# Soma-Series:

## Somatic Metaphors

## Evidenced in a Series of Medical Transactions?

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# Abstract

Aspects of the orthodox medical-gaze have long been the concern of artists, theorists and Complementary Medical Practitioners. This research explored an aspect of the pre-surgical transactional-interview related to the 'quest for prosthesis', as a specific paradigm of the way the medical-gaze implicitly disciplines its 'subjects'. A pragmatic feminist standpoint approach was engaged in conjunction with an Ayurvedic/holistic perspective, from which to observe and critique fieldwork and create visual outcomes from it, as it was observed to somatically affect both patients and medical team in an Orthopaedics Department of an NHS hospital.

Soma-Series: Somatic Metaphors Evidenced as a Series of Medical Transactions? parodically explored aspects of role-play and behavioural patterns that were seen to manifest through body-language that rendered the interaction as a simulation of events that were in themselves already 'artificial' as a result of the orthodox disciplines that engaged it. Three-dimensional images as interpretations of this 'evidence' were subsequently transformed into a 'scripto-visual' interactive hypertext. Through visual experimentation, new research was developed as www.soma-series.org.uk in conjunction with an exhibition of selected images as Soma-Series: Ten Constructs at the Northern General Hospital, Sheffield, U.K. [May 2002], for its Ethics Committee; fieldwork participants and members of the public.

The thesis compared this 'evidenced-based' approach to art making with the work by two contemporary women artists whose visual work also juxtaposed socio-medical discourse with art-practice [Jane Prophet and Christine Borland]. The outcomes as website 'artwork' anticipated opening up links between aspects of socio-medical discourse, cyberspace and feminism. Inviting audience response to the site was a central part of the research paradigm, with a view to expanding the debate relating to quest for prosthesis and its implications for notions of a 'bionic' body.

## Dedications

This thesis is dedicated to all the women who attend the Ayurvedic Practice I have run since 1992; to the memory of Peter Raymond Wigley [1952-1996] for introducing me to Ayurveda, and to my partner Christopher John Roberts for his continuing encouragement since 1996.

# Author Declarations

During the period of registered study in which this dissertation was prepared the author has not been registered for any other academic award or qualification.

The material included in this dissertation has not been submitted wholly or in part for any academic award of qualification other than that for which it is now submitted.

The programme of independent research of which this dissertation is part has consisted of:

**Research Design and Methods - Years 1 & 2**

**Planning and Managing your Research**

**Writing for Publication [exemption approval]**

**Supervision Tutorials**

[the above were held at De Montfort University]

**Attendance at Relevant Research Conferences**

[University of Leeds and Sheffield Hallam University]

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# Acknowledgements

# Chapter 1: Towards a rationale and hypothesis.

## 1.1. A Feminist and Visual Response to a Medical Transaction?

Aspects of socio-medical discourses have been of interest to Western artists from the beginnings of Galenic medicine[1]. The Enlightenment painters and engravers responded to medical narratives with both satire and pathos[2]. Subsequent artistic interventions were crucial to the emergence during the 1990's of feminist artists' examinations of medicine's notions of the female body as volatile and fragmented[3]. The new channels of enquiry opened up by artistic engagement with medicalisation enabled a gendered and more personal account of the medical process's impact on the body than a purely descriptive social-interactionist discourse would allow[4]. In particular, it was the notion of observing the 'lived experience' of women engaged in medical transactions in relation to how they negotiated ways of coming to terms with their own sentience [through the quest for prosthetic body-part replacement], that was of particular interest to this project.

As a feminist artist I am aware that there are significant understandings to be 'teased out' of medical institutional discourses. Subsequently I have chosen to visually record an observed series of medical interviews, in order to examine aspects of its structure and power/knowledge regimes

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[1] Dr Galen, the celebrated early Greek practitioner, conceived early anatomical investigations as a quest for 'metaphors for decoding, dividing and separating all branches of knowledge' B.M. Stafford: <u>Body Criticism</u> [p.17]. His systems have formed the basis of orthodox Western medicine, thus offering an opposite view of the Ayurvedic Eastern bodily perceptions.

[2] André Brouillet's <u>Une Leçon Clinique à la Salpetriere</u> [1879] commissioned specifically to demonstrate Dr Charcot's powers of observations of female hysteria as understood in the period before knowledge of Freudian psychoanalysis.It also demonstrated that the patient/doctor relationship was not only of interest to feminists.

[3] Exhibitions: <u>Pharmacopoea</u> RCA [1999]; <u>Spectacular Bodies</u> [2000]; <u>Art and Science</u>: The Wellcome Trust.

[4] Spence, J. <u>Cultural Sniping: The Art of Transgression</u>. [1995] and Susan Sontag: <u>Illness as Metaphor,</u> [1989].

that informs the 'medical gaze'[5]. The anxieties that were seen to arise within this dichotomy, revealed how the doctor in collaboration with NHS hospital politics, determined the health-care outcomes for individual patients. The intention of the research has been to show how the construction of the interview 'transaction' *itself* contributed to a 'somatisation'[6] processes based on the fear related to interventionist surgery that the quest for prosthesis manifest both in patients and the medical team as a whole, whose behaviourally mutually manifest a 'learned' role via their interaction.

As a practitioner of Eastern Ayurvedic health-care regimes[7] I was sceptical about interventionist orthodox surgical practices: this research developed out of observations that question the nature of transactional site of the patient-doctor diagnostic interview, since I see the patient within orthodoxy as the passive recipient of medicalisation. Through pragmatically examining how the quest for prosthetic surgery engaged the Foucauldian power/knowledge regime of the medical gaze, I set out to find 'patterns' of behavioural responses to it, in both patients and 'medical teams'; these were subsequently found to have been a 'somaesthetic' response. I had therefore set out to present scripto-visual research that might reveal 'patterns' of this physically evident behaviour that affected

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[5] I have used this term as interpreted by Foucault: the function of the 'medical gaze' was intrinsically 'disciplinary' since its earliest development in Galenic medicine. The women participating in the research as patient 'subjects', had malfunctioning bodies that become the 'object' of medical discourses – so the patients' personal narrative was not of concern to the way doctors viewed them diagnostically. Medical discourses were seen to be 'objectively' concerned with the impersonal bio-medical aspects leading to prognosis based on 'evidence' alone. Within this process, the medical team became depersonalised and thus also 'objectified' itself, metaphorically speaking, through their transactions about prosthesis. Because the visual research has interpreted this concept metonymically, it is meant here to specifically reference the paradigm related to Orthopaedic prosthetic intervention.

[6] Somaesthetics an 'embodiment' of feeling remembered through the body and related to ideas of the inseparability of 'mind/matter'; 'flesh/spirit'. The philosophical heritage of the mind/body split – which this terms intrinsically opposes – still permeates science, medicine and the arts. Hence the notion of the everyday idiom: 'psycho-somatic' has been interpreted for the purposes of this research as 'somaesthetic', since I feel the' psychosomatic' term is often used pejoratively [as though the person had indulgently brought an illness upon themselves!]

[7] Working over a ten-year period as a practitioner of this alternative medicine, I have observed frequently the problems many women have discussed in relation to their experiences of orthodox medicalisation in relation to prosthetic surgery.

both patients and the medical team who worked with them during the transactional interview.

