists.

How this works in practice is clear in the following example. The Vienna General Hospital, as well as the Donauspital, has a fully automated container transport system in which all essential items are transported: food, laundry, medicine, medical accessories (the container system of the Donauspital runs on magnetic rails and is computerised). Ernst Kopper, the architect, had the inspired notion of using the total money that the Vienna General Hospital had at its disposal for the acquisition of art for buying just one sculpture or one painting. However, the artwork would have to be small enough to fit inside one of the containers of the hospital transport system and would roll through the building along with the food, laundry and supplies. Everyone would know that a piece of art was being transported, but no one would know exactly where and at which time. The irony of this suggestion is apparent for it is just a variant of the demands made on the artists themselves by the hospital administrators, to produce paintings whose prime role is simply to fit into an allotted space; the subject and contents are unimportant. In addition, the concealed apathy of the authorities is satirised. If this proposal had gone ahead, one hopes that these repressed aspects would have been made clear. But of course the suggestion was never carried out. However, I believe this example shows clearly one of the ambiguities of using art in hospitals.

The organisation of art in the framework of a societal process (which a hospital indeed represents) is basically conflicting. The division of labour between those giving the orders and those carrying them out is a misalliance from the beginning. Artistic work seems to be a psychological symptom in this relationship, containing the unconscious drive activities

in their ambiguity. At the same time, a compromise reveals itself between the courage to transgress limits and taboos and the desire to maintain these taboos and tendencies. The organisation of such projects, such as in a hospital, is often only successful on condition that the artist is willing to compromise and use the means of alienation, sublimation and detachment to a large extent in their work.

For several years we have had a scheme in Viennese psychiatric hospitals and departments called Art and Creativity, a project which offers cultural and creative experiences to psychiatric patients; the unique circumstances of some patients call for a venture of this kind. Instead of finding their way back into private domestic accommodation, many suffering from psychiatric illnesses have spent decades in an institution. This is due to neglect by professionals and insufficient resources of the health services though the situation has improved greatly since the 1980s as a result of the so-called reform of psychiatry. No patient now remains longer than necessary in hospital. But for many patients, staying in the hospital itself is a psychological burden. For some of them it still means a condition of 'forced idleness', and as a further consequence they become passive, uninterested, apathetic and suffer a lack of competence. The public view of these psychiatric patients often resembles the existing distorted picture itself.

The isolation of this problem (that is, a patient's unwillingness to participate in therapeutic activities) blocks insight into the circumstances that are the cause of the patient's state. Animating patients to be creatively productive does not do wonders in itself but it is a substantial part of rendering the situation more positive and should not be underestimated. The programme consists of stimulating physical movement, dance, music and the fine arts but does not include flooding patients with 'consumer art'.

The opposite is the case. The programme attempts to stimulate existing talents and promote new ones, especially through interaction with artists, and to convert this into experiences. The outcome is often astounding, as in the case of one patient, an uninterested and withdrawn man who was encouraged to join in a dance. It then became apparent that he had spent

part of his earlier life in South America and not only enjoyed dancing but had mastered Latin American dance styles.

Such events are not part of the treatment programme and are therefore not regarded as therapy, but are one stage in a possible normalisation process. Art and creativity play a part in the lives of healthy people as much as in the lives of sick people. In the meantime the emphasis has shifted a little. In Vienna in particular, and Austria in general, art therapy is not officially recognised and there is therefore no official treatment of this kind. The consequence is that the leisure and normalisation characteristic of this arts programme has moved sideways into a sphere set aside for therapeutic matters. This classification is obviously unsatisfactory, but has evolved as a result of the situation.

Some of the pictures produced in this programme were made by a patient who has lived for more than six years in hospital. This withdrawn man suffers subjectively from pain attacks in his whole body. He took part in the programme in combination with my colleague, Frau Susanne Bulfon, who runs the Art and Creativity project at my hospital and helped on research for this talk, and with the help of this art therapy he was enabled to move to private accommodation.

Other people involved in the project are artists who visit the patients in hospitals, bringing with them a part of the outside world which the patients are confronted with and forced to deal with. Being a part of the project offers the artists an insight into the world of symbolism inhabited by mentally ill people and offers them a challenge, as well as motivation and stimulation.

The 1920s brought with them the integration of the insane into the general art scene as aesthetic values of their works were assessed. Declaring that these productions are 'art' began at the same time as expressionism, cubism and surrealism reached a zenith. The connection between the two is that both use anti-naturalistic methods and thus form a point of contact.

Several scientific disciplines (psychoanalysis, ethnology, sociology, transcultural psychiatry, the theory of the symbolic), have all played a part in deciphering the similarities of art produced by insane persons and that by normal persons.

Ethnology has shown that what is considered normal or abnormal, sick or healthy, depends on the culture. Further, it is obvious that even the productions of primitive cultures are strongly influenced by form. Transferred to art, it means that even art that seems wild and free is still determined or governed by a system of rules or symbols, however different it may be. Psychoanalysis points out that both the art of the insane as well as the art of the normal are dependent on the economic situation. Since the studies of Dr Hans Prinzhorn (the German art historian and psychiatrist, whose book *The Artistry of the Mentally Ill* advanced revolutionary theories about the psychology of expression), the science of art has tried to rationalise products by insane persons as having stylistic and formal elements that can also be found in the art of so-called normal people. An example is the existence of a synthetic intellectual form and an intact representation of one's own self.

The Freudian psychoanalytical interpretation of creative phenomena is extremely important in this context. With the help of psychoanalysis, the mechanisms of expression and formation can be more easily understood. The analysis of dreams shows mechanisms of compression, shifting and concrete representation of psychic 'materials', mechanisms that can be found in a more direct way in products of the insane. The 'normal' artist masters the mechanisms of dreams and psychosis, but where shifting and compression are used as a form of art, the result is called psychoanalytical secondary cultivation.

The above represents a difference in art produced by insane persons. It is not surprising that important Austrian artists such as Alfred Kubin and Rainer use hysteria, schizophrenia and catatonia as aesthetic, expressive mediums.

One of the aims of the project Art and Creativity is the institutionalisation of the exchange between the symbolic worlds of

'healthy' and 'sick' artists. Alongside this, the project is concerned with the social relevance of art and artists. It seeks also to influence educational institutions to expand the professional scope of the artist and allow for a more sensitive public response.

The acceptance of art and the understanding of its more extreme conceptions provide a way out of societal and symbolic isolation for the artist.

The project Art and Creativity is sponsored by an association called Pro Mente, which deals with those with psychiatric illnesses, and which recently celebrated its 30th anniversary. Originally it was a group of enthusiastic non-professionals, but it has since evolved and become a service organisation with more than 100 employees. In addition to Art and Creativity, there are many other projects in the psychiatric field, such as social accompaniments, training support, and so on.

Art and Creativity includes weekly group sessions in three Viennese public hospitals and, in addition, the psychiatric hospital Baumgartner Höhe also frequently organises cultural events. An attempt is thus being made to create a cultural link with the mentally ill by encouraging the general public to concern themselves with psychiatric patients and guard against their exclusion from society. Between six and ten exhibitions are organised each year, of which half are reserved for artists who have themselves had psychological problems.

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the aids memorial quilt as performance – creating healing narratives

MARCIA BLUMBERG

The subtitle of my paper, 'creating healing narratives', took on new resonance with the tragic death of Diana, Princess of Wales, on 31 August 1997. No one could have envisaged the unprecedented outpouring of grief by people in Britain and elsewhere around the globe. Despite marked differences, David Dunlap's description of the October 1996 quilt display in Washington raised certain parallels: 'A carpet of grief covered the nation's front yard this weekend'.

Here in London, particularly at Diana's former home, Kensington Palace, the unceasing flow of floral tributes and the continuing crowd of mourners who gathered to add their offerings, light candles, and read from the notes, letters, cards and messages on posters, toys, balloons, photographs, chocolates, flags, and items of clothing, all testify to an admiration for her warmth and compassion. The presence of a mourning

public at the palace perhaps most of all demonstrates the need to participate in a communal staging of grief.

It is appropriate to begin a paper on the AIDS Memorial Quilt with a reminder of the Princess's dedication to diverse issues and people, many of whom belonged to what her brother, Earl Spencer, termed the 'constituency of the rejected'. Her untiring energy and commitment translated into support for various charities and service providers, including those involved with HIV/AIDS. Mention of this work during the broadcast of Diana's funeral service to billions of people extended the high profile she brought to these concerns.

Memorial donations will continue to make an important and necessary material difference to this work, but particularly invaluable was her genuine physical and emotional engagement with people living with HIV/AIDS, when HIV/AIDS touched the lives of friends. Photographs of the Princess shaking hands with or placing an arm around a PWA (person with AIDS), her attendance at funerals, her explanations about the importance of this work, and her appreciation of many so-called ordinary yet special people who had deeply touched her life – all these confronted another terrible disease that infects too many members of society and which has been inextricably linked with HIV/AIDS, the disease of prejudice.

The AIDS Memorial Quilt, also known as the Names Project, came into being in the USA out of a sense of desperation at the growing numbers of deaths from AIDS-related causes, and anger at the disease of prejudice and the resulting marginalisation that rendered these deaths invisible. Cindy Ruskin asserts: 'As a nation, we have struggled not only against a disease, but also against the equally destructive enemies of ignorance, hysteria, and bigotry'.

The originator of the quilt, Cleve Jones, a gay rights activist from San Francisco, was planning a candlelight memorial march in 1985 for gay municipal officials gunned down in 1978. Noticing a headline in the *San Francisco Examiner*, '1,000 AIDS Deaths in S.F.', Jones was disturbed to realise that many of these were acquaintances or friends who lived nearby, yet, as he expresses it:

> *There was no evidence we were standing at Ground Zero ... If this were just a field with a thousand corpses lying in the sunlight ... then people would see it and understand and be compelled to respond.*

During the march, Jones asked participants to write the names of deceased friends and lovers on placards, which he and a friend fastened, one by one, on to the wall of a federal building. Surveying their handiwork, Jones remarked that it looked like a patchwork quilt of names and the idea was born. His great-grandmother's signed quilt, a treasured family heirloom, inspired a specific personal memory but it also resonated with a national, cultural pastime – the American quilt, which boasts a tradition that goes back to the 18th century. The death of his best friend, Marvin Feldman, in 1986, constituted the generating moment when Jones, unable to sew, used a can of spray paint to write his friend's name on a white panel as a tangible gesture of memorial. The following year, Jones and Mike Smith co-founded the Names Project and organised the first quilt display.

How do we conceptualise the art of quilting? According to the Oxford English Dictionary, the word is both 'the action of padding, sewing together' and the 'material for making a quilt'. A 'quilting-bee' presents 'a gathering of girls held for the purpose of making a quilt and serving as an occasion for enjoyment'. Here quilting as performing process and product is gendered female and signifies a pleasurable collaboration.

Patsy and Myron Orlofsky, writing on American quilts, accord the activity value beyond the present: 'When a girl gained proficiency, she would embark on a series of quilts for her own hope chest, to be completed by the time she was engaged'. Other quilts signified death: the 'Mourning Quilts', black and white or grey with a black border, were used during a bereavement; 'Memory Quilts,' were

> *Made of pieces of material taken from the clothing of a deceased member of a family or friend ... The center of the block ... [was] embroidered with the name of the deceased, the date of death and sometimes a sorrowful verse.*

At the close of the 20th century, quilting retains its traditional connotations; yet in the AIDS Memorial Quilt, quilting simultaneously employs and displaces the conventional art-form in a post-modern performance of mourning that celebrates lives, creates healing narratives, challenges and refuses elitism, values creativity, and inspires action.

The first display of the AIDS Memorial Quilt, organised by the Names Project, in 1987 comprised under 2,000 panels and formed one of the events for the Gay and Lesbian Rights March in Washington. Displays thereafter focused upon the quilt with ever-increasing panels: approximately 8,000 in 1988, 10,000 in 1989, 20,000 in 1992 and a staggering 40,000 panels with 70,000 names in 1996. Over the years, these changing figures affected the mode of reception, which is also intricately related to medical knowledge about the pandemic and the particular positioning of the spectator within the time-space of AIDS.

For Jones, the fulfilment of his dream bears testimony to the co-operation of thousands of diverse people, whose shared devastating grief and healing are performed and realised in the quilt in a personal, and therefore highly political, public celebration of mourning.

This project emphasises individual and collective loss while insisting on the ceremonial manifestation of valuing and remembering people's lives instead of their data. The making of the 3 by 6 foot quilt panels evocative of graves usually involves collaboration by lovers, friends, co-workers, and sometimes family in private venues; but groups of strangers often pool resources in specially organised public quilt shops.

Participants share mourning, solace, and even joy as they realise the special attributes of those remembered in ways that range from simple panels featuring just a name, or name and dates, to the most elaborate and artistic panels that also incorporate, in an often vibrant splash of colour, photographs, newspaper reports, documents, passports, credit cards, red ribbons, items of clothing, teddy bears, poems, badges, letters, maps, shoes, and even pouches with ashes. Presentation of the individual panel to the project forms another difficult stage of separation and the stitching of eight panels into a 12-foot square quilt, which is then placed on public view, rehearses the memorial performance.

The massive spectacle, performed at different locales and occasions using thousands of panels separated by 'walkways', constitutes a portable cemetery, a Foucaultian heterotopia. This temporary site of mourning is a 'real unreal place', and performs another version of the concept of cemetery, which Foucault argues changes location from the city-centre site, with the accent on resurrection and immortality, to the outskirts of the city in the 19th century, when corrosion of faith emphasises body rather than soul and recodes the cemetery as a place of death from illness.

The quilt as portable cemetery de-emphasises religion and refuses to be limited to the spectre of illness and decay so often portrayed in death from AIDS; instead it performs a post-modern ritual of memorial to celebrate life in a shared community festival that, like a theatrical performance, is set up, broken down, and remounted in these periodic large displays while individual 12-foot square blocks of eight stitched panels travel to different continents in varying formats for disparate audiences – in hospitals, theatres and schools – to accompany a vibrant education programme.

One pertinent example was a temporary exhibition of over 100 quilt panels that hung in the Concourse Gallery at the Barbican Centre in London as part of the European Association of Palliative Care Congress. In the Names Project, only the 12-foot square panels are permanently joined, yet there is no guarantee of an eternal memorial of quilts even though restorative needlework lovingly keeps memories alive.

An important new initiative addresses the necessary impermanence of cloth panels and is also an invaluable educational resource: the AIDS Memorial Quilt Archive Project has started the mammoth task of photographing and documenting every panel of the world's largest funerary art installation so that electronic images of the quilt will be available.

Large ritual folding performances of the quilt are constructed according to specific methods of folding and unfolding. The lotus fold, used for the opening ritual, transforms the usually flat object into the shape of a lotus. In October 1996, when I arrived early at the mall in Washington, long before the crowds, I saw huge areas of grass dotted with what appeared

from afar to be crumpled bodies; this overwhelming sense of devastation and loss was the most difficult moment of the entire three days of the quilt ceremony, and in retrospect has rendered concrete Cleve Jones' wished-for image: 'I saw what appeared to be many thousands of corpses lying in the sunlight ... and felt compelled to respond'.

This lotus fold engenders a slow and deliberate ceremony that anticipates the disclosure of the quilt panel and its reconnection with mourners and other spectators, while the simpler closing fold more quickly enacts each quilt panel's farewell. In contrast, the emergency rain fold procedure, if properly executed, enables the entire massive quilt to be folded in 45 seconds and then wrapped in plastic.

While treating panels with reverence, one organiser's instructions to volunteers demonstrate the complex physical and emotional involvement in the process: 'You're laying people's possessions – parts of people on the ground – but you can't be afraid of the quilt. In order to fold it up you have to walk on it'.

Physical care of the panels and concern for the emotional healing process experienced by the makers and other spectators are vital aspects of the performance. Special volunteers, known as Hand Maidens of the Quilt, tend the 12-foot square panels, moving around the entire display doing repairs or refastening individual quilts so that the panel remains as originally submitted to achieve a stability and a degree of permanence ultimately dictated by the materials of construction.

The very organisation of the performance reflects concern, too, about the healing quality of the quilt. Boxes of tissues around the perimeter of each 12-foot square panel are practical aids that recognise the value of expressions of sorrow. Most importantly, Emotional Support Volunteers, a designated category of people professionally trained in grief counselling who also have particular experience with AIDS, provide support for quilt makers, mourners, spectators, and other volunteers alike. A culture of caring operates within the Names Project that attempts to transform an artwork into a powerful force for emotional well-being. Volunteers, while instructed never to be intrusive, are available to hear expressions of emotion, answer questions, or just provide a hug for someone, whatever

their needs. This caring component is only one aspect of the multivalent performance.

The ritualised reading of a litany of names initiates the opening ceremony and continues until the final moments of the closing ceremony. Tellingly, Cleve Jones begins and ends with the name of Marvin Feldman, the friend memorialised in the first quilt panel. In so doing, Jones frames and encapsulates the very history of the quilt and the determination never to forget those who have died from AIDS in years past and in recent times. Readers include prominent political figures, artists, and personalities from popular culture as well as service providers, carers, activists, and those infected and affected by HIV/AIDS.

The continuous reading of names, in this instance 70,000 over three days at this large assemblage, corroborates Peter Hawkins' view that 'the quilt in any of its forms is most profoundly about the naming of names ... As with the Vietnam Veterans' Memorial, the names themselves are the memorial'. Mourners, makers of the quilt, volunteers and visitors celebrate the dynamism of the lives behind the names. Elinor Fuchs argues that the quilt is 'Cemetery as All Fool's Day, a carnival of the sacred, the homely, the joyous and the downright tacky, resisting even *in extremis*, the solemnity of mourning'.

In a challenge to the stigma and disinformation constructed through the complex discourse of AIDS, the quilt celebrates mourning and actively politicises and renders problematic what Paula Treichler terms the AIDS epidemic 'with its genuine potential for global devastation – [which] is simultaneously an epidemic of a transmissible lethal disease and an epidemic of meanings or signification'. The public celebration of mourning performed in the display of the massive quilt thus comprises both ritual and consciousness-raising to enact the AIDS slogan: Silence = Death.

White lettering on a black background accompanied only by an upturned pink triangle signifies early activism within the gay community, and represents gay pride and a challenge to the silence and oppression of the down-turned pink triangle of the Nazi regime. The quilt can, therefore,

also form a healing narrative when its mammoth presence and ramifications represent a catalyst to lessen the impact of the disease of prejudice.

For Cindy Patton, 'the narrative of AIDS overdetermines the virus, HIV', yet she cautions against what she categorises as silence: 'the unspeakable, the perceived but best not said, the ignored, the safely tucked away, the camouflaged'.

The quilt as memorial speaks eloquently of loss, love, and healing in its individual panels and enormous scope. It resists the simplistic equation of AIDS with gay men since the multiplicity of panels of men, women, and children emphasises the nexus of gender, race, class, religion, sexual orientation, and ethnicity.

At the same time, tribute should be paid to the many gay men who have suffered loss in this pandemic on an unprecedented scale and whose 'community', however problematic a term in its reductiveness and apparent homogeneity, has, despite continuing stigmatisation, resisted apathy, insisted on improved research and facilities, challenged heterosexist norms, imbued the term activism with new vitality, and demanded that attention be paid. Refusing, both physically and semiotically, to be 'safely tucked away', the quilt demands explicitness, education, research, and re-evaluated hegemonic power and priorities. Douglas Crimp, a gay American activist, articulated this perspective in 1989:

> *Seldom has a society so savaged people during their hour of loss ... The violence we encounter is relentless, the violence of silence and omission almost as impossible to endure as the violence of unleashed hatred and outright murder. Because this violence also desecrates the memories of our dead, we rise in anger to vindicate them. For many of us, mourning becomes militancy.*

The added ramification of an inherently militant performance of mourning intricately combines the threads of memorial, celebration, activism, urgency, and healing.