I first encountered this *possible* dichotomy 'to tease out' through women patients who attended my own Ayurvedic practice: as they narrated stressful accounts of how anxious they had been about their own medical transactions in relation to their quest for prosthetic body-part replacements [hip, spine and knee joints in particular]. They recounted experiencing their body as of interest only as 'material evidence' that became 'objectified' by medical scrutiny, rather than being responded to as 'human subjects' in search of a cure with their own specific narrative. From such an alienated perspective the medical industry could be perceived to form a possible '…..voyeuristic circuit in which the depersonalised body is central': it was obviously necessary for orthodox surgical practice to observe a patient's body from a disinterested viewpoint, in order to retain professional detachment[8].

To understand this further, women patients in consultation with Orthopaedic surgeons, selected through lengthy formal procedures by an NHS Hospital in Sheffield, in consultation with its Ethics Committee, became the basis on which to engage with fieldwork to see first-hand how these accounts from my own patients might stand up to detailed 'public' scrutiny. Thus, primary social-interactionist and photographic visual research began, which in turn informed the completed outcomes of the research as a whole as an interactive website www.soma-series.org.uk. It addressed aspects of these issues which took as the starting point the 'affect' the medical gaze had on both patients and hospital staff, through its power/knowledge structures, that artificially disciplined all who were engaged in its transactions. Whilst my primary interest had been the

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[8] In Sordid Sites, Jane Prophet discussed how a medical team needed to distance itself from a patient and so used the medical "screening material" to ensure that the body in question was always viewed mechanically – 'like a mechanical device in need of repair' [p.31]. The Women's Research Group. Cutting Edge: Digital Desires [2000].

women patients, I realised they could not be observed separately from the medical hierarchy where the hospital transaction took place.

When later interpreting the 'evidence' of the fieldwork from the hospital in relation to how female patients were seen to respond during their pre-surgical medical interview [against the social-interactionist interpretations describing more formally the sociological nature of the medical encounter] I recognised that there were 'gaps' in what the patient and medical team perceived and what was somatically taking place. I had already heard how my Ayurvedic patients had come to view their medical transaction as alienating and thus disempowering, but I did not know why. The ensuing investigations, after trial and error explorations related to body-language that revealed different ways of manifesting 'elements of fear' about the quest for prosthesis, I wondered to what extent others, whom I had not encountered, might have experienced similar levels of anxiety. Subsequently, I realised that the project could be further expanded if published as a hypertext to invite public response [as 'Feedback'] to these fieldwork findings[9].

Thus, the hypothesis of the research as a whole, was about how far the disciplining regime of the medical gaze actually created a certain kind of physically manifested behaviour, which I have referenced as 'somatised'. To seek out this type of 'behavioural pattern' in a visually metaphorical way was obviously a form of 'exaggeration'. From an 'artistic viewpoint' I decided that the observed transactions might be recreated as 'metaphorically somatised' as a way of visually drawing attention to the power that the medical gaze was seen to hold within its regimes of so-called health-care. Twenty-three patients [who agreed to be observed], all were found to have experienced a level of 'take-over' of their bodies in

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[9] I have focused on the idea of the patient-doctor interview as being a 'culturally learned experience', so drawing attention to the way patients generally *assume* acquiescence when engaging with medical practitioners.

their quest to prosthetically transform them. The quest for prosthesis, with its potential to create a 'bionic' being, demanded many levels of interpretation. However, to make artwork about such a contentious subject seemed to demand a potentially satirical approach, if the project as whole was to gain any public response via a website. My Ayurvedic 'perspective' indicated that there was an ethical factor related to the danger of engaging in the physical transition towards the 'bionic' body as almost a 'norm'. Therefore I aimed to open up debate that would place the role of potential audiences as central to the research outcomes, to engage public opinion. Might it reveal something I had not perceived?

Aiming to discover how far the idea of the 'somatisation', experienced through the medical gaze and its transactional regimes, could be rendered as a series of 'visual' metaphors, I consciously omitted my background Ayurvedic perspective from the completed artwork, leaving the created scripto-visual material to 'speak for itself', since I did not want to turn the debate that might arise from the fieldwork findings in the hospital into a 'Western versus Eastern medicine' approach to health. However, <u>Soma-Series: Somatic Metaphors within a Series of Medical Transactions?</u> has been conducted through an interweaving of hospital based interviews *against* my Ayurvedic background, where personal 'reports' about the problems relating to seeking surgical prosthetic solutions to physical debility indicated that I had entered into the research from a specific 'standpoint', as opposed to a position of impartiality[10]. It has also been developed from a feminist stance specifically because I had wanted to 'release the repressed voice of those who are silenced' in relation to how women experience aspects of medical practice within patriarchy[11]. Could new scripto-visual work, based on evidence of body-language/behaviour,

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[10] My work as an artist has responded to the quest for a feminist identity since 1984 with work: <u>Binary Fission</u> [1986] was purchased for the Arts Council Collection in the same year.

[11] Janet Wolff. In <u>Feminine Sentences</u>. [1995] discussed how aesthetic strategies in themselves '... subvert the rule of logic, reason and logic' [p.62], and work towards a 'liberatory potential', which is what I have aimed for within the research dynamic as a whole.

potentially challenge the 'medical gaze' and its power to create subtle levels of 'manipulation' in those who engage its disciplining practices within Orthopaedics? How far did the behavioural interactions between patient, doctor and hospital management contribute to transactions where all were in the venture towards 'artificial enhancement'? How might new artwork be evidenced from this fieldwork and how might audience response enhance the completed artwork outcomes? These were the core themes that the research set out to address.

## 1.2. Aims of Research

1. To create a scripto-visual hypertext in response to fieldwork based on a series of medical transactions in an NHS Department of Orthopaedic Surgery, and to visually interpret aspects of the medical gaze - through its power/knowledge strategies - as it was observed to 'somatically' manifest in participants engaged in its procedures.
2. To recall the experiences of working with women from an Ayurvedic perspective as a primary starting point for observing and interpreting the pre-surgical interview for Orthopaedic prosthetic replacement, as an example of practice of the orthodox patient-doctor transaction.
3. To present new visual 'metaphors' of the interview transactions, as both an investigative and an interpretative artwork informed by social-interactionism, and subsequently to examine this material theoretically through aspects of poststructuralist feminism and discourse analysis in the drawing up of a methodological matrix[12].
4. To expand connections between visual art and socio-medical issues beyond the exploration of pre-dominantly 'bio-medically-based' art into the social sphere.

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[12] Through the use of visual metaphor what was seen as learned behaviour in the interviews as visible in body-language within the patient-doctor transaction, could be interpreted in a Foucauldian way and then re-configured to signify something 'transformative' from an artistic viewpoint. Lois Mc Nay in <u>Foucault and Feminism</u> summarised this from the transactional behaviour as people '... responding to a set of socially defined techniques, which, when *selected* by the individual, provide a set of meanings or 'truths' with which the individual can interpret and understand his/her behaviour' [p.149]

5. To consider the work of two contemporary women artists who have visually examined aspects of socio-medical discourse as it was seen to affect its 'human-subjects', and to indicate to what extent <u>www.soma-series.org.uk</u> differed from their investigations and further opened up art-based responses to the body under medical surveillance, by encouraging prospective audiences to respond to research outcomes via an interactive website[13].

6. To metaphorically present a series of pre-surgical Orthopaedic transactions as a forum for debate about current notions of the 'bionic body' via the quest for prosthesis, and the way orthodox practice promotes it.

## 1.2.1. Introduction to the structure of the thesis and chapter outlines.

**Chapter 1** introduced a rationale and hypothesis that questions the extent to which there could be a feminist and visual response to a medical transaction. Researching other artists who had contributed their perspectives of socio-medical practices as artwork: the interdisciplinary work of Christine Borland, Jane Prophet, Katerina Fritsch and Jo Spence were of special interest and formed the groundwork for comparison. I was able to establish how 'the quest for prosthesis' became the focal point of the research. I re-examined my earlier health related art projects to establish
the use of somatic metaphors evidenced in the medical transaction.  In **Chapter 2** <u>Inside and Outside the Visible</u> I introduced six Mind-Map explorations leading into and graphically expanding these ideas. <u>Drawing up a Methodological Matrix</u> and presenting <u>The Developmental Stages of the Visual Work</u> in **Chapter 3** established how the research paradigm could be analysed and how the imagery, derived from the hospital fieldwork, could be interrogated. In **Chapter 4** <u>Reflections on the Three Stages of the Formative</u>

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[13] Jane Prophet's <u>The Internal Organs of a Cyborg</u>. [1995] and Christine Borland's <u>The Dead Teach the Living</u>. [1997], & <u>Progressive Disorder</u> [2000]. Images of examples of this work are in Appendix 6.10: Secondary Source Images.

<u>Findings</u> I expanded the experience of 'hospital fieldwork into studio practice' from a broader theoretical base. I interpreted the scripto-visual outcomes from a visual culture perspective. **Chapter 5,** <u>Conclusions and Action Plans</u> presented notions of how <u>Soma-Series</u> hypertext had been received through Feedback from 'audience' to 'evidence'. This enabled me to examine the limitations and gains of placing the project on a website. I concluded by reflecting on how far the aims of the research had been achieved and how the ideas realised from the project could become a springboard towards future research innovations. The thesis ended with a summary of how interactive media could become the means through which our perception of body modification or transformation could take place.

## 1.3. Review of Literature and Visual Art Sources.

## 1.3.1. Art that has contributed to my perspective of socio-medical practices.

Visual artists have responded to the domain of the patient–doctor interview since the Enlightenment. Whilst the eighteenth century use of 'cartoon' were popular means of satirizing the takeover of orthodox medicine over 'natural practices', it was not until after André Brouillet's famous painting in 1879: <u>Une Leçon Clinique à la Salpetriere</u> that it became possible to problematise the patient's responses to the complexities of the medical gaze. Edward and Nancy Keinholz's <u>The State Hospital</u> [1969] and <u>The Illegal Operation</u> [1971] further expanded the domain of a visual critique of the medical gaze directly from a patient's perspective as three-dimensional 'tableaux', harshly critical of orthodox practice[14]. The critical domain for artists could be said to have shifted from 'satire' to 'surveillance', engaging simultaneously the separate

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[14] See Kienholz: Secondary Source Images. Appendix: 6.10.

agendas of patient, doctor and medical administration[15]. Against this art-based background my research examined ways in which the patient's body remains perceived as 'objective' evidence by the doctor, so continues to be seen in 'fragmented' form [since holism is not part of its agenda[16]]. My research sought to portray also that the NHS environment contributed to the transactional procedures that could be said to have been 'somatically' experienced by *all* those who were engaged in it. In this respect, the collective 'somatising outcomes' of the pre-surgical interview resulted in a kind of 'constructed theatre', since each aspect of its 'organization' interacted with its 'players' as both medical team and patients: it was this inter-active aspect of the transaction that provided the 'material' for its visual metaphor which became translated into artwork. From this viewpoint I was also reminded of elements of early Russian Constructivist painting – particularly the work of Natalia Goncharova – as she perceived a changed, fragmented and politically manipulated human form against a background of scientific and technological change[17].

## 1.3.2. How my relationship to aspects of the social-sciences and Ayurvedic medicine have informed the research.

My art projects since 1992, Evolving Habits [painting], had been concerned with the gap between female bodily experience and reality. The conference 'Order and Chaos' Arnolfini Gallery, 1993, highlighted new visual-interdisciplinary responses to what had traditionally been the

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[15] As evidenced by discourse analysis in M. Foucault's Power/Knowledge [1988], as it was explicitly expressed in terms of the power held by institutions, particularly medical ones whose ethics were establishes through the broad perspectives of the inherited Enlightenment project.

[16] Modern allopathic medical science does not allow for the natural processes of healing to take place - "... it is divorced from nature's rhythmic flux": Dr.R.E Svoboda: The Hidden Secret of Ayurveda. [p.20] See also Ayurveda/Ayurvedic: in Glossary of Terms.

[17] Goncharova's Neo-Primitive work reflected a response and style of working visually that presented the human form/body as responding 'mechanically' to the changing political times in which she worked. In Amazons of the Avant-Garde [1999], Jane A. Sharp perceived this stylisation process as a 'laboratory of forms', with which the Soma-Series imagery began to resonate through its own 'manufactured' and 'substitute' body forms. [See Appendix 6.10 for an example of Goncharova's work].

dominant domain of science and sociology. This encounter with inter-disciplines became a focus within my visual practice, particularly after acquiring professional level qualifications in Complementary Medicine [Ayurveda] 1994. Out of exploring aspects of women's fragmentary experience of the health and illness, three projects were developed: Sig/nature, [painting] 1996; Epigene, [sculpture] 1997-98; Volaptuary, [digital video] 2000[18]. These exhibited works laid the foundations for research into an area of experience that was to include a response to an aspect of orthodox medicine that I observed to hold many contradictions within health care regimes of women I encountered through the Ayurvedic practice.

### 1.3.3. How 'the quest for prosthesis' became a focal point of artwork following the former projects.

To conceive new approaches for a more expanded form of scripto-visual material required formal social-interaction based research, to gather original fieldwork-based 'evidence', that might give new insight into some of the disparate experiences women had discussed with me in relation to their medical transactions for 'hip replacements'. Many 'medicalised' patients found prosthesis had insufficiently healed them and had alienated them from the practice of wanting to repair their bodies through 'artificial' means. However, it was predominantly the hospital regime and environment itself that was reported to have been part of their sense of exploitation and powerlessness[19]. Looking at this from a feminist viewpoint, I saw the possibility of undertaking 'fieldwork' and examining visually the medical transaction that I had heard so much about. The hospital paradigm of the pre-surgical interview for prosthesis, out which

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[18] See Appendix 6.10 for earlier examples of Rose Rose artwork.

[19] Foucault also developed knowledge about the disciplinary side of eighteenth/nineteenth century architecture and perceived it as designed to augment the medical gaze and provide an environment that worked to isolate medical transactions from the outside world. '.... It is a question of what governs statements, and the way in which they govern each other....' [p.112] He saw this as central to levels of surveillance control that were administered in both prisons and hospitals in Power/Knowledge. [1980]

the 'somatic metaphors' of this research emerged, thus became a site for speculation and investigation. The fieldwork basis for this research revealed 'disparate elements' within the patient-doctor dichotomy [that to me seemed less 'visible' when observed from an impartial perspective], but which my experience of holistic healing practices, through Ayurveda, revealed as ethically 'contradictory'. From this 'alternative perspective' the Western model of health-care appeared to powerfully 'envelope' and 'manipulate' all who become engaged in its transactions. The fieldwork focused on the patient's 'quest' for prosthesis, and so opened up the notions of the 'bionic' body as a way of fashioning resistance to natural aging processes. The whole process towards these outcomes placed the body/bodies concerned in what I perceived as a 'synthetic' situation. It was not incidental that the orthodox practice of 'prosthesis' had been shown to be inseparable from 'market economies' of medicalisation and its hegemonic regimes[20]. This research therefore aimed to *parody* elements of these practices [they thus appeared to encourage a cultural view of the body that *renders it dependant* on ever increasing 'regimes of artificiality'], which from the perspective that I approach it could be said to decrease its personal autonomy. Within this framework I empathised primarily with the 'female-as-patient', since my professional access to many women with 'skeletal weakness' indicated that their problem had been only partially addressed by orthodox Orthopaedics, and that the quest for prosthesis remained transitional[21]. However, my fieldwork revealed that the patient's response was inseparable from the socio-medical regime that enveloped it.