PWAs, who care less about the beneficial aspects for quilt-makers and concentrate on the person behind the name, may regard the quilt as a sentimentalising of an individual's struggle with AIDS. Derek Jarman, the gay British artist and film maker, reacted vehemently:

> *When the AIDS quilt came to Edinburgh during the film festival, I attended just out of duty. I could see it was an emotional work, it got the heart-strings. But when the panels were unveiled a truly awful ceremony took place, in which a group of what looked like refrigerated karate experts, all dressed in white, turned and chanted some mumbo jumbo – horrible, quasi-religious, false. I shall haunt anyone who ever makes a panel for me.*

This discomfort at the performance of the ritual provides one objection. Other criticisms indicate the paucity of panels memorialising black PWAs and an absence of panels for intravenous drug users who have died from AIDS-related causes. This observation places in the foreground the element of luxury associated with the time and energy to devote to quilt-making, let alone the money for materials. Here, the differentials of marginality play a part in the quilt as they do in life and emphasise how much more needs to be accomplished. The nexus of working-class pressures, poverty, and racial marginalisation constitute a trajectory of exclusion from these activities when mere survival heads the agenda.

Hal Rubenstein's decision not to see the quilt again stems from the emotional lacuna that develops when someone deeply affected within the pandemic has experienced multiple loss on a scale usually envisaged only in times of war, except that here the dead are loved ones, close friends and acquaintances; in short they represent his world:

> *I've had enough of feeling devastated by its acreage ... I'm tired of being almost too exhausted to remain still by the time I find the crafted tombstones of my friends and lovers. I don't want to be surprised any more by the sudden appearance of a patch of fabric embroidered with the name of someone I hadn't known had passed away. I don't want to be beat up any more. Been there. Done that ... Flippant? No. How can you be if you've been there from the beginning and are still standing? It's just that now there's hope. And I want to believe it. I don't want things*

to remind me that besides the glass's being half full or half empty, it can also shatter ... I want to remember. I have to. I've no choice. But I don't want to be overwhelmed any more ... When the heart wants to be touched, it goes down the list of those who aren't here, one by one.

This eloquent personal statement signifies a limit where the sheer extent of numbers, the degree of loss, precludes a healing narrative; here onlookers as well as the so-called 'community' of mourners only place in the foreground the distance between their experience and this trauma of a 'community' scattered among the 70,000 names in various locales within the huge expanse of panels covering the mall.

For Rubenstein the haphazardly separated panels of friends intensify the disjunctions and emotional dislocations that spell one actuality, the certainty of loss. The difference in position and perspective between the infected, the affected on an individual scale, and those affected by immense and seemingly unstoppable loss, translates into very different experiences of the world in this time of AIDS. It is instructive to recall Douglas Crimp's 1991 explication of 'the incommensurability of experience ... certain people are experiencing the AIDS crisis while the society as a whole doesn't appear to be experiencing it at all'.

This excruciating disjunction between the suffering of people experiencing the AIDS crisis and a general societal inaction is compounded and rendered more urgent by a situation described by Cindy Patton at the Acting on AIDS conference in London in March 1996 as an 'epidemic of discrimination'. Even for those who may disagree with Jarman or be positioned differently from Rubenstein and praise the quilt, Michael Musto's caveat that 'the quilt should always come with a warning sticker that reads, "Don't feel that by crying over this, you've really done something for AIDS"', raises valid problems of catharsis and passivity and deserves discussion.

Since the first 1987 showing of the quilt which was expressly initiated to draw attention to the existence of the pandemic, subsequent displays maintain this consciousness-raising component as well as the creation of healing narratives. The context, however, is vital: as the numbers of panels and deaths increased and a hoped-for-cure never materialised, the

quilt display – especially that of 1992 – emphasised that the performance of mourning and private healing often gave way to a sense of hopelessness. The 1996 quilt is a markedly different performance. The healing of personal grief and the confrontation of the enormity of loss continue, but now the normalisation of AIDS places the issues within a panoply of problems that exist in society and thereby denies its urgency.

Another vital aspect is the newly discovered anti-viral drug cocktails which have initiated dramatic reversals and concomitantly engendered enormous anger through exclusion, usually on financial grounds; this issue engendered a 'die-in', organised by the American gay activist organisation ACT-UP, against the pharmaceutical companies. Cleve Jones articulates 'the challenge of displaying the quilt [in 1996] ... is to attempt to transform what has been a symbol of grief and loss into a symbol of hope and determination'. Anthony Turney, the executive director of the Quilt Foundation, further extrapolates this notion: 'Our mission ... is to put ourselves out of business'.

While the pandemic still rages, the healing narratives of the quilt *do* provide something tangible. In articulating the 'miracle of the quilt' Robert Rankin's words resonate with many of the sentiments expressed in the mourning for Princess Diana: 'It allows us to come to terms with our grief, and at the same time inspires us to greater compassion, commitment, and strength for those who need us'. Yet these healing narratives insist that we as spectators learn lessons from the AIDS Memorial Quilt as we have from the actions of Princess Diana in her attempts to lessen the disease of prejudice. One of the questions we could ask is: 'What actions will *we* rehearse and perform?'

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ars gratia sanitatis
the art of the possible

SUSAN LOPPERT

We live in extraordinary times. In the week that Princess Diana died, when a family, a nation, a world flailed and hurt with grief, the Controller of BBC Radio 3 spoke of 'the power of music to heal and bind us together' and added the haunting 'Nimrod' from Elgar's *Enigma Variations* to the Promenade Concert programme on the night of her death.

He was honouring and invoking the ancient tradition of the Egyptians at Sakkara and the Greeks at Epidaurus, as much a healing sanctuary as a theatre, where music – described by essayist Joseph Addison as 'the greatest good that mortals know' – was used to heal those hurt in mind and body. The connection between the arts and medicine is as ancient as mythology: Apollo, god of music, sun and light, was, after all, father of Aesculapius, god of medicine.

Florence Nightingale, in her *Notes on Nursing – what it is, and what it is not* (1859), wrote that:

> *The effect in sickness of beautiful objects, of variety of objects, and especially of brilliancy of colour is hardly at all appreciated. Such cravings are usually called the 'fancies' of patients. And often doubtless patients have 'fancies', as e.g. when they desire two contradictions. But much more often, their (so called) 'fancies' are the most valuable indications of what is necessary for their recovery. And it would be well if nurses would watch these (so called) 'fancies' closely ... I shall never forget the rapture of fever patients over a bunch of bright-coloured flowers. I remember (in my own case) a nosegay of wild flowers being sent me, and from that moment recovery becoming more rapid.*

(This has interesting resonances at a time when we have seen carpets of flowers used to heal people's grief over the death of Princess Diana.)

> *This is no fancy. People say the effect is only on the mind. It is no such thing. The effect is on the body, too. Little as we know about the way in which we are affected by form, by colour, and light, we do know this, that they have an actual physical effect. Variety of form and brilliancy of colour in the objects presented to patients are actual means of recovery. But it must be* **slow** *variety, e.g. if you shew a patient ten or twelve engravings successively, ten-to-one he does not become cold and faint, or feverish, or even sick; but hang one up opposite him, one on each successive day, or week, or month, and he will revel in the variety.*

And, in writing of the physical effect of colour, she records that:

> *No one who has watched the sick can doubt the fact, that some feel stimulus from looking at scarlet flowers, exhaustion from looking at deep blue, etc.*

And this long before there were any psychologists.

So the use of the arts in health care is by no means a new idea, even in Britain, cocooned so often in superior ignorance. The earliest paintings for hospitals in England were uplifting and hortatory – Last Judgements

and the like – carefully planned for those about to die, to channel their thoughts along proper heavenly courses.

But, like Hogarth's two huge morality paintings emphasising charity and compassion, *Christ at the Pool of Bethesda* and *The Good Samaritan* for the grand staircase at St Bartholomew's Hospital, or, before that, the magnificent Painted Hall in Wren's Royal Naval Hospital at Greenwich, works of art were not for humble patients and *hoi polloi* but reserved for governors, grandees and council members; for the great and good, who might give and grow greater if not better, rather than for needy patients. Artistic benefactions, whether of Lambeth Doulton panels for St Thomas' Hospital or the extraordinary Byzantine chapel at Great Ormond Street Children's Hospital, were an insurance policy for the benefactor as much as balm for hurt minds and bodies.

But who makes the choice? And is it art for architecture or art for the heart and mind? Or a judicious mixture? In Britain we have no per cent for art, the sensible policy whereby 1 per cent of the cost of any building is mandated for decoration and adornment, and the only funding available for the National Health Service (NHS) or the arts seems dependent on one sort of lottery or another – a gamble.

At St Thomas' in the 1960s, the architect of the new wing, Eugene Rosenberg, commissioned uncompromisingly modern paintings and sculpture by Naum Gabo, Robyn Denny and Victor Pasmore which, now that Rosenberg's guiding vision has gone, languish forlornly, a forgotten oasis. John Weeks, the architect of the recent addition to St Mary's, Paddington, similarly raised the money for a mural by Bridget Riley and prints by Eduardo Paolozzi.

But what if the architect's brief for the building does not extend to its interior decoration beyond lighting, seating, signs and so on? To whom should be entrusted the artistic adornment (or otherwise) – should it be those in the arts or those in positions of power within the hospital?

Two new hospitals in Britain provide two different answers: St Mary's, Isle of Wight (completed 1990, opened 1991), designed by Ahrends Burton and Koralek, whose proposed 'carbuncle' for the National Gallery was

excoriated by Prince Charles; and Chelsea and Westminster, London (1993) – designed by Sheppard Robson, associate British architects for the Sainsbury Wing of the National Gallery and the new Bankside Tate Gallery – whose facade was denounced by that same architectural arbiter as a 'duff dud'.

Today, most British hospitals must attempt the ungrateful adornment of an accumulation of old buildings, sprawling modern accretions and unsightly Portakabins. St Mary's and Chelsea and Westminster were fortunate, however, in having a *tabula rasa* or blank canvas to begin with and each, uniquely in Britain, commissioned works of art while the hospitals were at planning stage, so that they were properly integrated into the buildings rather than optional added afterthoughts. The results at Chelsea and Westminster were Allen Jones's exuberant red, green and yellow *Acrobat*, at 60 feet the largest indoor sculpture in the world; Patrick Heron's three ravishing silk banners, the largest 56 feet, the smallest 34 feet; and Sian Tucker's rainbow-coloured mobile, *Falling Leaves*, which shimmers from the transparent plastic roof to the lower ground floor – over 100 feet – in homage to Matisse and Calder. Each hospital, in its individual way, illustrates the differing guiding philosophies.

Where Chelsea and Westminster differs from St Mary's – and, indeed, many other hospital arts projects – is not only in having inherited from Westminster Hospital (one of the five outmoded hospitals it replaced) a magnificent Veronese *Resurrection*, but in the selection of works of art. The distinction is between community art, patient- and staff-led, and art chosen for its artistic excellence first and foremost as well as its appropriateness for the context, the setting.

Appropriateness and suitability are crucial, but need not be inimical to artistic excellence. In the light, white building that is Chelsea and Westminster, colourful abstraction works very well in mobiles, sculpture, paintings and textiles. Works by Francis Bacon or Damien Hirst or even, say, Picasso's brilliant fragmented cubistic heads might look stunning but would be highly inappropriate. The late Helen Chadwick's last works, made during a residency at King's College Hospital, were excellent – and,

quite rightly, exhibited at the Barbican, not in a hospital where it is important to take patients' minds off the procedures they are undergoing. The superb and powerful pieces inspired by pathological specimens made by Zarina Bhimji – commissioned through the King's Fund and Public Art Development Trust for Charing Cross Hospital – and described earlier by Michaela Crimmin, are a case in point.

At the Chelsea and Westminster, thanks to the guiding vision of three consultants, under the chairmanship of James Scott, who ardently believe in the arts as an integral part of the healing process and that artistic and aesthetic considerations should be the over-riding criteria, we are not afraid to court controversy, to take the bold rather than the safe step, to challenge expectations, to surprise and invigorate patients and public alike. Acceptance may be slow – it has taken four years for some of our nursing staff to *ask* for bright colours instead of timid pastels, to go beyond the tasteful ideas of the cosy and chintzy, to join in with the weekly musical and other entertainments rather than recoiling in horror, exhorting silence: 'Don't you realise this is a hospital?'

Yes, it is a hospital, but it is also a community centre. People come in not just to see doctors or patients but to enjoy the building, its permanent works of art, changing exhibitions, music, theatre and dance, to buy from the daily stalls of knick-knacks and cashmere, shoes and gewgaws; some come daily for what is arguably the best coffee in the Fulham Road. It is a community centre in the way that – I think I am not fanciful in the comparison – in mediaeval times, cathedrals gave succour and shelter, physical and spiritual.

There is no longer a division between the healthy outside world and the hidden world of the sick; we no longer take a deep breath before stepping over a forbidding and foreboding threshold to inhale that characteristic smell of cabbage and carbolic while simultaneously crossing our hearts, hoping *not* to die. Times have changed since patients needed *Last Judgements* because they would, in all likelihood, never emerge alive; hospitals are as much about health and healing as about sickness and dying, and at the Chelsea and Westminster, that barrier has been broken down by the successful integration of light and colour with clinical white efficiency. It is a place of optimism and uplift.

The hospital, which replaced five much-loved hospitals which had outlived their efficiency (St Mary Abbots had found a new role as a site for making Hammer Horror films), opened to a barrage of negative publicity, testimony to the fact that the British do not like the smell of success or the shock of the new. At a time when both the NHS and the arts are pitifully underfunded, we have to convince sceptics that none of the paintings, sculpture or performances deprives anyone of treatment, a bed or research, and that, in any case, we see the arts as an integral part of the health care we offer. All our corporate literature is graced with our distinctive works of art, showing that the art is very much part of the hospital, alongside a prominent statement that the arts project is not funded by the NHS, that every penny is raised privately.

Perceptions are changing: at the hospital's first open day in May 1995, in answer to the question 'Which area particularly impressed visitors?', the answer that came almost top was 'art/exhibitions/drama/music', second only to the operating theatres, and above maternity, X-ray, accident and emergency, physiotherapy and orthopaedics.

What we provide is therapeutic, not therapy. And more: not an art gallery (although we were a finalist for the 1996 National Art Collections Fund Prize, and the great demand to see the hospital has led to weekly tours of the building and main works of art with volunteer guides, many of whom also guide at the Tate); not a concert hall (although we were the venue for the world's first hospital music festivals, free concerts for the whole community and, imminently, another world first – three performances of *Così fan tutte*, given by Pimlico Opera, the first complete opera to be performed professionally in a hospital), but a great hospital – the largest hospital development in Britain and the first new NHS teaching hospital in London since the 1970s – where healing is elevated into a fine art and, as a gratifying spin-off from the integration of the arts into the healing process, new audiences for the arts are being created.

It is a new and unexpected sort of arts venue, extending the uses of the arts, and open 365 days a year, 24 hours a day. Recently the art critic of the *Sunday Telegraph* said wonderingly: 'This must be the only place in Britain where people can see a great Renaissance masterpiece [the Veronese] for free, day and night every day'. Most people, whether

patients, staff or visitors, do not go to the National Gallery, the Tate or Cork Street, to Covent Garden or the Festival Hall, and reckon that to do so is elitist. For many, the Chelsea and Westminster is their first experience of art and music, and, since they are not in a hallowed hall of culture, they can succumb to the pleasures of colour and sound without feeling intimidated. There are, of course, still those for whom everything we do is in the 'that's rubbish, my child could do it' category. The public needs to be encouraged, to be helped and even educated to find out just how much it enjoys those pursuits – the visual and performing arts – which it perceives as exclusive.

Public art is as much about imagination, creativity and originality as it is public. Culture – a word which, till now and our newly named Ministry of Culture, had to be uttered in a funny voice lest anyone thought it was taken seriously – is an integral part of the environment, or, to use the word in the only way it became acceptable in the 1980s when we had no society, the culture.

I have been in the art world for nearly 30 years and can remember the heady days of the 1960s when we had an arts minister, Jennie Lee, and an active, or what now seems to be called pro-active, Arts Council to be proud of; it was the rarefied world of dealers, Sotheby's and Christie's, the *avant garde*, critics and connoisseurs, where one was part of and preaching to the converted. In those days, we still believed in doing things because they were good in themselves rather than because they were cost-effective – an ideal I hope that, in the new spirit abroad in this country since the election of the Labour Government in 1997, we can recultivate.

It was only four years ago, when I started running the Chelsea and Westminster Hospital Arts Project, that I discovered the *public* in public art. I soon learned that, although I assumed I had been hired for my expertise in a culture of specialists (neurologists, pathologists, orthopaedic surgeons, cardiologists, oncologists, dermatologists, physiotherapists, psychologists, nurses, technicians) art, along with politics, is the one thing that everyone knows about and can pronounce upon with authority.

But working in a community need not mean being led by the community. Involvement and consultation are, of course, vital, but in the end originality and creativity must be paramount; the artist must incorporate the needs of the particular project into a higher design. Nurses, doctors, teachers, tycoons may have an idea of what they want and need, but it is the artist who transforms those needs artistically. And, ironically, democratic selection is not always a good thing if it means reduction to the lowest common denominator; I am a passionate believer in democracy, but not if its tyrannical application results in timid, unsuccessful compromise.

Since consultation is very important, we try to provide choice for our selection committee (which comprises members of staff from every imaginable department in the hospital, from porters to the chief executive); but democratic consultation failed in the case of a mural for the accident and emergency department, where staff chose the least interesting design – a repetitive theme of swirls and swags – of six offered by the selection committee, prevented the artist from painting all the walls and then, after several months, decided they hated it. It has now, after further consultation, been altered to include balloons, birds and colour, but will never be a success – a case of too many cooks being afraid to take a bold step.

Of course, wild flights of fantasy and imagination cannot rule entirely unfettered. At Chelsea and Westminster, the first major project I initiated was for the transformation of the non-denominational sanctuary adjoining the chapel from a stark, awkward white box into a place of peace and meditation. We invited eight artists and two groups of students – design students from the City and Guilds of London Art School, and architecture and design students from the Royal College – to submit proposals. The brief was exact and the budget tight: £10,000. Everyone except the Royal College students stuck to the brief. The RCA students dreamed up a wonderful scheme – rebuilding most of the chapel/sanctuary building, elaborate plumbing for a water feature – which entirely ignored the needs of users: patients in wheelchairs, for example, would have been unable to negotiate the room since it would have been on different levels – and which would have cost £25,000. Maggi Hambling with her ten watercolour *Sunrises* was the eventual winner, and the £10,000 needed to

acquire the drawings, frame them, redecorate the room, change the lighting and provide more suitable, intimate seating was provided by an anonymous charitable trust, for whom the Sanctuary's multi-ethnicity was the main attraction.

It has not all been unalloyed success: although the triumvirate of consultants had persuaded the new hospital's Special Trustees of the importance of the arts as part of the healing process – something which only doctors, who had seen the calming effects of paintings on the ceilings of anaesthetic rooms could do, not art experts – and of the necessity of funding them, the initial implementation of their ideas was less than ideal.

The Manchester-based organisation, Arts for Health, was retained to advise the project, which was called 'Theatre for Health' – a nice concept, with its resonances of operating theatres and the links between hospitals and theatres – and it was decided that all works of art should have a theatrical theme; but a hospital is not a theatre, and many of the works which were originally installed – photos of athletic dancers in leaping poses in a waiting room for less than healthy people; photos of toy theatres; fantasies on the movies; watercolours of theatre rehearsals – were inappropriate and have, where possible, been replaced.

Mistakes were made which had nothing to do with consultation: £40,000 spent on indifferent paintings by an unknown Manchester artist with no connection with the hospital or community; £9,000 for what look like overblown microscope slides in the pathology department, seen only by the few who work there (and who would rather see something different from their daily grind writ large), when the project's stated aim is to provide works of art for patients, staff and visitors; £6,000 for circus hoardings in the underground car park, with a laughing pierrot gesticulating to the mortuary door. In short, we did not always get value for money.

In place of a commissioned mural which James Scott refused to have in the fracture and orthopaedic clinic, we asked Albert Irvin to submit a proposal for the long and narrow wall. He produced eight sketches which were placed on the wall with a questionnaire; opinions ranged from

'wonderful colour', to 'bullocks [*sic*]', to the inevitable 'my child could do that'. Staff who initially opposed the idea of a large, vibrant abstract painting by a young Turk in his seventies became passionate proponents, converted by the artist himself, who took them to his studio. Thereafter, several members of staff went to his exhibition at Gimpel fils in Mayfair, and more than one has actually started collecting his work.

The nomination for the National Art Collections Fund Prize was for an 'innovative and imaginative approach to health care' through 'outstanding presentation of the visual arts', and for 'promoting enjoyment of the visual arts', a salutary ideal. Achievements included ten site-specific murals or installations, one an 80-foot mural by Faye Carey in the dining room; works by young artists, mostly working in local art colleges (with whom we have developed fruitful relationships) or living locally, like Rachel Owen, Lucy Le Feuvre, Carey Mortimer, Shaun Dolan, Lara Carter, Jonathan Delafield Cook; loans of paintings and sculpture from the Arts Council, Contemporary Art Society, BP, Paintings in Hospitals, artists, dealers and collectors.

Mary Fedden (two of whose paintings we have bought) donated lithographs by her late husband Julian Trevelyan and herself, and Elsbeth Juda a series of 40 superb photographs of artists, musicians and craftsmen, with the right to sell reprints. We have recently installed William Pye's mesmerising *Water Cube*, an unexpected bonus of which is a continuing source of coppers and silver coins, thrown by children in search of a dream.

The performing arts – organised with our Performing Arts Co-ordinator – are equally important. We are unique in providing at least one performance a week of music, dance, theatre, mime, puppetry and storytelling for patients, staff and visitors. At least one a month is in a ward, at least one a month is for children. This Easter, a soaring performance of Thomas Tallis' great 40-part motet, *Spem in Alium*, transformed the hospital into a cathedral of sound; and in June children of all ages were enchanted by a performance of Prokofiev's *Peter and the Wolf* with Patricia Hodge as narrator.

In addition to the annual music festivals, we have an innovative three-year project with the City of London Sinfonia, our orchestra-in-residence, whereby on the first Tuesday of each month a quartet or quintet gives an informal public concert, followed or preceded by as participative as possible a workshop for children, the elderly, HIV patients, or ante- and post-natal mothers.

I can also report an exciting and significant breakthrough in our CLS workshops with expectant mothers. A cardiotachograph, or giant stethoscope, is placed on the mother's belly, over the site of the baby's heart, and the magnified heartbeat is broadcast over the machine. What I had not realised is that each heartbeat, like a fingerprint, is unique; even identical twins have different heartbeats. Hearing this primeval sound, the musicians begin improvising, the heartbeat providing an insistent and rhythmic counterpoint, rather like a work by composer John Adams; in the case of a woman expecting twins, both of whose hearts were heard simultaneously, there were two complementary insistent staccato sounds. It is the most exciting and, at the same time, moving experience, for mothers and listeners, to monitor and audit the babies' heartbeats, which become part of a creative process. And, of course, babies *in utero* as well as the cradle respond dramatically to different sounds – we've noticed that Bach puts them to sleep, while the habanera from *Carmen* really gets them kicking!

All this may appear trail-blazing, but in fact the first performance in the hospital in the Fulham Road happened 85 years ago. In 1912, while in London with Dyaghilev's Ballets Russes, Nijinsky was taken ill at a party given by Princess Serafina Astafieva in what is now the Pheasantry, a Pizza Express, in the King's Road, Chelsea. He was brought to St Stephen's Infirmary – the Victorian workhouse-turned-hospital on the site of the present Chelsea and Westminster Hospital. After three days, he emerged from his slumber, leapt into the air and performed *L'Apres-midi d'un faune* for the no doubt startled, if entranced, patients. Legend records that when Dyaghilev came to collect Nijinsky, he distributed gold sovereigns to patients and staff.

A museum conservator said to me not so long ago: 'The healing arts, eh? So you look after sick pictures?' Not quite. It's the art of the possible – not only *ars gratia artis* or art for art's sake, but *ars gratia sanitatis*, art for the sake of health.

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paintings versus vending machines

– the survival of artwork in hospitals

LINDA MOSS

You may think my title cynical, particularly after the earlier positive and inspirational presentations about the benefits of art in health care. It is true that I am going to take a more critical approach, and there are three main reasons for this.

First, on revisiting hospitals 10 to 15 years after the installation of a piece of artwork, I have been struck by the change in its appearance. When first installed in a public space, most art commands attention, looks pristine, and occupies the setting envisaged for it. But the condition of the work can deteriorate over time; its presence becomes familiar, if not unnoticed; and the setting changes in ways that the artist (or commissioners) never imagined and which are detrimental. This is more likely to happen in a public space than in a designated art gallery; it is most likely of all in a place whose function is not normally associated with art. While the

public square, for instance, has a long tradition of civic and recreational use which includes celebration and sculpture, the hospital is a place for curing, healing and recovery, and the arts are there on sufferance only because some people believe they may contribute to this prime purpose.

Second, if artworks in hospitals are damaged, or their setting aesthetically despoiled, what can we reasonably conclude? Does it mean that there is no adequate curatorship, or did the users never want the art there in the first place and therefore had no incentive to look after it? If work is in a good condition, can we assume that 'the public' has somehow ensured its upkeep? Or simply that it has some single, influential protector within the hospital administration who shields it from the effects of indifference? It is clear that in examining the survival of artwork we have, at least, a reliable and fairly objective measure of evaluation: either the work is damaged or it is not, the setting is maintained or it is altered.

The question of measures of evaluation in this field is a vexed one. To a large extent evaluation still relies on anecdotal comment which, if solicited, is almost invariably positive. Attempts to overcome bias are costly, time-consuming and intrusive to clinical practice: we still quote the research of Ulrich published in 1984 on how a landscape view contributed to faster recovery than a view of a wall. Parallel experiments involving art are yet to be attempted but it is not clear what their value would be nowadays, as greater emphasis on treating the whole individual rather than their illness is more common. This means it is difficult to separate the contribution of artwork from other benefits of a generally sustaining hospital environment. I am not arguing that the physical condition of artwork can reveal which sections of the hospital community like, or benefit, from it and which do not; I am suggesting that survival of artwork and its setting offers a useful measurement of the value placed on the benefits of art by hospital staff and other users.

Third, the context: we are entering a new phase of debate about art in public places in which promotion of the concept is being replaced by critical analysis of the benefits. To look critically at an aspect of arts in health care is to contribute to the maturing of the field, in which we can confidently debate, rather than simply promote, the possibilities.

To further the investigation, I chose four hospitals, selected because of similarities of catchment areas and type of art, and differences of curatorial arrangement (and cost of my visits). These are: St Thomas', Lambeth; Homerton, Hackney; Chelsea and Westminster; and Amsterdam Medical Centre.

In summary, the main similarities are:

- all serve large, socially mixed inner-city areas
- all occupy late 20th century buildings
- all include both commissioned and purchased artwork
- all had artwork planned from the inception of their current premises.

The main differences are:

- all the British hospitals funded their art acquisition from sources other than government funding for health. Amsterdam made use of a governmental per cent for art scheme which released 2.5 million guilders for art, and they also inherited many works acquired between 1949 and 1983 under a scheme whereby artists donated work to a state collection in return for funding of their work. In total, 5,600 works were acquired for the hospital by these two systems. St Thomas' and Chelsea and Westminster Hospitals make use of an annual allocation from their Special Trustees (and also raise money from other sources); Homerton has to rely on fund-raising for each project or purchase

- three hospitals employ curators or arts co-ordinators. Homerton does not have such a post. Three also benefit from the championship of a senior consultant.

Questions were asked of arts co-ordinators, featured artists, staff and patients to ascertain attitudes to the work and levels of awareness of its physical condition and location, so as to correlate the findings with the instances of vandalism or despoiled settings, and look for some connection. The same questions were asked in each hospital. It was not possible, however, to interview all groups in all hospitals. The only hospital where I was able to speak to the co-ordinator, two artists, staff and patients was Chelsea and Westminster.

One of the artists interviewed, Albert Irvin, also fulfilled commissions for Homerton and I was able to discuss this work with him. In addition, I had a thorough look round public and private parts of the hospitals, noting the attention given to the condition of the work, and suitability of its current location. All the curators permitted me to take photographs of vandalised work and despoiled settings, and I am grateful for their frankness.

This research is very much work in progress, and consequently the findings I offer are, at this stage, impressionistic. They are also obviously based on investigations in only four hospitals. I have arrived at the conclusions by taking the current condition of a piece of art as the starting point and then evaluating what seems to determine its survival in an undamaged state in a location which allows it to be seen to advantage. The conclusions are not startling (and some of them are exactly what we might expect) but have the big advantage of being relatively objective and clear.

To begin with, it is useful to distinguish between 'personal' and 'institutional' vandalism. By personal vandalism I mean the deliberate defacement of a work of art by an individual; or behaviour by an individual which results in damage and which could reasonably be expected to have this effect. Instances of the former include graffiti or slashing or scratching on the work and, the best-known example, the scorching of the Albert Irvin painting in a stairwell at Homerton Hospital. It should be borne in mind that some art may be intended to incite vandalism, and there are artists who see this as a welcome observer-response to their work; none of the artists interviewed ever suggested this, but in other types of public art it has become a serious issue.

The line between participation and vandalism can be a fine one. There are instances of theft where art has been wrenched from the walls, or surreptitiously removed when already off the wall; but these do not constitute vandalism, in the sense that such actions may indicate a real liking of the work.

The second type of individual vandalism occurs when trolleys are pushed into a work, or coffee spilt over it. Personal vandalism is not the exclusive

domain of patients and visitors. The curator at Amsterdam Medical Centre told me of staff deliberately ramming works with equipment so they would be removed. This suggests poor consultation procedures before the work was installed in the first place.

Institutional vandalism occurs when the work or its setting is altered detrimentally by a hospital management decision. There are stories of murals being painted over and sculptures demolished (although not at the hospitals in question); more common are changes to the setting of the work by moving it or placing obtrusive objects near it or in front of it. This seems to be a permanent hazard for art in hospitals, occurring daily in all those examined and all others I have visited. This is a more serious problem for site-specific work than for work purchased and hung, because with the former, the artist has given careful consideration to the setting. It happens regularly over time, and the effects are cumulative.

Corridors, and other semi-public, anonymous areas of hospitals are likely sites for artwork; for exactly the same reason they are fair game for the accumulation of spare trolleys, crates of dirty linen, equipment which has no defined home, material in transit, and even bags of rubbish.

The pressure to generate income has also led to the widespread installation of vending machines and telephones, cafés and shops. These, too, are naturally sited in areas open to the public alongside or in front of previously installed artwork. It is the more insidious because photographs of works of art, like those shown at conferences such as this, are taken at the celebratory unveiling, when most protagonists of health care arts make their first and only visit. Thus false images of ever-pristine work are perpetuated among those who are genuinely interested in the field and the menace of institutional vandalism remains hidden.

What conclusions can we draw from all this? First, personal vandalism is very rare, given the vulnerability of most artwork in hospitals, and its occurrence should not deter anyone's enthusiasm. I found twelve instances of it in the four hospitals from among over 10,000 works, equally distributed between figurative and abstract. Institutional vandalism is far more serious and widespread and includes the deliberate destruction of entire works, rather than restorable damage to them. Its

less dramatic manifestations affect every one of the hospitals with art that I have visited. Furthermore, every instance of personal vandalism occurred in an area where institutional vandalism was obvious. This implies that an institutional lack of respect for art encourages further vandalism by individuals.

What, then, best ensures the survival of both the fabric of artwork and its setting? A combination of physical and psychological factors is at work here. As we might expect, postioning works of art out of reach seems to be the single most important physical factor: this limits the possibility of casual, rather than pre-planned damage and this, therefore, eliminates most personal vandalism. It also discourages institutional vandalism because out-of-reach locations are unsuitable for the storage of trolleys and bins, or the siting of drinks machines, telephones or signs. The modern hospital with its huge atrium is particularly well suited, providing vast areas for hanging which are visible but inaccessible.

Another important factor is also an obvious one: a location under constant casual survey is safer from individual vandalism than a remote or private one. Two of the twelve instances occurred in hospital chapels, and two others in secluded stairwells. The opposite is true for institutional vandalism: spaces set aside for senior staff are usually free from the detritus of hospital corridors, and art placed here tends to survive well with the intended setting intact. The earliest instances of art in British hospitals, the Hogarth paintings at St Bartholomew's and Coram Fields, were only ever intended to glorify the charitable motives of patrons and governors; the notion of art for patient benefit is a modern one.

Whatever physical precautions are taken to protect the fabric of works of art, the principal dangers come from institutional vandalism. Although barriers such as perspex boxes, crash rails and security fixings may have been fitted as protection, they have no effect against institutional vandalism which by its nature is perpetrated by – rather than merely within – the hospital. Measures to counter it are therefore procedural and cultural rather than physical. Research concludes that institutional vandalism (and therefore personal vandalism which seems to derive from it) occurs least where the profile of the artwork is very high within the culture of the hospital.

At both Amsterdam Medical Centre and Chelsea and Westminster Hospital, leaflets are produced which feature the art and encourage all hospital users to observe and enjoy it for its own sake. Works of art are used on all Chelsea and Westminster's promotional literature. Both hospitals also attempt a policy of 'zero tolerance' not only of vandalism but of anything which diminishes the aesthetic integrity of the building. This does not mean that trolleys are never left in corridors but it does mean that when such things occur, they are quickly removed. Such a policy necessitates at least two conditions: first, that the building should have some aesthetic integrity worth preserving; and second, that there is someone with the sensitivity to notice breaches of it, who also has the time and the authority to correct it. It often happens that an arts co-ordinator is on a low pay-scale and may lack the personal authority to bring about a hospital-wide respect for the art and its setting. The two factors of high profile and zero tolerance of institutional vandalism are mutually reinforcing.

It might be thought that institutional vandalism is also less likely to occur when hospital staff have been fully consulted about the intended work before installation, and that specially commissioned works are less vulnerable than those bought *en masse*, such as the collection of paintings in Amsterdam. It is true that consultation helps to engender a sense of ownership in the selected work; but it is also the case that consultation is useful only within wards or specialist units which have a small and relatively stable group of staff. Continuity of organisational culture also ensures that stories about the choice of work are passed on to new staff. In such situations, vandalism is rare irrespective of whether the artwork has been commissioned in consultation with users or merely hung with their approval (although damage to art was inflicted by staff in Amsterdam when they were not consulted).

It is in the more anonymous locations that vandalism is likely to occur, and effective consultation becomes difficult simply because of a perceived lack of ownership and a rapidly changing community of users. Site-specificity seems to make no difference to the survival of work in these locations: commissioned work suffered equally with purchased work.

The condition of artwork cannot tell us unequivocally that people enjoy it, and even less is it an indication that they derive benefit from it. But it does show us clearly the value that is placed on it by the institution. These investigations indicate that a lack of organisational care leads to a lack of individual valuing. If the arts contribute to healing through the creation of a lively, distinctive and caring environment, they must themselves receive the care, space and respect to allow them to fulfil that role.

Linda Moss has written extensively on the use of the arts in health care and is currently Course Leader of the MA in Cultural Policy and Management, Sheffield Hallam University. Among her works are: *Art for Health's Sake* (Carnegie UK Trust, 1987); *Art and Healthcare: A handbook of healthcare arts* (DHSS, 1988); 'The Arts as Healing Agents in Recovery from Surgery: A critical review' (*Theoretical Surgery* 1986; 1:96–102); 'Hands on' (*Artists Newsletter* January 1989, p25); 'Patients, Paintings and Propaganda' (*Art & Artists* April 1986, pp15–19)

art in japanese hospitals

GRAHAM COOPER

In 1996 I lived and worked in Japan for nine months. This was an inspiring experience, during which I was fortunate to meet many talented artists and architects.

Before leaving for Japan, however, I was working on design for the Kent and Canterbury Hospital. At Canterbury, the Trust Wayfinding Group were developing the external circulation route along the approach to the hospital's Accident Centre. I was also working on designs for the maternity department and facade of the hospital's modernist 1937 main building.

For St George's Hospital in south London I completed an 'aesthetic and functional improvements' proposal for the landscaping and greening of the Cranmer Street site entrance. Also at this teaching hospital, I was able to secure an enormous 21-foot Portland stone bas relief by the

sculptor Gilbert Ledward entitled *Vision and Imagination* which 'represents activities in Africa'. Commissioned in 1960 by Barclays Bank in the City of London, this extraordinary work was rescued just in time from the demolition hammer.

Prior to my departure for Japan, I was commissioned as a design consultant on two churches there. My modest proposals in a neo-Gothic style were incorporated into the working drawings, and the wedding church in Shimonoseki was completed by Easter. The title of the study I undertook for the Japan Foundation Artist Fellowship was 'Art in the Context of Contemporary Architecture'. Although located in Osaka, I operated from the Tokyo office of my adviser Dr Kisho Kurokawa, from where I was introduced to many of the country's distinguished participants in the design of the environment.

During my stay I was able to bring together many artists and architects for a series of round-table discussions known as the Tokyo Exchange and the Kansai Exchange. Although my principal aim was to examine mainstream art and architecture, I did have the opportunity to visit a number of new Japanese hospitals. These included hospitals in the Kobe area damaged by the Great Hanshin earthquake in January 1995, and I hope shortly to review the Japanese Government Recommendations for the design of hospitals in the future. As a result of my hospital design experience and research in Japan, I was invited to undertake an international scholarship in 1997 at the Tokyo Metropolitan University. Much of what follows is the result of my time there.

Art in Japanese hospital design

For the last five years, despite its recession, Japan has been the second richest nation in the world. It is technologically the most advanced place on earth and although its influence penetrates every corner of our lives, we remain very uninformed about its social and cultural infrastructure. The global demand for less hostile and more patient-oriented hospitals has stimulated considerable debate on the kind of environment that is appropriate for healing. In Europe and the USA, 'healing art' programmes are well documented, but little is known about equivalent design initiatives in Japan. This summary of developments in Japan will include:

- urban hospitals
- community hospitals in Kyushu
- hospital art projects.

Urban hospitals

Much of Japan's homogeneous population of 125 million is to be found in an urban megalopolis which stretches from Tokyo along the seaward corridor west to Osaka and Kobe. A nation of full employment until recently, but with no weekends, Japan is a country where people literally work themselves to death, where space is so scarce and rents so high that new hospital developments need to use land efficiently. This section concentrates on three hospitals completed in the last five years, each demonstrating innovation in the provision of health care.

St Luke's Hospital

Consultants: Medical Planning Associates

Architects and engineers: Nikken Sekkei

A private hospital, St Luke's was established by the American Pentecostal Church in 1902. The new acute building replaces the old 1933 colonial Art Deco hospital, which miraculously survived the devastation of the Second World War. The majestic new St Luke's, opened in May 1993, is the first major all single-room hospital in Japan. All 520 beds, although relatively small, benefit from a large window view and all rooms enjoy a micro *en suite* capsule.

Tokyo Metropolitan Health Plaza Hygeia

Architects: Nihon Sekkei Inc.

The Hygeia Hospital Plaza, located in the central Shinjuku-ku business district, combines the Tokyo Metropolitan Ohkubo Hospital with the Metropolitan Health Promotions Centre. Both services are linked by a bridge across an immaculate public 'galleria'. The 400-bed Ohkubo Hospital is itself a distinguished 20-floor block. Co-existing across the public arcade, the Health Promotions Centre literature states: 'every Tokyo citizen needs to be aware of the concept 'I am responsible for my own health'. It suggests the pressures of modern living can damage your health and it concentrates on preventing illness in a serious way.

Hyogo Rehabilitation Centre

Consultants: Department of Architecture, Kyoto Institute of Technology
Architects: Hyogo Prefectural Government

This innovative and bespoke campus facility was originally set up in 1969 with the purpose of rehabilitating physically and mentally handicapped people. The unique 300-bed health care service recently opened offers a comprehensive total rehabilitation programme which co-ordinates medical, psycho-social and vocational rehabilitation services. The Centre serves its patients and other disabled visitors with the latest technology in the clinical and rehabilitation programmes. The Hyogo Centre also addresses Japan's most pressing problem, an ageing population. By the turn of the century, a quarter of the population will be over 65 years old.

During the long Edo period of isolation (18th century), the Japanese developed a sophisticated and richly integrated society. Their architecture developed from the tea house, creating a setting which encouraged contemplation, reflection and relaxation. Yet despite such valued assets, the new hospitals have abandoned this rich Sukiya tradition in favour of Western modernism.