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[20] In Risk Society and Contemporary Politics: Evaluating Foucault - Foucault: Health and Medicine: [1997], Bryan S. Turner points to profound changes in health-care made in the 1980's:'These changes in bureaucratic structures have occurred alongside major epidemiological change which in a sinister manner *appear to mimic the contingency of the market place'*. [My italics]. [p.xvii]. This survey stands as an indication as to how the seemingly unstoppable beaurocracy that runs hospital administration has in itself became a new kind of epidemic. Because of the increased costs of these structures more emphasis has been placed on protocol and procedures of patient-doctor surveillance and the way this has increased the cost effectiveness of surgical intervention, from a 'time-money' perspective.

[21] In the medicalisation context, the 'patient' only functions as such in response to a medical team as they hold the power to literally 'manipulate' and so hypothetically 'dislocate 'their bodies: their discourse is organised to make itself persuasive.

## 1.3.4. Socio-medical concerns of selected contemporary women artists, in contrast to this research.

Having observed Jane Prophet's interactive CD ROM <u>The Internal Organ's of a Cyborg</u> [1995] I saw how scripto-visual artwork could address notions of a dislocated reality of a medicalised 'patient-body'. The digitalised 'meta-form' of Prophet's CD ROM images resulted in what I perceived to have been a dramatic *layering of the processes* of making art[22]. Prophet's work emerged at a time when hypertext could invite new 'punctuated landscapes' to appear as visual and textual narratives, thereby opening up the multiple perspective dynamic that had not been available to Enlightenment artists; Brouillet; the Russian Constructivists or Keinholz. Whilst awareness of developments in the changing artistic and interdisciplinary viewpoints of the medicalised body was of importance to choices relating to my own artist/fieldwork processes, it was not until viewing the work of Christine Borland and, to a lesser extent, Katharina Fritsch [<u>Doctor</u>] between 2000 and 2002, that I became aware of the way that visual and textual responses to socio-medical discourse could radically alter the *type* of art-work that could be made and the way imagery could be contrived and evidenced. With the exhibitions of <u>Pharmacopoeia</u> [2000] and <u>Spectacular Bodies</u> [2000] I had observed how neo-conceptual artists were addressing issues of anatomical and socio-medical exploration from polemical perspectives. However, out of artists I perceived as working intrinsically from a 'dual-disciplined' perspective, Prophet and Borland appeared as the most appropriate to observe more closely[23]. Examining issues to do with human identity, Borland had elected to negotiate 'relationships with institutions'

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[22] In <u>Sordid Sites</u> Prophet focused on the interplay between female patient and male surgeon when engaged '... in attempting to control the fragmented and decaying body and make it whole again .... the experience of the "fragmented body" can result in great anxiety and aggression' [p32] [Ed.] Cutting Edge, The Women's Research Group: <u>Digital Desires</u>, [2000]. See also: Appendix 6.10.

[23] The early stages of Borland's work were undertaken in a medical establishment, and as part of a broader enquiry into the 'medicalised body', in the area of forensics and genetic engineering in the Public Health Services at Glasgow University.

to which non-specialists normally have no access[24]. This aspect of Borland's work resonated with my own experience of negotiating access to Orthopaedic patient-doctor interviews, where, only after lengthy negotiations, were photographically observed interaction within specified clinics permitted, [provided, in my case that no recognisable 'human identity' of research participants would become evident, for obvious ethical reasons].

However, there were areas of both Borland's work that differed fundamentally from my own in so far as she was not manifestly seeking to include audience interaction with the completed outcomes of her socio-medically based visual research and sculptural outcomes. Borland was concerned with showing through sculpture how aspects of human sciences become lost, impersonalised and thus scientifically objectified over time. In this way her work [as indicated by the work's detailed 'titles'] echoed a similar level of 'detachment' from her subject of research related to that of the historical socio-medical regimes she had investigated[25]. Borland had worked in laboratories and not as in my case, from observation of a 'real life interaction/exchange' between the lay person/patient and the medical team/doctor. This actual 'observed experience' and visual data-collection through hospital fieldwork, [with the consent of an NHS Ethics Committee] was paramount as my research starting-point. The inclusion of social-interactionist based texts 'phrasing' key observational elements of body-language that, as a completed research outcome became juxtaposed to the visual metaphors as joint 'core material' for a new scripto-visual hypertext.

Recalling another work by Borland's The Dead Teach the Living [1997] I was reminded how the artist had restored 'humanity' to a group of

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[24] As evidenced in Katrina M.Brown's Introduction to Progressive Disorder [2001] Exhibition Catalogue. [p. ii, iii]. See also Secondary Source Images: Appendix 6.10.

[25] Julian Heynen in Tate Modern's 2001 Monograph: Katarina Fritsch commented: ' 'Doctor' evoked the almost shamanistic status of the modern doctor, the invasive techniques of Western Medicine and the increasing technologisation and alienation of the body, particularly the female body' [p.30].

discovered 'anonymous' individuals found under the title: '<u>Study of a</u>
<u>Head</u>' in a Department of Anatomy. Using plastic industrial processes
Borland remade a number of 'found' heads and presented them on plinths
for public exhibition: the work raised the question of who and how
aspects of 'normality' became medically arrived at, and highlighted the
'frailty' of the basis on which identity is construed via the 'objectivity' of
the medical gaze. Similarly in <u>English Family China</u> [1998] Borland
visualised patterns of DNA that connected family members[26]. The skulls
resembled 'valuable commodities' and she remade them for gallery
exhibition exploiting the qualities found in technical china manufacture
laboratories. Whilst Borland's position as an artist in a medical world
created new visual connections between art and socio-medicine, I was
aware that her creative processes were the opposite of my own at most
stages, especially after my primary investigation/compilation of images of
twenty-three patient-doctor interviews in an NHS hospital. Borland's
metonymic domain brought historically dated subject matter 'to life',
whilst my data compilation sought out visual metaphors of living people,
rendering them metaphorically as 'non-living' parts in a medical
transaction. My <u>Soma-Series</u> 'constructs' held visual comparisons with a
laboratory experiment, as stand-in 'forms' to describe something else. My
choice of presenting 'ready-made' figures [mannequins and tailors-
dummies] might be said to 'materially' resemble the early plastic-models
used by scientists to explain the structures of DNA[27]. Each 'character'
played out an 'acquired' role, while each of my metaphorical visual 'props'
were selected to form a pastiche of the original medical transactional
'assembled' parts. Borland used minimal and austere settings for her
exhibited displays, whilst those from my theatrically lit 'constructs' were
in comparison comic and parodic. Borland had sought out the pathos of

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[26] See Secondary Source Images: Appendix 6.10.

[27] Rosi Braidotti elaborated on this concept of a plastic 'stand-in' body/model as the basis for the 'Deleuzian
construct' of the 'Body-Without-Organs' since it is a how metonymically the medical gaze constructs the
'patient as object from subject'.

her subject matter, whilst I had imbued my fieldwork interpretations with a type of hubris reminiscent of Kienholz's work[28].