Community hospitals in Kyushu

This brief review of recent community facilities in Japan begins with a selection of health buildings by three of the most famous and talented architects: Arata Isozaki, Itsuko Hasegawa and Toyo Ito. Some of the main services provided for are obstetrics and services for the elderly and mentally ill, all of which are located in Kyushu, Western Japan.

The Etoh Clinic, Oita, 1985

Architect: Arata Isozaki

Himself a native of Kyushu, Isozaki is a world-renowned architect of exceptional creative ability. The Etoh Clinic is a maternity unit of distinction and according to Isozaki, 'The client wanted to avoid the dismal atmosphere so common in hospitals since his patients in an obstetric clinic are not sick. The fundamental issue then was what to use as a model. One should certainly go a step further than the stereotyped images of coffee shops, clubs and hotels. In the end I came back to the

abstract concepts of space, light and colour which had been the basic elements of modern architecture in its early stages'.

The Sea Ward Stress Care Centre, Omuta, 1989

Architect: Itsuko Hasegawa

The ever-evolving Itsuko Hasegawa is the 'listening architect' with an enormous formal and design flair. Since the Kobe earthquake disaster, her concerns have increasingly been for social building types, and with her strong passion for caring, she will often intervene in the client's brief in favour of the users and their demands. The design of the Sea Ward Stress Care Centre at Omuta in Kyushu started as an extension to an existing Shiranui Psychiatric Hospital complex which was overwhelmed by patient demand in an increasingly stressful and commercially oriented society. Based on her extensive enquiries and on personal experience, she proposed selecting a site for the hospital along the shoreline. This location would provide the soothing open space of sea water, the reflecting light, the natural rhythms of tides and the motion of the waves, all of which contribute to the sensation of being one with the natural environment.

Hinuga Aged Peoples' Home, Yatsushiro City, 1994

*Architect:*Toyo Ito

The project is situated on reclaimed land beside the harbour in the fishing village of Hinuga and was designed by Ito, the master of lightweight structures, who has a repertoire of radical and extraordinary buildings. Accommodating 50 senior citizens, the rooms are arranged along a central circulation spine to maximise sunlight requirements. The day rooms, dining rooms, bathrooms and other common activity spaces are positioned according to acceptable walking distances and frequency of use. This is a surprisingly bright and colourful building for the care of the elderly.

Kyushu is Japan's ancient gateway to the Orient and the rest of the world. The West may have influenced the main urban Japanese hospitals, but these three small provincial and innovative community hospital projects may signal a reversal in the concept and phenomenon of universal design.

Hospital art projects

Osaka City Hospital

Architects: Osaka City Government and Itow and Tihata Joint Venture

This enormous recently completed multi-floored monolithic structure is an 800-bed hospital. As you might expect from an important advanced city hospital, it contains all the latest state-of-the-art diagnostic and theatre equipment. It is, however, the intervention of artists and designers who make this facility special. An impressive selection of artworks has been assembled from competitions held at the early stages of the building procurement programme. The theme of the art competition was 'warming hospital/gentle to people' but the strategy was clearly to use the artefacts as landmark and floor identification features, way-finding devices for the hospital's public circulation system. The works range in size, according to their context, from a huge hospital icon in the form of a giant letter 'O' in the hospital forecourt to corridor and individual ward identification symbols. The technical quality of the artefacts close up is considerable, from the enormous timber circle (*maru*) to the expertly crafted wood reliefs. The entrance assembly hall is elegantly adorned with appropriately scaled hanging lacquer works and banners. The main street junctions feature wrap-around landscapes which link the corridor elevations and soften the severity of the corners.

Tamananbu Regional Hospital

Architects: Yokokawa Kenchiku Jimusho

Tama City is one of the new orbital suburb cities which have sprung up as Tokyo attempts to decentralise itself. Consequently, the city now has a brand new 600-bed hospital which is capped with a distinguished barrel roof. Inside, the public spaces are elaborately adorned, featuring above the main reception area a monumental carved image of the rising sun. A large textile tapestry hangs in the entrance of the outpatients' department and has become a symbol for the hospital. A most satisfying feature of the building is the elegantly registered street elevations. For floor recognition, a range of different potted-flower arrangements, unique to each level, are positioned outside the elevators.

Ikebana is a unique and popular Japanese art form which induces contemplation and delight. The Japanese are a nation of flower lovers, and of course the shrub and plant arrangements change according to the seasons. The scroll paintings in the traditional *tokonoka* niche are also changed to suit the time of the year. Origami is another native craft form; examples of this folded paper tradition were presented by a former patient to the radiotherapy department in gratitude for the treatment he had received there.

Hekinan Municipal Hospital

Consultants: Department of Architecture, Nagoya University

Design & supervision: Kume Architects – Engineers

Located in the Nagoya Bay area of Aichi, the City of Hekinan has adopted the policy of a healthy port city with a green environment and regards its 330-bed hospital as a centre for the comprehensive care of its citizens. To harmonise with its beautiful lakeside location, 30 per cent of the site is reserved for natural vegetation. By clearly separating the outpatients' department diagnostic services from the wards, an opportunity has been created for the main reception hall to overlook a generously landscaped courtyard. To achieve a creative atmosphere, ceramic murals and works of calligraphy are generously distributed around the hospital streets. A clear entrance landmark is produced by a large monumental rock landscape: the enormous informally arranged stones present a safe haven and create a sense of a place to meet.

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evaluating
the arts in health care
and mental health promotion
– the example of creating writing

DR ROBIN PHILIPP

Evaluation of the arts in health care and mental health promotion, using creative writing as the working example, can be seen to have three parts:

- *theory* as to why creative writing helps people make sense of life and gives it subjective meaning, purpose and the feeling of being personally worthwhile
- *scrutiny* of personal experiences reported to us by patients, the general public and health professionals in our research undertaken since 1994
- *examination* of the evidence from published research for the benefits of writing, reading and listening to poetry, songs and verse, writing and receiving letters, keeping a personal diary, and writing autobiographies, drama, fiction, humour, essays, research and review papers.

The framework of 'environment and health'

Environmental health comprises those aspects of human health that include qualities of life determined by chemical, physical, biological, social and psycho-social factors in the environment. It is also the theory and practice of assessing, correcting, and preventing those factors in the environment that adversely affect the health of present and future generations. This definition articulates the desire to include elements of quality of life, and psycho-social and sustainable development issues within the sphere of environmental health.

The activity of creative writing is one way of collating and linking external environmental factors that impinge on each of us and of encouraging our own internal, constitutional make-up to digest and interpret life's experiences, understand them, and utilise them in ways that encourage healthy, constructive and purposeful living. The 19th century French physiologist, Claude Bernard, first described the possibility of such links in his scientific discussions of the 'milieu interieur' and the 'milieu exterieur'. There are parallels in the arts. For example, the poet John Keats (himself a doctor), asked whether we retreat from the reality of the external world into ourselves or from the outside world into the reality of our inner selves.

W H Davies opens his poem, *Leisure*, with the words: 'What is this life, if full of care,/ We have no time to stand and stare?', and closes it with: 'A poor life this, if full of care,/ We have no time to stand and stare'.

William Wordsworth described poetry as: 'Emotion recollected in tranquillity' and in his poem, *An Evening Scene*, he entices us with the words: 'Come forth into the light of things, let nature be your teacher. She has a world of ready wealth, Our minds and hearts to bless – Spontaneous wisdom breathed by health'. Rudyard Kipling begins his poem, *If*, with the lines: 'If you can keep your head when all about you/ Are losing theirs and blaming it on you', to incite us to believe in ourselves and achieve personal growth.

Creative writing is an acceptable way of discharging pent-up emotion and it can be constructive. Its pursuit is even more important and of wider potential value in society if we address new ways of fulfilling an urgent

request for 'sustainable development' from the World Commission for Environment and Development; that is, development that meets the needs of future generations without compromising our present needs.

The way we look outwards at the world influences our perception of it, our values of what is 'truly' important in it, and what we do with our lives in the world we inhabit. We each have a responsibility to ensure that environmental values and opportunities are sustained. The world is, after all, a beautiful place and life is precious. Living in it can, and should, be a wonderful, fascinating and pleasurable experience.

Essentially, therefore, each of us needs to retain a moral sense of personal responsibility and individual accountability. Retaining our sensitivity to all that impinges on each of us from the external world and using to the full our senses of sight, hearing, taste, smell and touch can foster feelings of wonderment and enjoyment and considerably enhance our emotional well-being. Creative writing is a way of expressing that feeling and of linking one's own *creativity* (the capacity to bring something into existence) with the human capacity for *aesthetic appreciation* (appreciating what is beautiful in accordance with the principles of good taste).

I attempted to express this viewpoint in a poem, *With All My Senses*:

In the eye of a storm
Bare to the waist
and for an hour
I jogged the shore.

Under my feet I heard the pebbles scrunch
Above my head the roar of wind
The cries of gulls
and all around the raging sea.

I watched the fury of an ocean swell
The foam curl
Waves crash
and clouds scud by.

I felt it on my skin
The gusts of wind
The sheets of rain
and the lash of spray.

I tasted with my tongue
Salt on my lips
Smelled the freshness
and breathed the air.

It was delicious and a precious hour
In which I moved my limbs and cleared my mind
and enjoyed with all my senses
What it is to live and come alive.

Creativity, environmental aesthetics and personal value systems

Aesthetic issues are important when determining environmental quality objectives. For example, the WHO Air Quality Guidelines for Europe note that value judgements are unavoidable when considering how to achieve acceptable environmental standards. The guidelines define a 'nuisance threshold' as the concentration at which less than 5 per cent of the population experiences annoyance for less than 2 per cent of the time and notes that many psychological and socio-economic factors influence annoyance. As I have written elsewhere, to achieve the personal goals of 'a life worth living' and 'a world worth living in', and 'in the interests of sustainable development to help ensure the health and well-being of future generations, there are urgent and widespread educational, information sharing and research needs, and for which universities, service departments and professional organisations have important roles'.[1]

Creativity becomes a way of looking outwards from our own internal environment, and *aesthetics* a way in which aspects of the external environment impinge on us from without. These philosophical issues become increasingly important if we reflect on the World Health Organization definition of health: 'a state of complete physical, mental

and social well-being and not merely the absence of disease or infirmity'. As such, 'it represents a balanced relationship of the body and mind and complete adjustment to the external environment. Disease, on the other hand, is maladjustment or maladaptation in an environment, a reaction for the worse between man and hazards or adverse influences in his/her 'external' environment. The response of the individual to these influences is conditioned by his/her genetic makeup or 'internal' environment. Indeed, powerlessness can be thought of as a broad risk factor for disease, and empowerment, or control over one's destiny, as an important strategy for improving a population's health'.

But there is nothing new in such views. Pericles said that: 'Health is the state of moral, mental and bodily well-being which allows one to meet every crisis in life with amiable dignity'. Epictetus, in the fourth century BC, noted, too, that: 'Men are disturbed not by things but by the views they take of them'.

The Ministers of Health and the Environment for Member States of the European Union support this interdependence of 'internal' and 'external' environments. They have reported in the *European Charter on Environment and Health* that: 'good health and well-being require a clean and harmonious environment in which physical, psychological, social and aesthetic factors are all given their due importance'.

Regrettably, however, in our efforts to identify suitable indicators of external environmental quality, such as for air, soil, foodstuffs, drinking and recreational water, and in seeking appropriate standards for our personal ideals, we are not always aware of those environmental values we want to keep, or those that we have lost and should strive to recover; they can be difficult to measure and quantify. Present-day society gives emphasis to knowing the cost of everything; but there is a danger that we could come to know the value of nothing. Nevertheless, environmental values are extremely difficult to cost.

In searching for intuitive insights, the arts are sometimes used to express the health context of environmental values. Indeed, we believe that in the medical professional framework that links epidemiological and clinical strategies for public health, the scientific and artistic aspects of

inquiry and expression can be combined. This is important because clinical experience suggests that many younger people nowadays seem to put more value on the emotional side of life than on purely scientific analysis. Poetry is one approach being explored.

The poet William Wordsworth likened poetry to air movement. He spoke of 'inspiration as a gentle breeze blowing from the green fields and the clouds and from the sky, exciting an inward creative breeze which grows and becomes a tempest'. Moreover, poets like Alexander Pope and William Shenstone were also environmentalists in that they were gardeners who sought to explore artistic ideas through shaping their environments; they were viewed not as amateur horticulturists but as social thinkers distilling ethical values from the transformation of their landscape. Wordsworth's poem, *An Evening Scene*, is worth reflecting on. It ends with the stanza:

> Sweet is the lore which nature brings;
> Our meddling intellect
> Misshapes the beauteous forms of things; –
> We murder to dissect.

Poetry and environmental values

There is mounting evidence that looking inwards, or 'inscaping', and the process of linking and giving coherence to different thoughts, feelings and emotions, and writing them down, is beneficial to health. It has a calming effect for many people, especially if the words are written in a poetic way, with cadence and rhythm. Such expression may even evoke a resonance with aspects of, and factors in, the external environment.

Prose, too, provides important ways of expressing and recording subjective experiences. Such personal creativity, sometimes flowing spontaneously while in a relaxed, half-awake state when the mind is in 'stillness' and untroubled by external stimuli, allows the gentle surfacing of inner tensions and delights and the outward expression of innovative, imaginative, evocative, inspired and inventive thoughts. With 'wordsmithing' they gain form, shape, balance and harmony, become structurally carved and can be 'sculpted' into insights and ideas.

This was beautifully put to us by 12-year-old Gemma Wisbey in *A Poem About A Poem*:

A poem is a literary fabric
Woven from the silks of the imagination,
Layered and textured with intricate, emotional designs.
Poetry is a language anyone can learn.

A poem is structured in the brain,
Where it cascades down a waterfall
To the river of love and hate, through good and evil,
Poetry is a language anyone can learn.

A poem is made up of ideas
Lined up waiting to join
The multi-emotioned and multi-textured rainbows of themes.
Poetry is a language anyone can learn.

At last the fabric is woven,
The river has completed its tracks and the rainbow is fading.
The three work together and end up with a poem.
Poetry is a language anyone can learn.

Accumulation of such personal writings can enable a record, or anthology, to build up gradually rather like a time sequence of snapshots in a photograph album. They reveal what one was thinking or experiencing, and may provide enjoyment, pleasure, reflection and learning not just for oneself but also for others and can be passed on within a family to subsequent generations.

The visual and emotive imagery evoked by direct experience can be extremely powerful. It may lead to acquired understanding and wisdom that can be imparted to others. At the least, a record of it helps to chart our personal progress and development in life. Writing can indeed be a way of 'looking', 'seeing', 'listening' and 'learning'. It allows us to preserve memories and visions of a life lived, shared and remembered. It can become an emotional and contextual inheritance, a family treasure, and a record of background which helps to build the treasures of identity and belonging.

Poetic insights and medical research

Creative writing explores and documents ideas, thoughts, feelings, emotions, events and issues. It can be subjective and intuitive or objective and rational. Thousands of years ago, Chinese philosophers taught the idea of continuous cyclical fluctuation, and the need to balance Yin and Yang, the opposing forces responsible everywhere for harmony in life. Creative writing can therefore be considered as 'a way of seeing' that brings together the Yin and Yang, and can provide intuitive insights into the workings of the world and the mind. These insights can become the starting point for deductive reasoning and the formulation of theoretical frameworks about an issue for which research questions can then be developed. Demonstrating the links between such insights and the outcomes of research helps to strengthen the interdependence of the arts (and their subjective, intuitive, intangible and emotional perspectives), with the sciences, which are more objective, verifiable, tangible and impassive.

Albert Einstein said: 'Creating a new theory is not like destroying a barn and erecting a skyscraper in its place. It is rather like climbing a mountain, gaining new and wider views, discovering unexpected connections between our starting point and its rich environment'.

Personal experience is a powerful motivating factor. For example, from our review of the published medical literature, we know that doctors and medical students have written poems to express their thoughts about:

- clinical cases
- diagnostic dilemmas
- personal experience of disease and well-being
- investigative procedures
- causal agents
- therapeutic techniques
- the quality of our environment
- attitudes to life and living.

Poetry has been likened to medicine in that it explores aspects of communication, and because 'the poet, using words as tools, demonstrates and communicates mankind's awareness of the complexity of the human

situation. Like the physician, the poet tries first to grasp, then to control, the reality of the human predicament'.[2]

Underlying communication is empathy with people or subject. This capacity of knowing how another feels refers back to the original Greek word *empatheia*, 'feeling into', a term used initially by theoreticians of aesthetics for the ability to perceive the subjective experience of another person. Empathy is the source of intuitive understanding. The Greeks struggled throughout the classical period from the sixth to the third century BC with the fundamental issues of adjusting the relationship of factual evidence to subjective emotions. Modern Existentialism can trace lineage back to Socrates' dictum 'know thyself' which was the root of his attitude to life. The Sophists, representing the emotional and inexplicable, opposed Plato's rational philosophy. It was reasoned that objectifying disease could lead to a rigid and unimaginative approach by the physician.

This struggle has many similarities with our own conflict of philosophies. Even in the sixth century BC, Thales was seeking a permanent force underlying the apparent chaos of change. He believed that such a force must exist in the seemingly permanent disorder concealed in a hidden permanency and unity and discernible if not by the senses then by the mind. Pythagoras speaks of the separatism, dualism and relationship between spirit and mind. He suggested that the mind as much as feelings needs continuous realignment.

Our modern problem of unifying the rational and emotional aspects of life is therefore part of a pendulum swing. At present we have considerable imbalance between that which is objective and measurable, and that which we instinctively and intuitively feel is right. Present thinking in medicine seems to overvalue the rational at the expense of the emotional. New movements in society are, however, coming to the fore to remind us of the strong ethical foundations of medical practice, and of the Hippocratic oath that requires doctors to be Samaritans. These new movements as ways of dealing with the imbalance between the rational and emotional aspects of life manifest themselves in the increasing emphasis on healthy living, healthy cities, schools, workplaces and hospitals, and the many new schools of meditation, different religious

groups and other emerging spiritual activities and complementary therapies which contribute to the stabilisation of society. They act as counterbalance to the current trend for personal freedom with its potential for unstructured thinking, lack of focus on constructive problem solving, and individual need for excessive emotion, over-stimulation from exogenous sources and immediate gratification.

These personal needs, as recognised historically by Chinese and Greek philosophers, can interfere with a collective responsibility for order and balance in nature. It is not for nothing that emotion and factual thinking have a physiological and anatomical basis in the plexus which intimately connects the neocortex of the two cerebral hemispheres with the amygdala of the limbic system. Nature shows us that both sides of the brain must interact as a natural, flowing process of interchanging information. It provides the physiological infrastructure of reason and emotion in our behaviour and attitudes.

Medicine and poetry, too, were seen by the Greeks as having a common source of inspiration perhaps to some extent because healers and poets in antiquity were widely assumed to possess some sort of magical power. Hypnosis is recognised as one bridge between the disciplines. Despite historical evidence of its therapeutic value though, the beneficial uses of literature are not widely recognised.

In the words of William Cowper, the 18th century poet:

> The responsibility of the poet is
> T'arrest the fleeting images that fill
> The mirror of the mind, and hold them fast,
> And force them sit till he has pencil'd off
> A faithful likeness of the forms he views.

It has been reasoned that 'to understand the impact of disease on a person seems ... the essence of the science of medicine, but the good doctor may well be aware that artists as well as scientists are concerned with the understanding of human thought, feeling and emotion. This may draw them to study literature and account for the number of doctors who have practised the art of poetry'.[3]

The images that result when patients are invited to write and illustrate poems about their experiences of doctors and hospitals are also evocative. In one study of children's paintings a five-year-old wrote: 'This is my doctor. He always tickles me sometimes'. Doctors have also used poems for emphasis. For example, the Chairman of the British Medical Association Council, Sandy Macara, talking about the health hazards of scientific and technological advances, quoted George Crabbe: 'Man who knows no good unmix'd and pure,/ Oft finds a poison where he sought a cure'. But with the increasing moves towards evidence-based medicine, does this activity have a substantive basis?

Poetry aids healing and health

In a letter published in the *BMJ* in January 1994, we asked whether reading, writing or listening to poetry benefits health, and whether we should encourage our patients or ourselves to express thoughts as poetry. By January 1996 when we completed the first qualitative study of responses to this letter, it had evoked 60 news reports and letters from 84 health professionals and 218 members of the public in 14 different countries. The responses were all positive and supportive. The health professionals included psychiatrists, general practitioners, psychologists, psychotherapists, counsellors and nurses, as well as occupational, speech and drama therapists. They said they had used poetry successfully with patients suffering from anxiety, depression, bereavement, terminal illnesses, post-traumatic stress and eating disorders.

Among 196 members of the UK public, three-quarters responded that reading poetry reduced stress, and two-thirds said that writing poetry also had the same effect as well as providing an outlet for their emotions. Ten per cent reported that reading poems improved their mood. These benefits also enabled 13 of the UK respondents to stop the antidepressive or tranquilliser medication they had been taking. The personal testimony was powerful and included the following comments:

'Writing poetry helps me to get something off my chest'
'I feel the need to write when I feel something very intensely'
'Poetry is infinitely preferable to a pill, has no adverse side effects and revitalises and enhances the human psyche'

'Reading poems is inspiring, therapeutic and calming'
'Provided one enjoys writing, the penning of poetry has a cathartic effect. Reading a poem with a relaxing rhythm can be almost hypnotic the most tranquillising effect comes from poetry with rhythm, and when in need of calm, the natural "rocking" sound of the words takes me back to being a child and I find the effect very soothing'
'Creative writing can be used to get the world into perspective and encourage understanding that allows us to see the reasoning behind other people's, as well as our own, actions'
'Hymns speak to one of the crying needs of our day – the need for space in one's life for times of quiet amidst excessive noise and over-activity'

We have identified similar findings in two other of our unpublished studies among 80 members of the National Association of Writers in Education. They also identified the health care settings where poetry workshops are being successfully held. These settings include general practice surgeries, hospices, adult and paediatric inpatient general and psychiatric hospital wards, psychiatric day hospitals, community psychiatric clinics, psycho-geriatric units and long-stay residential care units for persons with learning disorders, mental health problems, chronic physical handicap and problems of ageing.

The news media have spontaneously reported their interest in this work. Among the 80 news reports brought to our attention, some of the newspaper headlines have been as evocative as the public testimony:

- 'GPs to be versed in therapy'
- 'Try the rhythm method'
- 'A poem a day keeps dejection at bay'
- 'Let iambics take the measure of your stress'
- 'Rhyme that can restore reason'
- 'Exam blues? An ode could ease your load'
- 'From bad to verse'

Even people who are not avid readers of verse will sometimes come across poems they keep in their minds, have a strong emotional attachment to, and fall back on in times of crisis. A good example is *The Lake Isle of Innisfree* by W B Yeats. Patients have told us that they sometimes recite it

when feeling stressed to help create and identify with an internal 'island of space, stillness and place'. The poem begins with the lines:

> I will arise and go now
> and go to Innisfree
> And a small cabin build there
> Of clay and wattles made.

And ends with:

> I will arise and go now
> For always night and day
> I hear lake water lapping
> With low sounds by the shore;
> While I stand on the roadway,
> Or on the pavements grey,
> I hear it in the deep heart's core.

In 1995, 7000 people responded to the British Broadcasting Corporation National Poetry Day poll to identify the nation's favourite poem. Fifty per cent of all the votes were for Rudyard Kipling's *If*. The remainder of the 'top ten', in decreasing voting order, were: *Lady of Shalott* (Tennyson); *The Listeners* (Walter de la Mare); *Not Waving but Drowning* (Stevie Smith); *Daffodils* (Wordsworth); *To Autumn* (Keats); *The Lake Isle of Innisfree* (W B Yeats); *Dulce et Decorum Est* (Wilfred Owen); *Ode to a Nightingale* (Keats); and *He Wishes for the Cloths of Heaven* (W B Yeats).

Many of these are romantic poems with lazy, flowing, rhythms that people find relaxing. By contrast, there are poems that for some people increase the heart rate, cause sweating, and even make the hairs on the back of the neck stand up. In future studies we hope to use new brain imaging techniques such as positron emission tomography to identify precisely what happens in the brain when people write or respond to poetry.

Reading for relaxation seems to be a popular pastime, and perhaps of greater appeal than other less healthy behaviours. For example, in a point prevalence study of ours on 20 August 1995 of 300 adults sunbathing between two flags on Platanias Beach, Crete, we found that 35 per cent were reading books, another seven per cent were drinking alcohol and a

different six per cent were smoking cigarettes. Participants said they were reading to retreat, relax, escape, recharge their emotional batteries, restore balance within themselves, equalise the pressures arising from external stimuli, and buffer themselves against the year ahead. One interpretation of the findings that we would love to think is correct is that some people prefer reading to drinking alcohol or smoking cigarettes, at least on holiday!

Theory and reason for the health benefits of poetry

A lot of poetry is written at times of stress or other high states of emotion. There are plausible reasons for thinking that the calming effect of creative writing and especially poetry is related to an interplay between the left and right cerebral hemispheres of the brain – the left being the one which analyses and responds to language, the right visualising images and responding to rhythm. This interplay could activate the limbic system at the base of the brain where thought meets emotion. Romantic poems seem to have a calming or spell-weaving effect through their imaginative blend of illusion and effect, and logically constructed poems may have a stimulating effect from the rational and objective approach to their subject matter.

As Gillie Bolton, research fellow in writing therapy at the Institute of Primary Care and General Practice, Sheffield University, has reported:

> *Poetry can be a concise expression of extreme emotion or experience. In a very few carefully chosen words, a poem can communicate something very powerful. Prose, with many more words, cannot have the same intense rhythm and impact. For someone who is ill, a poem is short enough to concentrate on and encompass its meaning.*

A direction for continuing research

There are links between evidence-based therapy and emotional intervention. Personal accounts and the findings of small-scale qualitative research studies are, however, insufficient to convince health care purchasers to fund poetry and other creative writing intervention programmes. They seek more information about specific benefits for

patients with different health problems, the magnitude of these benefits and whether or not they are cost-effective.

In a continuing project with the World Health Organization we have, therefore, designed formal research studies for which funding is now being sought; they are intended to identify whether poetry is a worthwhile intervention in psycho-neurotic disorders and/or for personal mental health promotion. We hope to be able to divide patients with similar conditions randomly into groups, one group to be given medication, one to have psychotherapy, and the third to have 'poetry therapy' – perhaps a two-hour weekly session for ten weeks, reading, writing and listening to poetry. The quality of life, anxiety and depression levels of patients will, of course, need to be measured before and after the interventions to determine any benefits.

Pursuit of this work seems worthwhile for both theoretical and pragmatic reasons. For example, art therapy has evolved into one of the creative therapies used in psychotherapy. There is evidence too, 'that the average patient having psychotherapy does better than 85 per cent of control subjects'.[4] Sadly, emotional disturbance, insecurity and related depressions and anxiety are too often considered of less importance than physical problems and are treated mainly with drugs. Nevertheless, despite limited evidence of its effectiveness, most patients in primary care settings would prefer psychotherapy.

To help advance our work with the formal studies we are also seeking more information for:

- the merits of both qualitative and quantitative research methods in environmental epidemiology to identify and evaluate roles of the arts in health care
- the alleged therapeutic benefits of trance-inducive poetry; analogies can be identified with music, dance, drama and visual arts therapies
- what poetry practitioners and members of the UK National Association of Writers in Education actually do in their work in mental health care and for mental health promotion
- findings and outcomes from the Poetry Society, UK, pilot project, 'Poets in Hospitals'

- experience from pilot studies with the WHO Regional Office for Europe for a possible multinational study to determine whether children's poetic imagery of the world around us and their illustrations for the contributed poems are associated with any particular socio-economic, demographic and/or personal factors.

These issues should be considered in the context of two points of view that need to be evaluated with inquiry into any complementary therapy: that of the critical scientist and that of the enthusiastic practitioner.

Costs and benefits of creative writing

Poems and other forms of creative writing may, for some people with certain health problems, be better than pills. If so, from the evidence available to date, it seems the activity could possibly reduce the prevalence of mental health problems and the national costs of medications. For example, at any point in time, between two and seven per cent of the UK adult population are suffering from an anxiety state and the lifetime risk of developing a depressive disorder is greater than 20 per cent.

In England and Wales during 1981–82, there were 56 consultations with a National Health Service general practitioner per 1000 persons at risk for anxiety, and these rates were higher than for all other consultations except depressive disorders, uncomplicated hypertension, and upper respiratory infections. Furthermore, in England and compared with 1991, expenditure on antidepressant drugs rose by 50 per cent in 1992 from £54 to £81 million. In addition, there are many clinical consultations where emotion forms part of the problem and, at least in general practice, some 30 per cent of patients have problems that are primarily emotional.

More generally, arts projects and programmes can provide for basic human needs such as purpose, dignity, identity, humour, relaxation, creativity, harmony and meaning. We should therefore be aware of the UK Government strategy of 'Health for the Nation' and the WHO European 'Health for All' programme. Both draw attention to the need for mental health promotion and ways of improving psychological well-being for individuals in society. The criteria for mental health depend on:

- one's attitudes towards oneself
- opportunities for personal growth and self-actualisation
- the integration of personality, personal autonomy and perception of reality and mastery over one's environment
- empowerment of the individual to think and act for themselves in their best interests.

Empowerment is an essential element of this approach. As the WHO 'Health for All' programme has noted, it is important for health professionals to provide information and technical support to encourage personal decision-making possibilities and thus better enable people to share in their opportunities and responsibilities for action in the interests of their own health.

Conclusions

For truly sustainable development, education, research, policy and information are all interdependent. Furthermore, if society and individuals within it are to develop, the following points need to be considered:

- a community is more than a collection of individuals in that it has 'synergism' and not just 'summation' of its parts
- becoming actively involved in a community gives a sense of belonging and helps to increase personal well-being
- 'self-esteem' (a sense of personal value and worth) and 'well-being' (a sense of contentment, happiness and health) are interdependent
- heightened self-esteem is likely to lead to a healthier lifestyle
- creative expression through group and personal activities provides health-promoting opportunities that help individuals to improve their well-being and self-esteem
- improved well-being and self-esteem lead to (i) reduced dependence and prescriptions for psychotropic medication (those that help the mind); (ii) less repeat attendances at primary health care centres and hospital accident and emergency departments; (iii) healthier lifestyles (less smoking, use of alcohol and addictive drugs, improved diet and more physical exercise); (iv) less delinquency; (v) less crime; (vi) less sickness absence from school/work; (vii): more constructive leisure-

time pursuits; and (viii) greater participation in adult extension further learning courses.

In addition, we need to move beyond a somewhat limited outlook which says: 'If you can't measure it, it's not worth doing', and 'What gets measured, gets done'. A more reflective and artistic approach often leads to intuitive insights that warrant subsequent scientific inquiry. Louis Pasteur once said: 'When meditating over a disease I never think of finding a remedy for it, but instead, a means of preventing it'.

As T S Eliot so beautifully expressed it in the poem *Choruses from the Rock*:

> Where is the Life we have lost in living?
> Where is the wisdom we have lost in knowledge?
> Where is the knowledge we have lost in information?

A comment in the *American Journal of Medicine* pointed out that 'true knowledge cannot be divorced from wonder, and wonder cannot be divorced from life'. Thinking about, and learning from, our experiences and our capacity for individual awareness are basic prerequisites to human understanding. This, in turn, influences our personal attitudes and behaviour. Satisfaction with ourselves is a prerequisite for what we do in, and with, our lives. The humanistic qualities of fundamental understanding, empathy, judgement, kindness, tolerance and humour remain important, not only for those of us in medical practice, but for all human beings.

Poetry and other forms of creative writing are an expression and tool of those qualities. They can be used to:

- unburden negative thoughts, feelings and emotions
- broaden the way we look at our present-day patterns of living
- help us better identify ways we can enrich our own lives
- express our delight, wonder and enjoyment of life and living
- improve our personal well-being
- identify ways we can help others and share thoughts, ideas and experiences.

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what is special about music in hospitals?

Highlights from 25 years' experience as a music therapist

MARGARET DANIELL

Editors' Note

This talk, which was given extempore, was a personal account from the point of view both of a trained musician and music therapist mainly at the Humboldt Krankenhaus in Berlin. Some of the talk was illustrated with diagrams, but unfortunately no written record was made. Shortly after the conference, Margaret Daniell was taken ill with a stroke and has spent most of the intervening time in hospital. We wish her a complete recovery.

Australian-born Margaret Daniell is a musician and music therapist at the Humboldt Krankenhaus, Berlin.

arts and storytelling with young people in hospitals – educating the emotions

JANETTE STEEL

Legend has it that hope was the last of the 'gifts' to fly out of Pandora's Box and I am going to make many claims that the arts can help families hold on to hope. My first experience of using art with children was after drama school with Michael Croft's National Youth Theatre. Forty young people came from all over the United Kingdom to write and present a play. During this period these young people grew noticeably in stature and there was an incredible increase in their social skills, self-esteem and confidence.

I then went to work at a school for children with emotional and behavioural difficulties and persuaded the head teacher there that drama and creative arts could be an agent of change – and it was: we had chaos all around. Everywhere I looked, little boys were fighting.

So I decided to temper my enthusiasm with theory and went to San Francisco to train as a drama therapist. I was lucky enough to work in a variety of settings with psychiatric, paediatric and elderly patients. People like Elizabeth Kubler Ross were doing some very exciting work examining how to reduce stress for siblings of children who were in hospital, and I would like to confirm what Dr Robin Philipp said earlier at this conference about working with the elderly – drama and validation theory reduced incontinence and enabled the patients to improve communication. Despite concerns expressed during this conference about a lack of research into the therapeutic value of art and leisure, over 100 years ago in Vienna in 1889, doctors showed that children had fewer neurotic tendencies if they had play and education in hospital. That is, less bed-wetting, separation anxiety, and fear of men in white coats. Unfortunately, 100 years later, research in 1989 showed teachers of special education, and particularly hospital education, had more neurotic tendencies.

Chelsea Children's Hospital School, of which I am lucky enough to be head teacher, covers Chelsea and Westminster Hospital, Royal Brompton Heart and Lung Hospital, Collingham Gardens Child and Family Psychiatry Unit and the Cheyne Cerebral Palsy Unit. Statutory education for children between the ages of five and 16 is provided by the local education authority during school term. However, many of the young people who are in hospital long-term are not there neatly during conventional term time. Some have conditions that are progressive and spend more time in hospital after 16, and their education is often delayed because of illness. Our programme therefore also covers the age group 16 to 25 and we run an enriched arts programme during the holiday periods.

The hospital school based in the Royal Borough of Kensington and Chelsea has a team of teachers covering primary, secondary and further education as well as peripatetic creative artists such as a storyteller, two musicians, an artist-in-residence, a potter, a drama therapist and an art therapist. We aim to provide an enriched experience of creativity during our art-based holiday programme.

At a time of reductionism in education (if it can't be measured, it doesn't exist), the creative arts and hospital education are seen as an expensive

luxury. Chelsea Children's Hospital School is facing an official inspection by Ofsted (the body charged with checking standards in education), where one of the main criteria is 'value for money'. One of the questions I was asked recently by an inspector is: 'Why are you spending your time fund-raising and organising arts projects?' Why? Children in hospital have limited choices, they have lost their personal freedom. Creative arts can:

- alleviate stress
- reduce boredom
- provide reassurance
- give comfort
- increase motivation and mobility.

Involvement in arts projects helps children and young people feel connected. As part of research at the Institute of Education (the University of London), I asked children, young people and their parents, nurses and the multi-disciplinary team to fill in questionnaires and arranged focus groups to ascertain the impact the arts project had on their lives while they were in hospital. Some of the comments included:

'Getting together on an arts project makes you laugh'
'It gives me purpose and dignity to my life'
'It is a reason to get up in the morning'

From the nurses' point of view children were 'less anxious and more relaxed'. 'Oh yes,' said the inspector, 'I can see that makes sense, but is it education?' I smiled through gritted teeth. It is absolutely and fundamentally about education. There is a wealth of new experiences. Our students learn to select, record, examine, reject, access, reason, code and decode, stimulate inquiry, highlight perception and, more than that, develop self worth.

Hospital education has a very low profile. After the demise of the Inner London Education Authority, the six London hospital schools all faced cuts and one lost its school status. At that time we lobbied for legislation to protect sick children's entitlement to education, and with that lobbying came a new Circular, the first for 38 years: Circular 12/94 – The Education of Sick Children in Hospital. A petition in response to this

went to the House of Lords and was supported by Lord (Michael) Young. I was horrified at the time to hear Baroness Blatch say, 'The last thing I would want is some awful teacher fussing around if a child of mine was ill'.

This attitude is hard to understand considering the plethora of studies that show the long-term impact of hospital on a child's future achievement. Most famous is the Alexander Hospital Study in Brighton. Looking closely at asthma patients, it revealed that missing even two or three weeks' school over a two-year period has a significant impact on a child's ability, apart from the disorientation children feel on returning to school. They have to face not only catching up with their work but also changes in friendship groups.

Storytelling

Another question I am often asked is: 'Why have you got a storyteller on the school staff?' During my first few weeks at Chelsea and Westminster, a young boy of 12 called Paulo came in after a horse-riding accident. He was completely paralysed but still conscious. He responded well to music and story tapes and I asked a famous London storyteller, Roberto Lagnado (he is a storyteller at Hampton Court and Kensington Palace) whether he would mind visiting and telling Paulo a story. After each session, reduced levels of anxiety were reported by the family, nursing staff and physio team. Roberto continued for a year to offer weekly storytelling sessions throughout the hospital for children who were confined to their beds, and he is now a member of staff for three sessions per week.

Storytelling has the power to reconcile the painful. The archetypal images date back 25,000 years. Stories contain metaphors of powerful emotions and enable children to talk about their fears. When the school opened at the Brompton Hospital, it was the first time that we had worked with children who had cystic fibrosis. One day Paddy, a six-year-old boy, was hiding by his bed and I asked him why he wouldn't come into school. He said in a very breathless voice, 'I can't talk and breathe at the same time and everybody keeps talking to me'. Roberto came in and spent some time with Paddy, telling him stories, and the next day when I asked Paddy how he enjoyed it, he replied, 'Yes, I like storytelling, it keeps on working when everybody else is asleep'.

Recently we had a rather difficult time at the hospital. A much-loved young patient had died. The parents and children between the ages of four and 40 sat around to listen to the story of *Hades and the Underworld* and the *Wicked Cupid with a Golden and Lead Arrow*. The tale was about Persephone picking flowers and being spied by the god of the underworld, Hades. As the earth split open and he arrived on a black horse with a whip, Cupid decided to shoot the golden arrow of love into the hard heart of Hades, whereupon he fell passionately in love with Persephone and took her back to the underworld. Then Demeter, Persephone's mother, froze up the earth and let everyone suffer. Zeus, the king of the gods, intervened and decreed that she could return to earth but only if she had been so heartbroken that she had not been able to eat. Just as she was returning to the surface, the gardener said that Persephone had eaten four pomegranate seeds, so she was made to spend those four winter months in the underworld.

This story about the loss of a mother, feelings of abandonment, grief and loss of control, enabled each person to express their feelings in a way that was valuable to them. One young boy, Tom, has great difficulty socialising with other children. He often uses inappropriate sexual language if he wants attention from girls or aggressive behaviour if he wants attention from other children or adults. He was able to enter into a drama session using Cupid's arrow and showing love through the gold arrow and anger through the lead arrow. Now when Tom comes into hospital, instead of showing his anger in an inappropriate way, he will say to the person, 'I am going to shoot a lead arrow at you'. He has also been able to express great love and affection through this same metaphor.

Many of the children and young people at the Royal Brompton Hospital face huge choices in life. Cystic fibrosis is a chronic lung disease and many young people will have to choose between palliative care or a heart/lung transplant. How were we to answer questions such as: 'What do you look like after death?', or respond to casual comments in class such as 'My sister died last year with the same illness that I have'?