Like other artists in the 1990's Borland sought to simulate her visual practice between the two disciples of art and socio-medicine. The *processes* of her studio production and that of other women artists [including that of the late Helen Chadwick] were visually responsive to and mimetic of those photographic processes utilised by medical laboratory practice[29]. The main difference of my research paradigm was that it set out to become metonymic of the medical 'diagnostic' gaze within its 'closed power/ knowledge environment', so was reliant for its visual evidence on social-interaction between the lay-person and professionals. Borland's and Chadwick's work arose from a primarily aesthetic position taken through their respective interpretations of objective documentation rooted in material gleaned from laboratory style reductionism: <u>Soma-Series</u> however, was primarily an examination of discourse analysis and body-language rooted in lived experience. Parodic of the 'world' it had observed, it set out to reflect the 'findings' as a challenge to the status quo of the socio-medical gaze from an Ayurvedic and feminist perspective[30]. The end results would both 'comment on', and question the way that the medical gaze affected the behaviour of those engaged in its transactions since they reinforced the idea that the transition towards a bionic body was already implicit. Thus, <u>Soma-Series</u> as an artwork outcome anticipated a viewpoint of antipathy towards medical interventionist practices and those concerned with prosthetic enhancement[31]. In this sense the projects' culturally biased formation, consisting of both verbal and visual discursive strands, allied it on some

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[28] Edward and Nancy Kienholz <u>The State Hospital</u> [1962]; [see: Appendix 6.10].

[29] Chadwick's residency at King's College London produced work based on in vitro fertilization, setting up an analogy between the artificially fertilized egg and the fabrication of an art work: <u>Nebula:</u> [1996].

[30] It was also biased from my knowledge and experiences of Eastern holistic practices of Ayurveda.

[31] This has clearly been evidenced through my former art projects and continued practice of Ayurvedic medicine for women.

level with the work of artist Jo Spence, who had also challenged medical orthodoxy, with photographic images suggestive of militarism and civil disobedience[32].

Whilst these artists' work had bearing on the investigative processes involved in the primary formation of Soma-Series, it was the work of Jane Prophet that was significant at the point where I was devising the form of presentation of my findings and outcomes, both as a public exhibition and simultaneously published hypertext. Prophet had researched the assumed intimacy that developed via a surgeon's 'voyeurism' of the 'depersonalised' patient under anaesthetic, whilst undergoing transformative implant surgery. Prophet's 'cyborg' body[33], focused on the idea of a fragmented, seemingly 'post-bionic' body as metaphorically 'somatising' extreme levels of anxiety, since an individual was, a Prophet stated: '…. left "covering" a lack of completeness in herself: the ego causes the body to become alien to itself, un-coordinated and in pieces'[34]. The Internal Organs of a Cyborg [1995] questioned the current 'obsession' with technological implants but parodically related it to the practice of Lacanian analysis of the 'hysteric', whose symptoms might also be said to have been 'somatised'[35]. My research, however, did not recount the journey of an imaginary 'individual subject' as Prophet's had done, but sought out the lived 'patterns of interactive behaviour' that metaphorically exemplified the

[32] Jo Spence in Putting Myself in the Picture [1983]; Photography/Politics [1986]; & What can a woman do with a camera? [1995] made images responding to her own illness and subsequent resistance to medicalisation processes up until her own death.

[33] The Internal Body of a Cyborg [1997] uses images taken from science fiction novels, superimposed with imagery from medical technologies, with a narrative text fused into website hypertext pages. It held parallels with that of my allusions to a bionic body. [see: Appendix 6.10]

[34] In Sordid Sites Prophet stated how surgeons can view a body as '… meat, stone or wood', and that '…. conversing with a patient in an office and discussing medical procedures [is] in an atmosphere that is often emotionally charged….' [p.31] [Ed]. Cutting Edge: Digital desires; Language, Identity and New Technologies.

[35] This question takes Prophets work back to the image of Brouillet's Une Leçon Clinique à la Salpetriere [1879], where the patient [Blanche Whitman], was depicted as an interesting specimen of Dr Charcot's analysis of the mind-body split.

power of the medical gaze to 'objectively' transform its subjects[36]. But, as in Prophet's work [focusing on a fictional 'cyborbesque' model of the body], I presented Soma Series as also a parodic 'simulation of medicalisation' in hostile response to medical hegemony's persuasive attempt to control the decaying and fragmented body. Experience, through working with women patients in relation to Ayurvedic concepts, had shown me that the body retains its own unexpected and unknown patterns of response to its own demise; so the body, in any attempt to become bionic through prosthesis, was rendered 'in denial' of its own sentience. Thus the Ayurvedic perspective I had learned presented the practices of orthodoxy as essentially detrimental to the 'holistic' integrity of the body through its invasive 'artificiality', [since the quest for prosthesis frequently contains also an 'iatrogenic effect' on its unsuspecting host[37]]. Whilst this research focused only on the visual transactional-evidence as seen in a series of hospital interviews, these underlying notions informed what I perceived, and so influenced the 'inclusions' and 'omissions' that each informed the developing visual metaphors I sought. Soma-Series as hypertext set out to present its compositional components as similarly containing elements of the 'unknown' and 'unexpected', thus inviting response to its 'findings' via a potential audience[38]. Unlike the work of each artist referred to, this was also a core component of the art-work's polemical stance.

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[36] Because I was observing 'transformative' orthodox medicalisation from an Alternative perspective, prosthetic surgery, as a method of healing an 'anatomical dysfunction', was contrary to the personal integrative methods adopted by Ayurvedic medicine, so would in most circumstances create disharmony and alienation within a patient.

[37] In Limits to Medicine [1977] Ivan Illich pointed to the 'knock-on' effect of medicalisation where the solving of one problem unavoidably creates others, which he saw to cancel out the supposed benefit to health-care.

[38] Parodying the medical industry's ways of perceiving the body as 'depersonalised', Prophet describes it: 'The CDROM depends on our egocentric need to see the *whole body*, we are almost guaranteed to want to scroll around and explore the distributed body, represented via scans, x-rays and slices, in an attempt to make the body complete.' Digital Desires [p.32].

# Chapter 2: Processes towards preliminary research initiatives.

## 2.1. Six Mind-Map explorations.



1. As a series of expanding circles, I put forward the following questions in relation to the patient-doctor transaction:

   a. Was seeking a prosthetic body-part a deviation from the body's normal function?

   b. How could the body/bodies 'observed' be shown metaphorically to represent the mechanical and disfunctional bio-medical model 'mind/body' split?

   c. How might artwork be constructed that would indicate an antipathy towards this fragmented 'model' of health-care?

   d. How might I create artwork where all compositional elements were metomynic of the subject matter to be communicated?

   e. How could the women who looked to Alternative health-care [via Ayurvedic Practice], inform a piece of 'objective' NHS research?

2. Creating a series of linear entries on a single page entitled: 'Towards Assumptions' I juxtaposed ideas from my earlier projects informed by the holistic health care with a facsimile 'body-without-organs'[39]. Within this concept a human subject and its 'desires' were seen as series of 'flows' and 'fragments' capable of being linked together in infinite ways. This diagram mimicked both the Ayurvedic practice of 'holism' and the creative 'assembling processes' that had become central to the feminist creative visualisation practice. This process was best described as rhizomatic: within this model there were no hierarchies, so that each fragment of an idea is seen as 'equally consequential' in its contribution to a series of loosely linked assemblages[40].