Storytelling can open up a way for young people to talk about deep and difficult issues. At one level, we listen to a story, but at a symbolic level we listen to concrete images from our own consciousness. Whether a

child is working through a difficult crisis or processing normal development issues, the theme of fairy tales reflects current and often unconscious concerns. These sessions enable children to have discussions about getting old or being sick. 'What would happen if we didn't die?' The secrets and magic contained in these stories possess a hidden meaning and children interpret it at the level that is best for them. The stories reach them in their own imagination. We all experience the story in a different way.

Two 16-year-old patients, Carl and Alice, were clearly in love with each other. Carl had chosen palliative care, Alice was having treatment to prepare for the heart/lung transplant. It seemed important to explore those issues of loss and bereavement. Education for young people with a possible short life cannot be seen only as preparation for something that happens later. They need to explore opportunities of the moment and we need to be able to help them make sense of their lives now, along with the psychological and emotional changes taking place. We need to 'give sorrow words – keep the heart from breaking'.

After Carl's death, Alice became withdrawn, unable to relate to the other patients or staff. Roberto Lagnado, our storyteller, took her along with others to Dulwich Art Gallery and told the story of the painting of *Lady Digby*, commissioned by her husband after she was dead. For the first time Alice was able to ask questions and talk about the physical body after death. She described rooms in the hospital where she saw Carl and felt the presence of the dead. She could say for the first time that she saw the ghost of Carl and said, 'I am not afraid to die or of his spirit. I know he is all right'.

The themes of fairy tales reflect current, sometimes unconscious, concerns. These stories touch part of our inner selves and enable us to reflect on life's difficulties. Distancing is provided by the framework.

Myths, legends and fairy tales provide a safe distance from our lives. A story that stimulated a great deal of debate was that of the king searching for the secret of life. He went on a long journey to an enchanted island. Here he discovered a plant that would give eternal life to all his people, but after a long exhausting journey he fell asleep by a well and, as he was

sleeping, a snake ate his plant. If he hadn't fallen asleep, we would live forever.

This provoked a great deal of discussion about what would happen if we didn't die. Suni, a 15-year-old patient with muscular dystrophy, and aware of the prognosis of her condition, was on the ward at the time. She is continually on oxygen and unable to move more than a finger. After this storytelling session, using a computer, she wrote a story that has all the elements of the fairy story: a journey, magic and healing. A young girl who is facing the death of her father goes on a long journey to find a magic potion that eventually heals him, but then, shortly afterwards, her father dies.

On one level it is just a story, but at a symbolic level, it represents images through her consciousness: her knowledge that, although she is being kept alive by the medical treatment, Suni and her family need to prepare for her early death. Many of these stories therefore have enabled children to have discussions about getting old, being sick, what happens when we die, what would happen if we didn't die. The secrets in magic and stories have a hidden meaning and children interpret it at their level.

Foulis Ward patients and the Arts Project

Artist-in-residence

During 1997 we had an artist-in-residence from the Bahamas called Lyn Parotti. Having a real artist present is a challenge for children and one that they can recognise. Working with an artist can give them a valuable insight into the nature of the personal process of commitment, efforts of achievement and the interest and motivation which drive them. Children and young people are fascinated by the artist's story. Meeting an artist can enable children to experiment, and fosters their ability to express ideas fluently and acquire new understanding and experience of their social and physical world.

The language of art develops communication skills and self-expression, gives voice and form to the many losses children might experience in hospital and develops attitudes and skills that may be helpful in times of sadness and grief. Our artists represent a wide variety of cultures and

viewpoints, class, gender and ability. This demonstrates to children that art is not only for the privileged few but belongs to all of us.

One patient, Hayley, who was in and out of intensive care over a period of many months, became very withdrawn and angry and unable to talk to staff in the hospital or her family. After an art and storytelling workshop, although electively mute, she stayed and listened to the story. She then drew 'a rainbow of hope and a smiling face'.

Many patients with cystic fibrosis have prolonged periods in hospital in isolation. Some have known each other for a long time and have to face the fact that a friend may have an infection that would be dangerous to their condition, or multi-resistant bacteria, which means that they spend long periods in isolation. How can we overcome their feelings of isolation and alienation?

Many of our arts projects mean that each patient, whether on a ward or in a room of their own, can still feel part of the ward community through projects such as quilt-making, weaving and murals. These projects enable patients to explore ideas and to feel connected, and engender a sense of group co-operation and identity. It is a means to rework the past, to risk making mistakes, relieve tension and explore problems important to the individual or the group. The contribution to the whole is necessary, as we all play a small part in a greater whole. Such insight may have metaphorical meaning so that one can see how each life, however brief, fits into a larger pattern.

One 15-year-old patient who was in hospital for a prolonged period had become very depressed. I went into her room while she was talking on the phone to her mother. She was saying, 'I know you have kept me alive for 15 years but what was the point?' Her saturation levels (oxygen in the blood) were very low and in her diary she wrote about her confusion and sadness, saying that she felt that all her autonomy was lost. She became involved in the arts project and played a major role in a quilt that is now hanging on the ward. She also found writing in her diary helped her cope with her feelings of loss and fear. After one afternoon spent with her mother making squares for the quilt, her saturation levels, which had been at 75 previously, were raised 10–15 degrees after the arts session, and

this improvement continued during her stay in hospital. She wrote in her diary: 'I was aware that I had not been conscious of struggling for breath and I felt really proud of my achievement as the quilt was hung on the wall and admired by everybody'.

However, things don't always go smoothly and in one photography project that we organised with the Photographers' Gallery, I was in charge of the youngest group of children from the psychiatric unit, who had all been given disposable cameras to use. When they asked what disposable meant, I replied, 'Well, it just means that you throw them away when they are finished'. The other groups returned with wonderful photographs but my group had thrown their cameras away. Another time, a boy coming into hospital with depression and faced with a session on *Wuthering Heights* said to me, 'Oh no, please Janette, I'm here to get better not to be thrown over the edge'.

Poetry workshops

Over the years we have been visited by many poets: Gerard Benson, Adrian Mitchell, Roger McGough, Wendy Cope and John Agard have all run poetry workshops. They bring their experience, skills and techniques, of course, but the most important aspect is the personal encounter with the poet. Patients on Foulis Ward were asked to paint a picture using not just their eyes but taste and sound, the feelings on their skin. They were asked to describe it in such a way that the reader would know their feelings – and then write these expressions down in a poem. The following is an example by Alison Brown:

The Space Before Dawn

If you listen hard
through the retching, choking, chimneys,
on a still night.
Maybe if you step outside the noise
for a second.
Swim against your current of thought for a while,
you might get to the other side
to a mental stillness.
If you're willing to leave those painful possibilities,

the worries that wring your heart but
Give you an objective.
Reassure you you're alive ...
and fighting
always fighting,
... why don't you
l
e
t
go
just for a few seconds.
Leave those familiar, reassuring fears
see yourself as truly alone
but stay still – don't run from yourself.
While unconnected from concerns and people
Listen hard,
Climb through footsteps, babies crying,
trains passing, horns sounding,
voices calling ...
I don't know what you'll find in your silence
But I felt loved.
For a few seconds, while I let it,
something reached out to me
as I waited in the silence.
At its touch I could see my life from a different perspective,
and all seemed well.
And then a train came
I climbed aboard the noise as it passed
and was carried back to things I know,
A tap dripping, a light humming, someone coughing,
conversations passing beneath my window and
my internal monologue, that rattles on and on
carrying me further into myself and all the familiar voices
of my little world.

Alison Brown spent many months in hospital during the period she was completing her English degree. This poem, with a train journey, are all metaphors and ways of expressing life and death. Research into cystic

fibrosis has shown a correlation between feelings of satisfaction and goals in life, and certainly Alison and her family gained a great deal of satisfaction in the completion of her degree and the writing of her poem.

Children who come into hospital through accident and emergency departments are often young people in despair. Some have taken drugs and overdoses, many are facing major changes in their lives. The paintings at Chelsea and Westminster Hospital are fascinating to children and the artist's story can add another dimension. Adam, a 15-year-old, came in with a very bad leg fracture. It was his dream to be a footballer and that dream, with his leg, was smashed. He became very angry and difficult to manage. He sat in the sanctuary one day looking at Maggi Hambling's work, watercolours painted on three successive days. She had painted the morning before sunrise, the dawn, the hope of a new day. Then we looked at Albert Irvin's work, full of energy, the use of colour filling up the space in the orthopaedic waiting area. After that there was Lara Carter's story of dyeing the silk she uses for her textile collages, and five miles of washing in Wales that always brings a smile to the children's faces; and we are developing a portfolio of children's work in response to the artists' work and their story. All these experiences gave Adam a new interest in art and an aim for the future.

Music

Ann Noble referred earlier to the predominant feeling of fear. When a child or young person dies in hospital, it is not only a loss of a friend but an occasion when their own feelings of fear rise to the surface and, if we don't recognise these anxieties they increase. We therefore have memorial services that enable the patients to participate in various ways. A long-term patient, Heidi, died at 17. She had had a degenerative condition and could only communicate with her eyes and one finger, but was an excellent communicator nevertheless and an example to many. Lily had come into accident and emergency, a suicide bid. 'What was the point of life?' she said. At Heidi's memorial service, Lily stood up and said that Heidi had 'given her strength and a feeling of purpose in life'. Susan Loppert noted earlier the 'power of music to heal and bind us together'. Brian, our musician, composed a song and rehearsed it with the children on the ward who later played it at the service.

With the words of this song I would like to remember all the young people whom we have worked with and their courage and vitality. I would also like us to remember Princess Diana, who played such an important part in the lives of sick children, and particularly Danielle, who was waiting to have a heart operation after being in hospital for three months at the time of Diana's death, who said 'It's a bit scary when even a princess can die'.

Song for Heidi

Like a flower
Prised from the earth
You showed your colours through life
For all you are worth
Oh for a while we lost and found
Everything in your smile
Your sweet smile
Your sweet smile.

Like a flower
Scattered, scattered, to the wind
Where the petals now fall
New seed will once again bloom
So please, don't be deceived
Into thinking this is the end
We travel on, travel on.

Like a flower
Tilts its face to the sun
You lifted your head
For you were that strong
There's a feeling deep inside
That brings us together
At times like this in our lives
We're leaning on, leaning on.
Give thanks and give praise
To the loved ones now on their way
Who travel on, travel on.

Finally, I feel very privileged and recognise how lucky the Chelsea Children's Hospital School is to work in the stimulating environment brought about by the vision and expertise of James Scott and Susan Loppert of the Chelsea and Westminster Hospital.

Janette Steel is Head Teacher, Chelsea Children's Hospital School, London.

a picture of health

DR GEOFFREY FARRER-BROWN

A Picture of Health Limited is a new charity using art as a means to relieve the distress and hardship experienced by patients suffering from cancer and other serious diseases. The aim is to be informative and by using a series of oil paintings, each with a short descriptive text, help the patients, their families and carers understand the disease and its treatment.

Painting medicine at work

The idea of painting medicine at work first came to me after meeting Susan Macfarlane in 1992, and hearing that her latest exhibition of paintings covering the working environment of a woollen mill had been very successful. I decided to invite Susan to paint my medical laboratory, which I thought an equally stark workplace and which, as far as I was aware, had not been recorded in detail in paint. Although the laboratory

is bleak, it deals with critical diagnostic decisions and is filled with a hidden emotion. I explained each procedure that was carried out in examining, processing and reporting tissue and cell specimens, after which Susan sketched each scene.

A few months later when I saw the nine oil paintings, I found them to be excellent – they illustrated in a human way the work in our laboratory. It then occurred to me to ask Susan to paint a major disease. The aim would be to use pictures to explain and demystify the disease by showing the pathway down which a patient travelled from the first consultation, through examinations, treatment and then recovery.

My reasoning behind the idea was based on the importance in my own life of learning by visual means. As a histopathologist using the microscope to diagnose tumours and cancers, I need a visual memory. As a lecturer, I use photographs in transparency form to illustrate the development of diseases. When producing medical atlases, I use short descriptive captions alongside each photograph to explain each process of the disease.

It thus seemed a logical extension to use oil paintings in the same way. I was now aware that each of Susan's paintings produced a complex image that went beyond the sketched scene. Her skill in portraying the body language of the staff within the scientific laboratory background suggested that strong emotions could result from a painting.

One of my main interests was breast cancer, and so I suggested this as a topic to Susan. I approached colleagues, who were very supportive, and Susan then sketched Mr Jerry Gilmore, a consultant surgeon, in his own breast clinic and in the operating theatre. She completed the series with paintings at the Gloucestershire Royal Hospital; in the home of Jill Miller; at Amersham Art School; and, finally, at the Imperial Cancer Research Fund unit at the Churchill Hospital, Oxford.

Art consultant Imogen Lock then organised the paintings into an exhibition entitled *A Picture of Health*, also commissioned and edited the exhibition catalogue, and arranged a British tour of the exhibition with the first viewing at the Barbican Centre in London.

When learning that the series of oil paintings was on breast cancer, some people were disturbed by the notion of viewing the exhibition, yet once these paintings are seen they are never forgotten and the interest was such that the exhibition was very well attended throughout its tour. However, lessons were learnt from it and the principal request from viewers was for more medical information.

The majority of people who viewed the exhibition – and there was a broad cross-section of society and age groups – were emotionally moved by the paintings and considered them enormously informative. The paintings encourage viewers to talk about the disease, which for many is a taboo subject, and this is of particular value to breast cancer patients and their relatives; many viewers wrote very favourable comments in the visitors' book.

This positive response, in particular from breast cancer patients, encouraged us to publish an essay by Sue Sefi, a breast cancer patient herself, in which she expressed her thoughts and emotions about the exhibition. We also made a video recording of Sue's comments, during which she explained how the paintings had provided her with an inner strength and helped her come to terms with the disease.

Out of the success of the breast cancer exhibition arose the idea that another series of paintings, this time depicting the world of childhood leukaemia, might be of considerable value in showing the treatment and effects of this disease to the general public.

Work on this new series began with a written objective in which I defined why I considered an exhibition of paintings on childhood leukaemia might help in the understanding of the disease, and who might benefit from seeing them. I made a long list of all the topics that I wished to be included within the series and from this list I selected main headings for 25 paintings under which all the topics would fall. Conveniently, the subjects of the paintings divided into four groups. First, diagnosis and typing of the leukaemia; second, investigation and treatment in the paediatric oncology ward; thirdly, the bone marrow transplant unit, and fourth, follow-up including children back to school, and bereavement.

I then asked Susan Macfarlane whether she would be prepared to paint such a complicated disease, which from necessity would have to be sketched in a number of different centres and which could be emotionally harrowing. She agreed and we took the planning to the next stage.

I contacted a number of doctors who specialise in childhood leukaemia, most of whom I had never previously met, and explained the project. I asked whether they would be prepared to participate in the scheme and allow Susan into their hospital units to sketch the various scenes. All my approaches were met with enthusiasm and there were detailed discussions to ensure that the work of their staff would not be hindered and that patients would be approached for permission before drawing began.

At on-site visits, Susan and I discussed the content of each proposed painting and Susan then arranged to return at convenient times to sketch. On many occasions the scenes she saw were different from what we had planned, but she was always able to capture the essence of each topic in her final painting.

At this stage patience was required. After Susan had sketched a scene, I would have to wait a few weeks before I saw the painting. Usually, I was only shown the painting when it was finished, although with the more complex illustrative topics Susan would discuss the layout or content of the painting with me while work was in progress.

During the two years that it has taken to paint childhood leukaemia we have reviewed the works to see whether each one still fits into the series and illustrates the intended topics. New ideas have arisen and two extra paintings have been produced to complete the story. There has been a constant input from medical colleagues, other health professionals, patients and parents who have been involved in the planning or sketching of the paintings. No painting could have been produced without this participation and support.

The presentation of each painting was then considered and a short description for each was written. This was intended to help the viewer understand the main content of the picture, but did not include

interpretative comment as this must remain in the mind of the viewer and vary from person to person.

While Susan and I concentrated on the paintings, Imogen Lock was planning the exhibition and launch at the Barbican Centre in London in February 1998. In the meantime we formed a charity, A Picture of Health Limited, to promote the showing of the exhibition on childhood leukaemia and the previous one on breast cancer. If the public response to *Living with Leukaemia* is as positive as the first exhibition on breast cancer, then the project will have been worthwhile.

Summary of projects

Breast cancer care: 'A Picture of Health'

This is a national touring art exhibition of 25 oil paintings on canvas by Susan Macfarlane produced after a four-year study and launched in February 1995. The paintings include images of the first consultation, the initial investigations, work in the laboratory, theatre and recovery, the first day of the future, radiotherapy, chemotherapy and back to work.

The exhibition is accompanied by:

- an 86-page colour catalogue with essays, written with the lay reader in mind by doctors specialising in the treatment of each disease. There are also essays by an art critic, the artist, the doctor who initiated the project and a breast cancer patient who had had a mastectomy. The proceeds from the sale of this catalogue during 1995 and 1996 were donated to the charity Breast Cancer Care

- handlist catalogue including the text describing the medical topic of each painting

- a booklet entitled *Reviewing a Picture of Health*, containing an essay by a breast cancer patient vividly expressing her thoughts and emotions about the paintings

- a 13-minute video featuring the same breast cancer patient commenting on each painting and explaining how the pictures helped

her to come to terms with her disease. Included is an introduction by me and Susan Macfarlane describing the concept of the exhibition. Over 50 videos have been requested and one, for instance, is available in a Cancer Counselling Unit in Oxford. This video has been made into a three-hour loop to accompany the exhibition.

Venues where the exhibition has been shown: The Royal College of Pathologists, London; Gloucestershire Royal Hospital, Gloucester; The Town Hall, Gloucester; Foyer Gallery, Barbican Centre, London; The Royal College of Surgeons of Edinburgh; The Bonnington Gallery, Nottingham; St David's Hall, Cardiff; The Manchester Museum, Manchester; The Central Library, Westgate shopping area, Oxford; CPHVA (Community Practitioners Health Visitors Association) annual conference, Torquay; Chelsea and Westminster Hospital, London; Ideal Health Show, Celebration of 50 Years of the NHS, Olympia, London.

Future venues: The Crucible, Sheffield; Art Gallery, Bucks County Museum, Aylesbury; Poole Museum Service (three different venues); World Symposium of Culture, Health and the Arts, Manchester; Musgrove Park Hospital, Taunton.

Other venues will be arranged through to the end of the year 2001 and the exhibition may be included in a touring BMA Millennium Festival of Medicine.

Childhood leukaemia: 'Living with Leukaemia'

A national touring art exhibition of 26 oil paintings on canvas by Susan Macfarlane produced after a two-year study and launched in February 1998. The paintings include images of the first taking of a blood sample, work in the laboratory diagnosing and typing the leukaemia, the children's ward, the bone marrow transplant unit and follow up. Within the latter group, in addition to paintings of back to school and outpatient follow-up, the topic of bereavement has been included.

The exhibition is accompanied by an 86-page colour catalogue with essays, similarly written with the lay reader in mind by doctors

specialising in the treatment of each disease. There are also essays by an art critic, the artist, the doctor who initiated the project and a mother whose 10-year-old daughter died of leukaemia despite treatment with radiotherapy, chemotherapy and a bone marrow transplant.

Venues where the exhibition has been shown: The Foyer Gallery, Barbican Centre, London; Gloucestershire Royal Hospital, Gloucester; Musgrove Park Hospital, Taunton.

Future venues: BMA Conference, Priorities in Health, Queen Elizabeth Centre, London; Royal College of Physicians, London; Chapter House, Bristol Cathedral, Bristol; World Symposium of Culture Health and the Arts, Manchester; Royal College of Pathology.

Other venues will be arranged through to the end of 2001 and the exhibition may be included in a touring BMA Millennium Festival of Medicine.

The artist

Susan Macfarlane was born in Sussex in 1938. After training at the Winchester School of Art under David Peare, she lived in the Far East and then spent a year in Greece, where she studied with painter John Dragoumis. After returning to England in 1986 her choice of subject changed dramatically. While drawing in the prehistoric sites of Wiltshire, she studied the reactions of the modern visitor. She developed this interest in observing people at work, their machinery and instruments. In these two exhibitions linking art and medicine, she portrays with infinite skill the body language of patients, parents, relatives and medical staff against a stark scientific background, creating images of beauty that succeed in stimulating us on both an intellectual and emotional level.