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[39] Nicholas Fox in Postmodernism, Sociology and Health [1996] and; Buchanan, I. & Colebrook, C. [2000] in Deleuze and Feminist Theory. Both these studies have shown how this model has become a central form of 'human presence', without reference to gender, race or class, so has been of use for this research.

[40] Elizabeth Grosz in Volatile Bodies quotes Deleuze and Guatarri [and *their* debt to Antonin Artaud] and summarises that: 'Assemblages are the provisional linkages of elements and fragments of disparate status and substance...their law is *endless* experimentation, metamorphosis, transmutation and realignment' [p.167].

Questions raised:

a. Did this 'construct' suggest also that an 'equality' exists between ideas and each 'visual' or 'textual' element had a parallel influence on the creative process, or is there a hierarchical "creative" process at work? If so what might I prioritise?

b. How far was this pattern of response useful in pulling together all areas of relevance [they correspond closely to the 'l'ecriture feminin' approach] into the juxtaposition of the visual or textual 'components' that at this early stage formed a seeming endless continuum?

c. Could I focus on the single issue about 'power-relations' between a patient and doctor? Because the idea of 'cause and effect' had no place in this rhizomatic way of thinking it seemed contradictory to be seeking out *one* area to explore at the expense of the others that had emerged. Nevertheless, the decision to make work focused primarily on the *dilemma* that can be brought about as a consequence of the *quest* for a prosthetic body part [and surgical intervention] was arrived at here.

d. But if the research was about the way the patient was affected by her transaction with a doctor, then might the environment where this took place also form an intrinsic part of what was to be 'observed'?
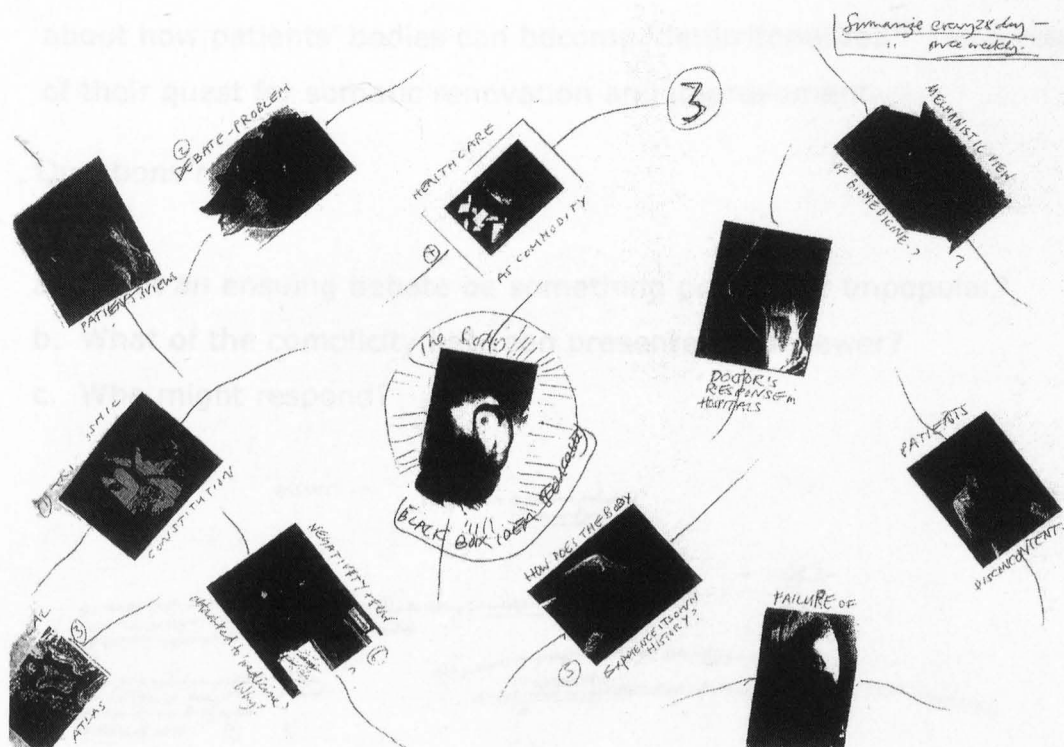
3. This mid-map created further 'rhyzomatic' sequence of boxes each inter-linked from the centre which presented the idea of the body as a 'Black Box'[41]. From here metaphorical 'examples' of health care expanded: to all the different viewpoints between Western and Eastern [Ayurvedic] medicine emerged in a spontaneous and nomadic way. However, I was aware that the quest for prosthesis and its dangers of creating a transition towards a bionic body had now become the central issue[42]. I could see now how this dilemma rendered a prospective Orthopaedic patient in a temporarily 'destabilised condition'. I perceived here that making artwork about this dichotomy could open up public debate about several issues connected to these processes of medicalisation: a visual/ textual interplay metaphorically linked to medicalisation procedures *as artwork* could open up new discourse

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[41]   Foucault related the idea of memory to a 'Black Box', [like the black box in an aircraft that holds all the information of the flight passage]: Birth of the Clinic: An Archaeology of Medical Perception. [1978].

[42]   I recalled the stories of the women from my Ayurvedic practice who had who had spoken of their powerlessness in the face of medical authority and the additional evidence of this within the observed hospital interviews.

about how patients' bodies can become 'deterritorialized'[43], as a result of their quest for somatic renovation and improvement.

Questions raised:

a. Might an ensuing debate be something popular or unpopular?
b. What of the complicity between presenter and viewer?
c. Who might respond?
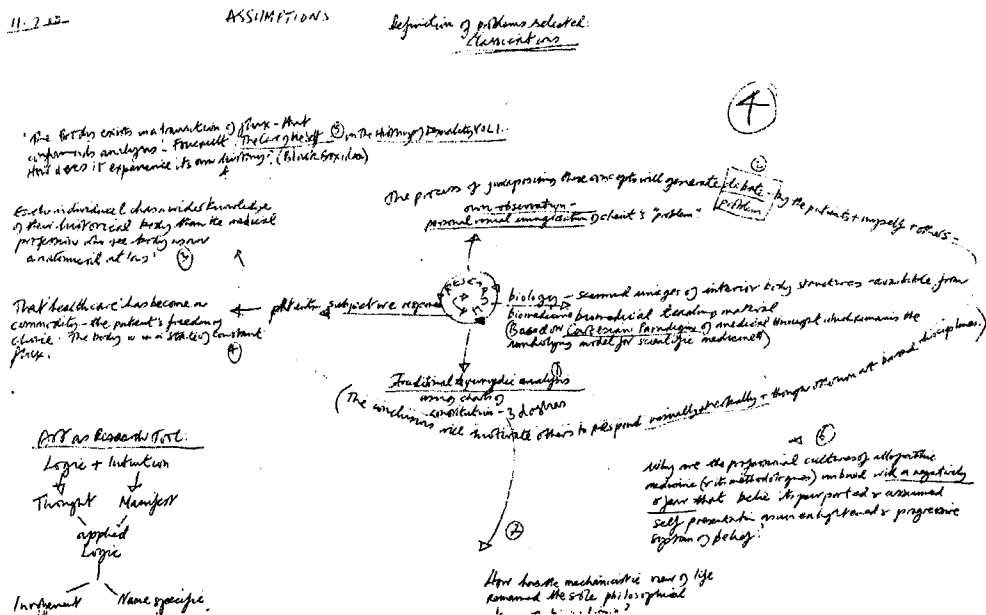


4. Presenting the word 'Research' in a circular form [centre page with four arrows branching out of it each corner] pointing to specific concepts: each one revealed a contradictory approach to ways of thinking about the body as a 'medicalised object' or a 'biological subject'. [I was aware that Ayurvedic patients had frequently mentioned that *after* reflecting on a hospital 'transaction' they considered themselves objectified, which had *only then* made them feel powerless].

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[43] Deleuze and Guattari in A Thousand Plateaus, were investigating ways of understanding bodies as 'subjects' as *more* than 'psychic beings' with their own systems of compliance and resistance, but these have only been *alluded* to here, as one of a myriad of components that respond to the requirements of order and organisation.

A sub-map following this sequence presented an arbouresque model/ mind-map entitled 'Art as Research Tool' with branches pointing to the dual forces of 'logic' and 'intuition'. I returned to this 'foundational' model at this stage of juxtaposing the central 'components' of the 'research-area' I had decided to address: I recognised that the rhizomatic model, whilst offering *endless* possibilities, could not aid my quest for creating work that challenged the status quo of the medical protocol and 'its gaze', since the subject area was inevitably related to cause [by requesting prosthetic transformation] and effect [by entering into the pre-surgical transaction].



5. Another circular map appeared with eight radiating spurs from the centre which drew on what the Ayurvedic women patients had reported about their experience of allopathic medical transactions: each time the words 'discord' and 'harmony' arose. I had recalled that some women had brought me small drawings to visually describe how they

experienced pain in their joints – [they also reported having related this to their allopathic doctor, but had found no positively response to presenting them]. It became evident here that the focus for new visual research on these women's medicalised experience lay specifically in the way they were able to effectively communicate with their consultant surgeons, since it was this 'contentious' transaction that gave rise to their fears and anxieties about seeking prosthesis.

A Research Procedures Programme for Artists & Designers

PROGRAMME

INCREASING AWARENESS OF RESEARCH PROCEDURES

stage 1 M.Phil.
1. Introduction to the programme & The purpose of research: examining our assumptions
2. Research in Art & Design
3. Managing your research project
4. Creative thinking & innovation
5. Preparing a research proposal
6. Research design & analysis

assumption

stage 2 M.Phil.
7. Research ethics
8. Presentation / communication skills
9. Information retrieval skills
10. Organising a contextual review

synthesis

contextualisation

11. Visual / artistic research methods
12. Qualitative techniques

data gathering

stage 3 Ph.D
13. The role of evaluation
14. Analytical methods

evaluation / analysis

15. Ph.D thesis - preparation, content, & examination
16. Public output of research
17. The future of research in Art & Design

conclusions

6. This mind-map was useful because it returned to a traditional 'arbouresque' model showing the concept of direct 'cause and effect' [as manifested during the Enlightenment as a 'Tree of Life' concept, where roots and shoots grow in logical sequences]; as such it was appropriate here for moving the research process forward[44]. I realised that if I were to attempt to make art-work about the 'medical narratives' referred to by my Ayurvedic patients, I would have to start at the source of where the problem lay: this would require

[44] The map was from an existing programme of Art and Design research procedures, published by Carole Gray at the Robert Gordon University, Aberdeen [1996].

observational fieldwork in the NHS system where the patient-doctor interviews occurred.

## 2.1.1. Conclusions relating to the six Mind-Maps.

These processes determined that I would present aspects of these ideas to an NHS hospital and undergo examination by its Ethics Committee, with the aim of obtaining new visual data from its Orthopaedics Department. This would allow me to expand and 'experiment' and enable me to focus pragmatically. Would the stories provided by the Ayurvedic patients recounting negative experience of the allopathic patient-doctor dynamic ring true? I needed to keep an open mind as far as possible to gain the full 'effect' of the NHS transactions. Might I discover aspects of social-interaction that could become specific sites for a new scripto-visual production?

## 2.2. Conceptualising the Mind-Map outcomes into an NHS medical environment and obtaining the visual data.

Out of these specific contexts a discursive visual and methodological investigation was set up to observe a poignant aspect of the 'medicalisation' process - the patient-doctor transaction prior to interventionist surgery. In order to comment visually on the institutionalised transactions, the task was to make work with the potential to promote a spectator-response from a prospective future audience. To reach potential interested audiences it seemed appropriate to create a series of hard-edged constructivist/formalist type of images capable of juxtaposing visual metaphor with 'informative' textual elements to contextualise the work as 'fieldwork and research' based[45].

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[45] Constructivist Art, as part of the early avant-garde incorporating a matrix of figurative/geometric shapes, symbolised the new technology which produced it at this time. Now, the dual technology of surgical innovativeness with new digital communication 'enhancement', could be seen to mimic an early twentieth century visual 'coding', whilst it could also be a powerful contemporary metaphor, within this research.

To maximise visual impact, the form of the completed outcomes [that was to become <u>Soma-Series]</u>, would require digital manipulation to integrate the scripto-visual rather than purely 'image' with the aim of referencing the social-interactionist aspect of the research process.

Through metonym, using a series of visual and textual permutations emerging from the initial investigative research, a viewer could contact some of the core issues that lie invisibly behind the veneer of the medical interview; and while simultaneously creating access to elements of the 'visualising pathways' of the <u>Soma-Series</u> production[46]. In this way artwork as 'comment' on the 'medicalised-prosthetic-body' might open up future debate on regimes of health-care and notions of 'bionic-bodying'?[47]

The gathering of data[48] for the visual investigation, which formed the 'visual constructs' for the completed artwork-as-website underwent major developmental stages[49]. The central task became the merging of the visual and textual 'language' that metamorphosised and transposed the major 'issues' that the twenty-three photographed interviews had opened up. How and why was the body of the patient 'inscribed' and identified by socio-medical discourses of professional 'care'? This idea seemed to extend well beyond the remit of this research: the task thus became to show how both 'practitioner' and 'patient' took on significant 'artificial' identities within the framework of Orthopaedic transactions as I had

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[46] In reference to contemporary western medicine, many argue that technology is harnessed in response to our paranoia and fractures self. Medicalisation could be seen as an attempt to control the fragmented and decaying body and make it 'whole again' [Jane Prophet in <u>Sordid Sites/Digital Desires: Language, Identity and New Technologies</u> [p.31].

[47] New media technologies can be said to have changed the relationships between audiences and artefacts, resulting in what Rosi Braidotti describes as 'the new and potentially fruitful alliance between technology and culture': <u>Cyber Feminism with a Difference.</u> [1996]

[48] All the patients who participated in the initial fieldwork were women: that all the participating doctors/consultants were male, was due to the fact that there were no female orthopaedic surgeons in the NHS hospital that agreed to participate in the research See also: Appendix 6.2. Fieldwork: Rationale and Practice.

[49] <u>Ten Constructs</u> juxtaposed with social-interactionist texts became the finished outcome of the research and were subsequently framed as series of images for the NHS Hospital Exhibition In May/June 2002, and also formed a central focus in the simultaneously published website: www.soma-series.org.uk

observed them[50] and how the hospital environment contributed to the fieldwork evidence that gave rise to my interpretations[51].

Undertaking the fieldwork did not in itself indicate that I was challenging 'modernist' definitions of the healer/patient contract[52]. The NHS Ethics Committee accepted that the work to be made out of the interview observations would be 'from a feminist viewpoint': but the agreement to work photographically through [predominantly] unspoken behavioural signs and body-language within 'specified' interviews would lead to interrogating NHS interviewing 'protocol'. Whilst my artwork interpreted the 'findings' in one way via a hypertext and exhibition, reflecting in the written analysis of what took place and how this might be theoretically reviewed centred around harnessing aspects of post-structuralist methodologies, especially feminist theory[53].