Projects in progress

Cardiac and vascular disease: *'A Tree of Life'*

This exhibition will combine a variety of different modes of fine art, namely: photography, pottery, patchwork quilt, and paintings. The exhibition is being produced in phases.

Part 1: A cardiac surgeon, behind and beyond the hands. To show the stress and loneliness in his life, a series of 12 large photographs are being produced by Ben Edwards, who shadowed the surgeon for eight days photographing all aspects of his life as a cardiac surgeon. This was launched in the Art Gallery, Bucks County Museum, Aylesbury in October 1998.

Part 2: The blood vessels of the myocardium of the heart. The tree of life concept has been taken by tin-glaze potter, Alan Caiger-Smith, and the pattern of the arteries and veins in the myocardium (muscle wall) of the heart included in the designs of his latest pottery bowls. Three large bowls were exhibited in the Art Gallery, Bucks County Museum, Aylesbury in October 1998.

Part 3: The main coronary arteries and myocardial blood vessels of the heart. To be depicted in a patchwork quilt, combined with the branching patterns of oak trees or other trees as appropriate.

Part 4: Pathology of heart disease. Colour photographs taken by Dr G Farrer-Brown to illustrate and explain to the general public the pathology of coronary artery disease causing a 'heart attack'.

Part 5 – The human side of the heart attack. Oil paintings by Susan Macfarlane or another appropriate artist will illustrate and explain to the general public the sequence of events in undergoing a heart attack not covered in previous Parts 1–4.

Art by long-term hospitalised children

Part 1: Paintings by children with leukaemia. This is a selection of 12 paintings by children aged five to ten years resulting from art workshops held by Anne Greer, Arts Co-ordinator at the Gloucestershire Royal Hospital, where the children were asked to paint a picture of 'being in hospital'.

Venues where the paintings have been shown: Gloucestershire Royal Hospital, Gloucester; Musgrove Park Hospital, Taunton.

Future venues: The paintings will be shown alongside the exhibition *Living with Leukaemia* by Susan Macfarlane, where the venue has sufficient space.

Part 2: Art by children in the Chelsea Hospital Children's School. This exhibition will comprise a selection of art produced by long-term hospitalised children suffering from such diseases as cystic fibrosis and congenital heart disease, taught within the hospital school. Art is used as a contributory factor to help the children re-integrate into society by giving them the confidence of achievement when they leave hospital and meet their peer groups once more. The exhibition, entitled *Healing Art*, includes paintings, photographs, designs of rooms in wooden boxes, pottery produced following storytelling, and a patchwork quilt. This was launched in the Art Gallery, Buckinghamshire County Museum in October 1998.

Blindness and sight

Preliminary discussions have taken place about painting the causes and results of blindness. As with other exhibitions by Susan Macfarlane, the aim will be to explain blindness to the general public using images and captions together with a catalogue including essays by doctors and blind persons. There is considerable interest in the project, but careful planning is needed for such a wide-ranging topic. The planning stage will probably take six months and, if it goes ahead, will involve the charity Living Paintings Trust.

Appreciation of pottery by the blind

Preliminary discussions have taken place to determine whether it is of interest to understand the factors involved in the selection of a piece of tin-glazed pottery when bought by a blind person. If the project continues it will be in conjunction with potter Alan Caiger-Smith, and the charity Living Paintings Trust.

A web site and the internet

Preliminary discussions are taking place to plan a web site for the exhibitions.

The charity: A Picture of Health Limited

The charity A Picture of Health Limited (registered charity no 1064061) was registered in August 1997. Its object is: 'To relieve the distress and hardship experienced by cancer patients and others suffering from serious illnesses, producing materials to serve as an aid in counselling them, their families and carers, and in particular to provide them with images of the information about the medical processes involved in their treatment'.

Geoffrey Farrer-Brown is a consultant histopathologist and formerly Senior Lecturer, Middlesex Hospital Medical School, London

sydney art for sydney health:

the evaluation of art as part of the healing environment at the New Children's Hospital, Westmead

JOANNA CAPON

In 1995, Sydney's Royal Alexandra Hospital for Children, now better known as the New Children's Hospital, moved from the site it had occupied since 1908 in the inner Sydney suburb of Camperdown to a new location at Westmead, a suburb in Sydney's outer west, close to the site of the year 2000 Olympic Games.

The New Children's Hospital is in Sydney's fastest-growing area and at its demographic centre. It is a public hospital whose patients come from all over the state and from a wide range of cultural backgrounds, as well as from a number of countries in the Asia Pacific region. It has 21 wards, 350 beds and over 150 departments.

The decision to re-site the hospital was taken in 1988, construction began in February 1991, and the first patients were admitted to the completed building in November 1995.

When my involvement with the hospital began in 1993, the building was beginning to take shape. My brief was to collect and place paintings, works on paper, sculpture, photographs, ceramics, murals and wood panels throughout the building before the first patients were admitted. This included the parents' room attached to each ward unit, the parents' hostels, and staff areas. Known as the Art Collection programme, this involved commissioning site-specific pieces, helping staff select artworks, assisting in the development of other projects, and developing community commitments to the arts programme.

It was the move to the 11.2-hectare site which allowed the hospital's Chief Executive, Dr John Yu, with the support of his Board of Directors, to build the modern children's hospital which he had long wished to see, and it was designed as a complete healing environment in which art was to be an integral part of the health care.

After ensuring the hospital had the best and latest medical facilities, the first objective in this initiative was to create a building which projected a supportive, friendly atmosphere. The artworks were the conclusive element in creating this desired environment.

Great care was taken in the design of the building to prevent it from feeling like an overpowering, monolithic institution. It was constructed on three levels and designed by four architectural firms, each responsible for a different area; these, however, meld to form a cohesive whole. Great emphasis was placed on light, colour, space and detail. The building is set in a garden with rustic courtyards spaced regularly throughout in order to give every ward a view of the garden or a courtyard.

Much attention was paid to small details to ensure that children feel, if not at home, at least cosseted. There is carpeting throughout the building in a variety of styles, including one interwoven with a pattern in which there is a track the size of the wheelbase of a Matchbox toy car. Vinyl flooring is inlaid with brightly coloured designs. Each set of lifts has individual designs that range from a Mondrian-type interior to a moonlit night. Bedside lockers are in the shape of faces. Ward windows allow the children in bed to look outside, and circular windows in the ward unit play areas are set low enough even for small toddlers to see the garden or

courtyards when they are walking about. In the outpatients' area 'trees' disappear into a 'cloudy' sky.

As well as the Art Collection programme, the hospital has two other health care/arts programmes which had originated at the old hospital: the Youth Art programme and the Hospital School Art programme. All three reflect the hospital's declared philosophy of using art for the benefit of patients and to aid their recovery.

While the welfare and well-being of the children was, and is, the main consideration in the development of the distinctive atmosphere and environment in the hospital, the importance of the impact of that environment on adults, particularly parents and staff, was not overlooked. Great emphasis is placed by the hospital on lessening parents' anxiety and apprehension about their children. It was felt that if parents could observe the thought and attention that has been taken to establish a friendly ambience in the hospital, it would reassure them that their children would receive the best medical attention and nursing care. This lessens their anxiety, and the reduction of parental stress transmits itself to the child. This, in turn, helps speed recovery. Staff also find it pleasanter to work in such an atmosphere.

It was, therefore, important that the artworks supported the atmosphere evoked by the architecture: they, too, had to radiate a positive feeling – nothing with a negative content, nothing that could frighten or disturb children, nothing which could offend the different cultures who come to the hospital was appropriate. In addition, art from different ethnic backgrounds was selected. It was also felt that art should be included on its own merit. Nothing was chosen merely to enhance the architecture.

Although it was important to take adults into account here, art for children was the priority. However, as children enjoy and respond well to 'adult art' sometimes more than adults themselves, it is art in this category which forms the foundation of the collection, though specifically childish subjects were not entirely omitted.

A priority in the selection process was good art by good artists, works which the children might not have seen before, and also the selection of

pieces which would make their visit to the hospital as rewarding an experience as possible. With this in mind, we chose pieces from contemporary, established and up-and-coming younger Australian artists, mixed with art by children. The policy was to stimulate, amuse and surprise but pieces which offered tranquillity, refuge and sustenance were also included.

The children's pieces come mainly from a scheme run by the hospital in partnership with the New South Wales Department of School Education which involves all schools in the state. Every school, private and public, is asked to submit one work by a student painted especially for the children in the hospital.

Before any of the paintings are hung in the hospital, Operation Art, as the project is known, is shown at two locations. Fifty paintings were chosen at the first venue and these were shown in an exhibition at the state's museum, the Art Gallery of New South Wales, before they came to the hospital. From 1997, these final 50 works were also exhibited in 14 regional art galleries around New South Wales and, after their return, it is planned to make the growing Operation Art collection available for loan to children's wards in hospitals around the state.

The children's art, like all other art placed and hung in the hospital, is accessible to children. There are no barriers and they are encouraged to interact with the sculpture and to get as close as they like to everything on the walls. The art is hung low for this purpose. We hope this will dispel any mystique relating to art and the children will leave the hospital understanding that art is approachable and can be enjoyed by everyone.

The initial small budget for the programme, provided from privately raised funds, was spent on commissioned work, mainly sculpture, and these pieces were placed in key areas. The hospital's art policy was explained to the commissioned artist and they were asked to execute a piece for a specified site which would reflect that policy. They all understood what was required and fulfilled the requests admirably.

Areas chosen for the commissioned pieces included the forecourt, which we felt was an important 'scene setter' for children about to be admitted

to show them that this is a hospital with a difference, with more good surprises inside. Here, five brightly coloured acrobats fabricated from mild steel cross the space while two figures abseil down the outside of the building.

Inside the hospital entrance a steel, coloured plastic and neon aerial sculpture hangs in the sunlit two-storey galleria which runs from the front to the back of the building and along which everyone who comes into the hospital must pass. In the emergency waiting area to the left of the entrance is a water sculpture of a high chest of drawers with water running intermittently down the open drawers. Children love to splash in it and they – and adults – wonder aloud where the water comes from.

Large sculptures were also commissioned for some of the courtyards, which are visible to the wards and the offices. These are used as places of refuge and also for work breaks. The courtyard for the sole use of the paediatric intensive care and neo-natal intensive care units, areas of intense stress for parents and staff, demanded particular attention. The brief here was to divide the space to give each group an area in which to relax and regenerate in privacy from the other. Water was chosen as a soothing element and creepers are being grown over the sculpture which divides the garden courtyard.

After the initial budget was spent, it was the support of individual donors, and the particularly generous involvement of Sydney's artistic community and private art galleries which gave the hospital works of art of the highest quality, which enabled this programme to succeed. There are now over 800 works in the collection and it continues to grow. However, no work was accepted that did not come within the established criteria. That included rejecting a 3-metre long painting of dancing skeletons offered by a well-intentioned and well-established Sydney artist.

Although some of the staff wished to choose artworks for their departments and units at the beginning of the project, most preferred to leave the decision to me as Art Curator. However, as the Art Collection programme became a continuing part of the hospital's daily life and the effect the artwork was having on the hospital began to be appreciated, this view changed. General interest in the art grew and staff began to take

great pride in what they saw on the walls, and joined in the positive response the collection was receiving from children and parents. Opinions were readily expressed and different aspects of the art discussed, which led to a desire to select works for their own areas.

At present we have a two-year programme which involves the ward units' nursing staff and the second-year design students from the West of Sydney University. This involves decorating each unit with murals. Each illustrates a story in which the unit's Australian animal emblem plays a central role.

The Design Schools' first involvement with the hospital was in the initial stage of the art programme when the doctor in charge of the paediatric intensive care unit asked for murals to lighten its atmosphere and to remind his staff that this was a children's hospital. The success of these murals led to the current programme, which provides direct involvement for the nurses with pride of ownership, while the students gain useful experience and insight into the whims of clients.

Elsewhere, murals are to be used in a project being developed by the histopathology and oncology units. Here, they are seeking ways to alleviate needle phobia in blood collection and to help pain management for their long-term patients. After consultation with the children, parents and staff, including social workers, the doctor in charge of the programme asked for the room set aside for the project to be covered with a mural of realistic undersea themes. We feel that transformation of this room and the different elements incorporated into the mural will help soothe and divert the children and convert the room from an area of apprehension to one of tranquillity. We hope this mural will be another successful collaboration between art and health care.

One undertaking which was far more successful than had been anticipated was the commissioning of a sculpture by parents involved in the support groups and fund-raising activities for the oncology department. The move from Camperdown to Westmead was particularly traumatic for many of those who had seen their children die at the old hospital or their treatment begin there. They wanted a focus in the new hospital which would keep the memory of the old hospital alive and

commemorate the children who had died there, as well as being a memorial to the children who have already died (and, sadly, will die) at Westmead.

The commissioning process was an emotional experience and involved a great many discussions. Since the sculpture was placed in its special garden, it has proved to be very cathartic for many parents, including some whose children had died many years ago. It has become a focal point and parents often visit it in silence and leave flowers there. The child of one couple who came to the unveiling ceremony had died 15 years ago and, before they left, they said that at last they felt there was a memorial to their child, and they went away feeling at peace. The sculpture plays an important part in helping the grieving process and has done much to aid parents make the emotional step from Camperdown to Westmead.

While these initiatives use existing art as part of the hospital's all-embracing programme of healing, the Youth Art programme originated by the Department of Adolescent Medicine at Camperdown in 1984 uses the creation of new works of art as a direct method of helping its adolescent patients.

This programme reflects the holistic role art can play in health care, in particular in young adolescents. It was established because of the hospital's belief that a young person, especially one with a chronic illness, should feel that admission to hospital was less a burden than an enhancing opportunity. Our department's continuing involvement with this programme demonstrates that within a supportive environment, creativity and self-expression bring out the best in teenagers and almost certainly aid theie healing process and quality of life.

The Youth Art programme provides an active involvement in care and an all-important sense of personal control at a time of pain, fear and uncertainty. Rather than distracting patients from their plight, young people find in it a means of interpreting, articulating and actually changing their circumstances through artistic expression. 'I'm too sick' often becomes 'I can do this', with exuberant consequences.

The adolescent ward, which has a mixed population of medical, surgical and psychiatric disorders and illnesses (including 83 per cent with chronic illness), has a full-time visual artist who is also the artist-in-residence, and an occupational therapist. They work together to change the experience of hospital for the adolescents by enabling them to express themselves creatively as unique and valued individuals. This reduces the effect of hospital shock and the feeling of isolation from family and friends. Encouraging them to work as individuals and also in groups helps them maintain their individuality and form strong peer support relationships. As they express and explore issues in creative media, this activity becomes a very important part of the hospital's art in health care philosophy.

While the Youth Art programme and the School Art programme are run separately from the Art Collection programme, they are mutually beneficial. Works by adolescents and from the School Art programme are displayed around the hospital. In turn, the patients in the two programmes benefit from easy access to the artworks by established artists they see around them.

Like the Youth Art programme, the aim of the School Art programme is to stimulate and support children in hospital through a positive experience. The creative programme is seen as enhancing the recovery process through the promotion of psychological well-being. It encourages the expression of feeling, thought and the use of imagination to foster harmony and personal and social growth. As a divisional therapy, art in the school allows freedom of expression for the sick child, is a great motivator, facilitates social interaction and is fun.

One of the school's recent success stories is a teenager who came to the hospital with hysterical conversion syndrome. Through this psychological illness he had temporarily lost the use of his hands and legs. An individual arts programme was created for him using his interest in computers, art and craft and, through this, the unmotivated and depressed child regained the use of his limbs and confidence. Since his recovery he has continued to make paper works which he now sells commercially. His is a perfect case of how art can assist the healing process.

Has the hospital's policy of using art as part of its health care achieved its objective? The hospital had been open for about three years in 1997 and no academic survey has yet been undertaken. While the achievements of the last two mentioned programmes speak for themselves, the success of the Art Collection programme is more difficult to evaluate. However, from the evidence I have gathered from patients – which includes a 'cool, mate, cool' from a small child who stopped on his dash to freedom to look at a wood tiger sculpture I was installing; a letter from an ex-patient asking whether she could return as she had not had time to see all the art before she left; letters from parents and grandparents saying how much they appreciated what they saw and how much strength they drew from the atmosphere; the interest shown by staff and their very positive reaction, pleasure and pride in the artworks and their growing involvement with the programme – I have no hesitation in saying that this programme is achieving the expressed request at the planning stage that art be part of a total healing environment in the new hospital.

I feel the art also plays an important role in enabling the whole building to reflect John Yu's stated aim for the hospital that 'though it may not be possible to cure every child, you can heal them, soothe them and make them feel better'.

Other strong evidence of the programme's success is reflected in the interest the Art Collection and other arts programmes have generated in those who run hospitals, public and private, old and new, in other states in Australia as well as in New South Wales. Many of them have visited the hospital to see what has been achieved, and a growing number leave determined to set up similar programmes.

This increased interest has also led to the establishment of a website (<http://www.central.com.au/artmed/projects/nchw/index.html>) and the hospital is including the Art Collection programme on its forthcoming website.

Postscript

Since presenting this paper, I have had first-hand experience of the benefits of the Art Collection programme to patients, their parents and family. My 18-month-old grandson was admitted as a seriously ill patient a week after I spoke.

As I flew back from England to be with him, his parents and his four-year-old brother, I wondered what their, and my, reaction would be to the art seen from this perspective. What I saw reinforced my feeling that it does help. I saw how the whole environment of the hospital helped to calm his very anxious parents when he was admitted; how it was able to distract and amuse his elder sibling (as well as making it easier for his grandmother to look after him); how it gave his parents something to show their sleepless and very distressed child as they wandered through the hospital in the night trying to calm him; how it provided points of interest to him as he began to recover, and how it continued to give support to his parents at a period of great stress by helping to create a pleasant and revitalising atmosphere.

Joanna Capon is an art historian and Curator of the Artworks Collection at the Royal Alexandra Hospital, Westmead, Sydney.

healing through the arts at the C Everett Koop Centre, Dartmouth, New Hampshire

HAJ WIKOFF

Variety of form and brilliancy of colour in the objects presented to patients are actual means of recovery.
Florence Nightingale, 1859

I should like to report on recent health care in the USA and the development of the arts in medicine, and then explain the work of the Koop Institute. In terms of arts and healing, we have to keep in mind that healing does not take place only inside a hospital, it can be community healing. This is clear from what we have already heard at this conference about the AIDS Memorial Quilt.

The arts were vital in helping heal the people of Europe after the war. The arts were also extraordinarily vital after the recent bombing in Oklahoma City, where young artists used masking tape inside the shelter where all the broken bodies were brought to make it a place where angels

were being assembled and sent to heaven, and it helped heal the workers. Healing therefore takes place in the community, it takes place in the hospice, it takes place in the hospital, it takes place in your homes. All of this is our daily work.

In the USA, as elsewhere, health care is driven by economics. The length of time patients remain in hospital is shrinking dramatically and a lot of surgery is carried out in one day. When patient stays are cut, that means ultimately that some staff may also be cut and medical workers are losing their jobs. Doctors are being asked to do more work for less money so medical schools are also going to be reduced, and we already know in the USA that there are a number of medical schools that are going to close or be merged in the near future. The ramifications are stressed staff and less money, and patients being asked to take more responsibility for their health and well-being.

Another consideration is that people are living longer. As a result of science in medicine, a patient often knows when he or she is going to die, yet for a lot of doctors, death is regarded as a failure and many of them don't know how to deal with this. They don't know how to talk to their patients about death. Types of discussions like this are awkward, and are not currently addressed in medical schools. Doctors need to know how to deal with these issues.

In addition, many people are not satisfied with formal medicine. People do not trust their doctors as much as they used to. If somebody has cancer in the USA, currently up to 90 per cent of them will seek alternative methods of healing and 68 per cent will not even tell their doctors. Alternative medicines could be visualisation, diet, all sorts of different things. This growth in alternative medicine, or complementary medicine, is a multi-billion dollar industry and much of it has come about because patients are treated as human beings in alternative medicine; in many ways orthodox medicine is dehumanising the central relationship between doctor and patient.

What does this lead to? It means, and we are starting to see this already, that the cost of going to one hospital will soon be much the same as another, so what is going to make the difference? Patient satisfaction is

going to make the difference, because patients will choose the place they believe takes best care of them, and we can expect a shift in health care based on patient satisfaction. Therefore, the most important study to undertake of the value of the arts in healing begins with an examination of patient satisfaction.

The arts in medicine in the USA started in much the same way it did in Britain. After World War Two, people started putting paintings up on walls of hospitals and the practice slowly spread. About 25 years ago in New York City, a very interesting programme started called Hospital Audiences Inc. The idea was to take patients to concerts and shows, and they all loved it. I used to run a performing arts centre in a church, and I often gave a lot of tickets away to these groups.

Then a community artist, Janice Palmer from Dukes University Medical Center, became interested in getting the arts going in her hospital and wished to do more than just put paintings on the walls, although that is extraordinarily important. She decided to bring the artists into the hospital itself and she began to develop what has become an extraordinary programme in the USA that includes carts filled with art supplies going to patients' rooms, poets in residence, poetry contests, etc.

Janice Palmer learnt that other people like Irene Walt in Detroit were doing similar things, and about ten years ago these art advisers created an organisation called the Society for the Arts in Healthcare. Initially, the people in this organisation really came from three strands. There were people like Janice Palmer, who were hospital arts co-ordinators. Others acted like art consultants to a hospital, putting up really good works of art that made the place more exciting. Lastly, others were involved in the design of the hospitals themselves – in the shape of the walls, the letting in of light, the bringing in of trees and other beneficial design developments. The Society for the Arts in Healthcare has been extremely helpful, and for the last ten years has organised conferences to share ideas and developments, which is what I want to do now as regards the Koop Institute.

Recently there have been changes in this organisation. It now takes consideration of who the players in arts and healing are, and brings them

both on to the hospital board in order to serve that broader constituency. The second change is that it is breaking into regional areas: I direct the New England area; then we have the mid-Hudson River Valley area, represented at this conference. So, we are breaking into regionalism.

One of the most recent artists featured is Deborah Johnson, who has made over 400 drawings in hospitals for the terminally ill. Her work is beautiful and is available on our website.

Healing and the arts

The C Everett Koop Institute, founded in 1991 by the former Surgeon General of the USA, Dr C Everett Koop, and dedicated to the improvement of human health, launched Healing and the Arts to explore and evaluate the potential for using the arts and humanities to accomplish the following goals:

- build more effective doctor-patient relationships
- enhance medical education
- support the process of healing
- promote good health habits.

Healing and the Arts seeks to achieve these goals by developing and testing model programmes, helping to further existing initiatives, and by linking people and programmes that examine the interface between the arts and health care. The Institute promotes the results of its work to both targeted and general audiences, and is available to assist others wishing to develop activities in the arts and humanities to promote well-being.

Healing and the arts activities

Through Healing and the Arts, the Koop Institute sponsors a number of activities both at the Dartmouth Hitchcock Medical Center and in the community at large, co-operating in a number of community workshops, retreats, presentations and conferences addressing health care issues. Healing and the Arts has been working in co-operation with others to create projects in the hospital designed to improve the quality of healing. The ArtCare programme and the In Poetry and Prose reading series both result from these efforts.

In accordance with its efforts to enhance medical education and improve doctor-patient relationships, Healing and the Arts also develops arts electives for medical students in partnership with the Dartmouth Medical School.

The involvement of undergraduate and medical students is the key to the success of many Healing and the Arts activities. Through Healing and the Arts, students have served on committees to plan ArtCare, helped develop electives and related activities for the medical school, volunteered their time, and participated through work-study and Learn and Serve programmes. At the hospital, students work in various departments, including the Children's Hospital at Dartmouth (CHaD), the Elder Life Pilot Programme on the Medical Specialities Unit, and the Psychiatry and Medical Unit. At least one student is at one of these departments every weekday, and students are occasionally there on weekends for special events. Healing and the Arts activities are:

- ArtCare Programme
- In Poetry and Prose Reading Series
- Concerts and Performances
- Arts and Humanities Electives.

ArtCare

As a member of the Dartmouth-Hitchcock Medical Center Arts Committee, and in co-operation with DHMC Volunteer services, Healing and the Arts helped create ArtCare – a programme designed to improve patient morale and to enhance the process of healing. The programme was co-created with the active participation of medical students, patients, artists, hospital volunteers and health care professionals.

'Enhancing the healing process through creative expression'

Over the year a growing team of musicians, visual artists, poets, storytellers and other artists of all kinds have been volunteering their time and passions to assist patients and staff in creating a total picture of health. The experience of working with ArtCare is a challenging one. It is also extremely rewarding and unique. The bonds that are forged

through the process of art intervention change both their lives and those of their patients. ArtCare provides a number of volunteer opportunities for students, hospital staff and community members.

Art programmes in hospitals provide many benefits. There is much anecdotal evidence to show that blood pressure, heart rate and respiration can be positively affected by exposure to the arts, stress can be reduced, fears released and communication improved. Art expression also lifts patient and staff morale. Soothing music can relax tense muscles, promote rest and relieve troubled moods, and creativity can relieve boredom for hospital patients.

Some of the ArtCare programme activities are listed below.

'Art cart'

A cart filled with paintings and posters is brought into patient rooms so that patients can select artworks to hang on their walls. A second mobile 'art cart' allows art supplies to be brought into patient rooms so that the patient can create artistic projects. Sculpture (from tinfoil), weavings, drawings and watercolours have proved popular.

Arts and crafts

A room at the hospital has been transformed into an arts and crafts studio. Filled with art supplies, it is a place where both patients and staff can come to create art projects either on their own or with the assistance of student and community volunteers.

Time line

Working with patients in an Elder Care unit, students are helping to create a time line of the 20th century. The patients contribute reminiscences of various significant incidents which the students/patients then illustrate (poetry, prose, visual) and attach to the time line. When completed, the time line will be displayed permanently in the patient care units of the hospital.

Pot luck art

Special events where patients, community and student volunteers, and staff from throughout the hospital are invited to co-create art projects. Such projects have included a 'healing tree' and group sing-alongs.

In poetry and prose

> *Take a noontime break! Bring your lunch! Bring a friend, colleague or patient! Enjoy, relax and educate yourself at one of our In Poetry and Prose reading series presentations.*

The Koop Institute, in co-operation with DHMC Volunteer Services and the Art Committee, sponsors In Poetry and Prose, a lunchtime reading series focusing on issues related to health and medicine. The series has featured the works of a wide range of authors, including doctors and nurses, medical students, patients and sometimes their family members.

Four consecutive readings take place during three autumn and winter months, and are extended throughout the spring and summer for one reading every month. The readings are held at the medical centre and draw varied audiences of hospital staff, medical and undergraduate students and community members. Each reading touches upon health issues in some respect or another.

Past readings have included poems written by cancer patients, a lecture on hospital design, and a discussion of doctor-patient relationships throughout history. Each one, in its own way, brings the human dimensions of the medical profession to light and creates a connection between the arts and science. In Poetry and Prose is free and open to the public. Notices of up-coming readings are posted on the events section of the Koop Institute website and on DHMC bulletin boards.

Concerts and performances

Whether you are a patient, visitor or staff member of the Dartmouth-Hitchcock Medical Center, you can enjoy classical chamber music, the collaborative voices of an a cappella or glee club group and the popular songs of a solo guitarist and singer.

Local, student and visiting artists perform in DHMC public spaces, patient care units and, when appropriate, in patient rooms. These performances include quartets, soloists (flute, guitar, violin, and so on), singers, magicians and clowns. Some of these performances are organised by Dartmouth students through the ArtCare work-study programme, and some are organised by the Healing and the Arts staff at the Koop Institute in co-operation with DHMC.

Arts and humanities electives

Healing and the Arts also develops and evaluates arts and humanities electives for medical students in partnership with the Dartmouth Medical School. These activities, complemented by efforts already established, are designed to teach communication skills, help medical students learn to be effective doctors, and provide access to methods of dealing with job-related stress.

Life drawing

Weekly two-hour drawing classes with a live model. The purpose of this course is to provide a greater understanding of human anatomy, to teach drawing skills, and to provide a forum for creative outlet.

Improvisation

Instruction in the basics of improvisational acting – a form of comedy theatre that focuses on developing stories without any prior scripting. Team building, listening, observation and related skills are taught.

Literature and medicine

Exploration of what it means to be a doctor through readings and discussions of world literature and creative writing assignments.

Creative writing

An introduction into creative writing as a means of self-expression, communication and discovery. Included are reading assignments in poetry, plays and literature, weekly writing assignments and introductions to a variety of techniques to break creative blocks.

Pulp fiction

Attitudes about health, nutrition and medicine are constantly being shaped by the media and other aspects of contemporary culture. This course looks at what is being said, who is saying it, why they are saying it, and what the implications are of both the message and the media on doctoring.

Conflict resolution

Instruction in techniques for resolving communication conflicts (such as doctor versus doctor, doctor versus nurse, doctor versus patient), through role-playing using real-life examples.

Very special arts

Instruction in communication between doctor and patient, on a one-to-one basis, using the arts as the vehicle for experiencing and developing appropriate techniques.

Collaborations at the Koop Institute

Dr Koop has won national recognition for his efforts to promote good health habits during and since his service as the nation's Surgeon General. His warnings to the nation about the hazards of smoking and second-hand smoke are but one example of this. Healing and the Arts is currently working on several projects that will incorporate creative images into the process of encouraging good health habits. Through the Koop Institute's Partner in Health Education Programme, medical students use various methods of teaching health information to elementary school-children.

The Healing and the Arts Programme is also working with Partners in Health Education to develop and evaluate a strategy for improving doctor-patient relations. By creating and evaluating specific experiential-based learning activities, the programmes hope to teach and reinforce humanistic skills. This strategy will include activities for students in high school who are interested in medicine, pre-med students, medical students and residents, health care professionals, and patients and their families.

In addition, Healing and the Arts works with the Northern New England Health Information Initiative to develop methods and programmes for serving rural disabled people and other rural community health care needs. NNEHII provides telemedicine technology, and Healing and the Arts provides content.

Other partners in Healing and the Arts initiatives include: The Dartmouth Medical School, The Dartmouth-Hitchcock Medical Center (DHMC) Arts Committee, DHMC Volunteer Services, and Very Special Arts of New Hampshire.

Selected examples of recent events

In poetry and prose

A series of lunchtime readings about health and related issues featuring the works of doctors, nurses, patients, medical students and celebrated authors. Sponsored by: ArtCare – an activity of the DHMC Arts Committee with the Healing and the Arts programme at the C Everett Koop Institute. Some examples are:

- *Echoes from a Dungeon Cell*. The writings of a doctor incarcerated in mental institutions for manic depression. Presented by Mimi Baird, July 15, 1997

- Selected readings of Dr Woodbury, 27 June 1997. Dr Woodbury has published several articles in *Dartmouth Medicine*, the most recent concerning the death of his wife, which was published in the Spring 1997 issue. Dr Woodbury read from sections of several of his writings, including some work he did while in medical school at Dartmouth. During the readings the audience shared with him his written recollections and thoughts upon his wife's tragic death from ovarian cancer. He began the reading with excerpts from an essay about the birth of his first son before his wife had become ill. He then proceeded to read from two essays about her illness and eventual death. Much of the story he told was about how he struggled through the loss together with his two boys, trying both to console his children and comprehend the questions and mysteries of cancer and death.

Concerts and events

The Big Apple circus goes to DHMC

Lucky was a plump clown who sported the classic big black wing-tip shoes and polka-dot tie. He had a red nose and permanent smile. Dr Potsdam, on the other hand, was tall and skinny with a neon-yellow suit, red plaid pants and matching yellow top hat. I had gone to meet them on the outskirts of Hanover so that I could escort them over to the Dartmouth-Hitchcock Medical Center to visit with the patients in the children's hospital.

When all the available children had been gathered in the main play area, the camera lights were turned on and Lucky and Dr Potsdam started their show. To the children's delight the clowns pulled coloured ribbons from behind ears, made wads of toilet paper disappear into thin air, sneezed confetti all over the floor, folded two pieces of flimsy tissue paper into a stylish hat, and tugged rubber frogs from scratchy throats. There were lots of unbelieving eyes and several indulgent smiles from the hospital staff.

At the end of the visit, Lucky and Dr Potsdam made some extra time to visit two rooms whose patients were too sick to leave their beds. Recreating their tricks and signing autographs, they brightened the morning for all the children who saw them.

ArtCare time line of the 20th century

Through the winter and spring terms of 1997, several of the Dartmouth undergraduate ArtCare work-study students worked at the Dartmouth Hitchcock Medical Center with patients and staff to create a 20th-century time line, which was finally unveiled on May 30th at the Medical Specialities Unit in a brief ceremony. This has been, and will continue to be, a way to facilitate patient healing by getting patients to reflect upon significant times during the course of their lives.

In addition to being publicly displayed in the hospital, the time line will be used extensively in future discussion and reflection groups. The students plan to walk patients to the time line and talk about the pictures that are there, and also gather a list of new pictures and recorded memories which represent the significant times not yet depicted. We are

looking forward to using the time line in this second phase of its life for as long as it hangs on the hospital walls.

An on-line version of the 20th-century time line, capturing the images and text of each of the panels, is available in the resources section of the C Everett Koop Institute website (under Healing and the Arts).

Dartmouth Glee Club hospital performance

Dartmouth Undying, *Twilight Song* and *Pea Green Freshman* were just a few of the many songs that the Dartmouth Glee Club sang while visiting five different patient care units at DHMC, in a performance organised by the ArtCare work-study programme. The ArtCare programme is a joint effort between DHMC Volunteer Services and the Koop Institute. The club set themselves up in patient rooms, waiting rooms or pods where several bed-bound patients could listen at once.

Apple Hill Chamber Players

The Apple Hill Chamber Players from East Sullivan, NH, arrived at DHMC to present an afternoon of classical music for the hospital community. The Chamber Players performed in the rotunda for 45 minutes to large crowds made up of hospital staff, patients and visitors. After the concert in the rotunda they moved on to the Psychiatry Medical Unit where they played for patients that had gathered for tea-time. The ensemble played two pieces, one by Paganini and the other by Schubert. The music complemented the tea and refreshments to create a restful and relaxing atmosphere.

Lectures

College of Physicians of Philadelphia

As Director of the Healing and the Arts Project of the C Everett Koop Institute, I presented the Mary Scott Newbold Lecture of the College of Physicians of Philadelphia. The lecture was entitled 'Breathing Life into an Academic Medical Center: the Impact on the Arts on a Medical Environment', and was jointly sponsored by the College and the Section on Arts Medicine.

In 1995 the College endorsed the formation of a section on arts medicine to explore the multifaceted relationships between the creative and healing arts. My presentation inaugurated a public discussion of this important new initiative reflected in the growing use of the creative arts in medical centres throughout the world.

As part of my lecture, I discussed how and why arts and humanities can make a difference for the carer, patients and their families – as well as the health care facility. Dr Michael C Magee, a member of the Academy's Section on Arts-Medicine Executive Committee, provided commentary on the lecture, explaining how arts-medicine programming could be expanded in the Greater Philadelphia health care community.

Electives

The life drawing elective, which is a part of the Healing and the Arts Programme, is an eight-week course for first- and second-year medical students designed to develop the ability to communicate ideas through art. By working from a live model, the participants gain a better understanding of the human body; they study how it works in motion, and what the shapes of the surface tell about the underlying structure. The elective is also meant to be fun and relaxing. The class provides the medical students with a genuine change of pace, plus a chance for each one to exercise their creative talents.

Our English cousins: healing and the arts in England

During 1997 I was honoured to be included as part of an international exchange sponsored by the New England Foundation for the Arts and the Arts Boards of Northern England. My particular interest was to examine how my English counterparts used the arts to support health and well-being within health care.

I had the opportunity to meet with the directors of hospital arts programmes in Gateshead, Leeds, Manchester and London. I also spoke with the director of a new MA in Arts and Health programme being developed by the Colchester Institute, and the head of the British Association for the Performing Arts Healthcare Trust (an organisation concerned about the health and well-being of artists), individual artists

who work in or who have created work for hospitals, religious leaders, and community arts directors who use the arts to communicate messages about safety and health, rebuild communities and foster individual creativity. I believe that we have a lot to learn from each other, as has been demonstrated by this conference.

The Art of Healing – The Koop Institute's website gallery

<http://www.koop.dartmouth.edu>

The Healing and the Arts programme has been seeking out artists around the USA who have dedicated some of their work to art as a process – or a study – of healing. This gallery will serve as a collection point for some of these works, which will eventually be featured as a fully fledged on-line gallery.

Our website is consulted up to 20,000 times each week. Roughly one fifth of the web communications with Dartmouth College are directed to our site, which partly reflects the prestige of Dr Koop but partly the enormous interest from around the world.

I think it is important to keep in mind that one of the oldest statues on record is the Venus de Milo, a pregnant female torso. It is a torso of life, an artwork of health, of renewal. The arts have been about healing since the very beginning of time: they have celebrated life and nurtured the souls within everyone. What binds us together is that spark of creativity. It exists in every single one of us and it also exists in all life, so what we have been doing during this conference is developing a renewal of this most fundamental value of the arts, which is to heal, to nurture and to connect.

Naj Wikoff is a sculptor and Director of Healing and the Arts Project of the C Everett Koop Institute at Dartmouth College, New Hampshire.

Afterword

It was a great pleasure to take part in the organisation of this meeting and, especially, to be present at the lecture sessions and social events. Speakers, audience and subject matter ensured that it was both international and wide-ranging in its coverage of many art forms and types of health care.

What the text does not record are the critical but informed – and always enthusiastic – contributions, both during the formal sessions and outside them, by members of the audience. They helped greatly towards making it the 'learning experience' for which we had aimed.

My own perspective of the National Health Service, in which I worked for 40 years, and my knowledge of other health care systems, ensure that I have no illusion about the problems facing those who wish to establish art works and arts programmes in hospitals and elsewhere. The competition for scarce resources from all directions, but especially the clinical pressures, will always make this a hard and lonely road for its advocates. But I believe that a climate has now been created, in the wider public as well as among those concerned with health care, which recognises the value and importance of the arts. The growth in membership and attendance at King's Fund Forum meetings confirms this: the data collected by Phyllida Shaw from questionnaires she sent to all NHS trusts and health authorities provide compelling evidence to support it.

This is the fruit of over 20 years of generous support by the King's Fund and the efforts of many committed individuals. Since the Roehampton conference, the Nuffield Trust has organised a series of valuable meetings centred on the Humanities and the Arts in Medicine. An Arts Forum for the North East has been set up in Gateshead. The Health Education Authority has recently decided to establish an effectiveness database to evaluate the benefits of the arts in health. And Arts for Health plans to hold a major conference in April 1999.

The main recommendation of the review undertaken by Phyllida Shaw for the King's Fund Grants Committee proposes the establishment of a National Arts in Health Forum with two full-time professional staff. In addition to organising the forum, there will also be an information and advisory service which will be invaluable, especially to those in the early stages of creating a new arts department. It will provide continuity and accessibility. The Grants Committee has agreed to provide £20,000 a year for the first three years towards this, the Health Education Authority has recently confirmed a grant of £30,000 over three years, and it is hoped that others will make similar contributions.

These are all encouraging signs and the Roehampton meeting and publication of this book record an important stage in this journey.

Last year, the National Health Service celebrated the 50th anniversary of its foundation in 1948. The histories of those 50 years make little reference to the role of the arts in health care, notwithstanding the achievements of a pioneer like Hugh Baron over the whole period. Despite the difficulties, I believe there will be no such omission when the centenary histories are written.

John Plant
Chair
King's Fund Art in Hospitals Forum
(formerly Chief Executive, Royal Brompton Hospital, London)

These days it is widely accepted that the use of creative arts in health care can promote physical, mental and social well-being. The arts can be an effective way of providing people with the confidence to put their views forward and of promoting health messages to those who do not usually listen.

This King's Fund publication looks at some very different arts in health care projects, from the design of hospitals to the use of the visual and performing arts. It draws together experiences of fourteen contributors from Britain and abroad, who use original research to describe the links which exist between the arts and health care.

The Arts in Health Care: Learning from Experience makes a significant contribution to the analysis and evaluation of the use of arts in a medical context.

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