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[50] The NHS Northern General Hospitals', Sheffield, Department of Orthopaedic Surgery.

[51] In Power/Knowledge [1980] Foucault points out how eighteenth and nineteenth century hospital architecture contributed specifically to the modes of medical surveillance, since these buildings had close resemblances to prison architecture of the same period. The department of Orthopaedics in the Northern General Hospital was built in the 1980's so contained no such surveillance structure, and was in comparison claustrophobic and cramped and able to be surveyed only with difficulty.

[52] In Postmodernism, Sociology and Health, [1993] N. Fox examined how medical hegemony's 'will to mastery' [p.122] needs to be deconstructed in order to break with what is claimed to be authoritative, logical and universal practice within Orthodoxy.

[53] See Chapter 3 **Engaging Theory and Practice.**

## Chapter 3  Engaging Theory and Practice

## 3.1. Drawing up a methodological matrix

Having re-assessed the research hypothesis through Mind-Maps from my first sketchbooks, and by reviewing initial ideas about the research and in establishing comparison with the work of artists past and present as its aesthetic context, the primary task was to discover how to position the research's scripto-visual outcomes within a feminist theoretical framework[54].

Based on a series of 'transactional bodies' governed by institutionalised power as it had unfolded between hospital and the individuals who had agreed to participate in the research, presented a 'challenge' to orthodox health-care ethics[55], so was open theoretically [through my own specific Ayurvedic standpoint and pragmatic response to the medical gaze], to a feminist epistemological interpretation[56]. Whilst the hospital interviews provided the opportunity to interpret denotive body-language and power/knowledge relations as manifest through the medical gaze[57], I was aware that I needed a theoretical framework that could form a bridge

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[54] Having recognised that psychoanalytic theory and ethno-methodology were inappropriate tools for evaluating the construct of the somatic metaphors as evidenced in the patient-doctor transaction, I needed to enter a lengthy process of considering how the hospital fieldwork could best be related to its outcomes, and to refocus on one or two key issues that were most poignant.

[55] I was indebted to Sandra Harding in so far as she recommended that women researchers remained open to innovation, since art is inherently expansive and ever appropriative of new materials, thus opening the way for a new kind of aesthetic pluralism, in the introduction to The Science Question in Feminism. [1986].

[56] In Sex and Medicine, Gender and Power in the Medical Profession [1998] Rosemary Pringle explored the masculinist culture of orthodox medicine through stories and life histories of both patients and doctors and argued for a theory of knowledge that is rooted in 'everyday' experiences of oppressions and closely tied to their context of production; thus echoing Liz Stanley's ideas that: 'all social knowledge is generated as part of and a product of human experience' [p.192] in Breaking out Again: Feminist Ontology and Epistemology, and my own observations via the Ayurvedic practice.

[57] In Well women and Medicine men: gendering the health policy agenda' Anna Coote and Liz Kendall discuss the connections between women's health and their subordination in a patriarchal system: 'Feminists challenged the orthodoxy, asserting women's ownership of their bodies, the value of their experiential knowledge, the fallibility of the medical establishment, and their right to participate in their own health care on their own terms' [p.150].

between my holistic perspective and feminist art maker[58]. Whilst I was aware that artwork was not 'illustrating' a given viewpoint, it was evident from the diversity of feminist aesthetic theories, that the notion of 'objectivity' was problematic in the making of the artwork at each stage, and in the drawing up of a methodological matrix. Essentially, I had 'artistically' been responding to the female body seeking prosthetic alteration as a 'transactional body', so mostly the 'visually aesthetic' elements of feminist discourse might be appropriate for a methodological explanation of some core issues that the research paradigm had raised in relation to notions of [current] bodily-transformative processes. Firstly, linking it with elements of feminist discourse allowed for an open ended evaluation of the research: this was welcome since I hoped to avoid an 'arts' *versus* 'social science' polarisation [an aim of the research was to create new links between visual evidence and socio-medical discourse] in relation to the medical surveillance procedures that I had touched upon.

Considering this idea further, it became evident that aspects of feminist theory could help to situate the 'somatic metaphors evidenced in the patient-doctor transaction' since I had, through my website presentation aspired to create a possible 'liberatory' project[59]. But how might the 'audiencing' of the research as hypertext be part of promulgating ideas that discursively has a feminist voice within it? Would a viewer of www.soma-series.org.uk think differently about entering into the quest for prosthetic surgery having surveyed my *interpretation* of the medical transaction that precedes it?

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[58] Recalling Hilde Hein's idea about artists aiming to involve aspects of feminist aesthetics in their 'productions' and their need also to circumvent the 'exclusivity of theory' ...' leaving women free to write and paint .... and to celebrate ... the jubilant re-appropriation of experience.' From: Feminism - Art Theory. [Ed]. Hilary Robinson. [p317]

[59] Jane Haggis in Defining a Topic in Feminist Praxis [1991] discussed the 'purpose' of a personal voice within feminist research: '... it requires an independent intellectual base and awareness outside the academy' [p.76]. To a large extent I see this research as hovering between different dominant practices within feminist social science production, art making and opposing contemporary health regimes.

I was uncertain as to how this 'response' to the research outcomes might be critiqued from a feminist viewpoint, since it was not referenced specifically as such in the website. However, I could not, for example align the project with a scientifically originated 'Standpoint Theory' type of methodology: I saw was there was a danger that the visual research outcomes could be viewed negatively as 'essentialist'. Sandra Harding's had developed 'Standpoint Theory' for both qualitative and quantitative research methodologies to exemplify the idea that there can be no simple *neutrality of position*, in any research; hence it was of interest to consider momentarily but not of specific use to my visually orientated research. However, Harding had stated that feminists needed to be theoretically 'open' with their 'background-revealing' position, and as both artist/Ayurvedic practitioner I needed to clearly manifest the duality of my perspectives[60]. Thus, I experienced the quest for a 'workable' methodological matrix as a 'forensic examination' seeking out 'evidence' [as Borland had been seen to do when photographing 'specimen examples' of muscular dystrophy 'secretly' in a medical museum and in so doing 'question the ethics and politics related to the dangers of prosthesis' behind the research outcomes as www.soma-series.org.uk.[61]].

But to 'deconstruct' the many layers of ideas that could be read into the different stages of the research as it moved from Mind-Maps to hospital; to studio; to computer and cyberspace, I needed feminist interpretations of these theoretical paradigms that could be seen to connect each of the unfolding aesthetic considerations of the visual work as it developed in

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[60] I was indebted to Sandra Harding in so far as she recommended that women researchers remained open to innovation, since art is inherently expansive and ever appropriative of new materials, thus opening the way for a new kind of aesthetic pluralism, in the introduction to The Science Question in Feminism. [1986].

[61] Christine Borland 'Cet etre-la, c'est a toi de la creer'. [1996] [see: Appendix 6.10.] Spectacular Bodies Catalogue [2000] [p.185]. This work, whilst not undertaken from a feminist viewpoint, was pragmatic and disinterested but sought to challenge notions of the 'secrecy' and 'non-availability' of much historical medical 'evidence'.

stages towards a completed hypertext[62]. Integrating a semiological analysis of the 'completed' visual components that formed the main visual catalyst of the hypertext I could see that the interpretative aspect of the project was an integral part of its feminist stance as it merged realistic imagery [fieldwork] into mimetic and illusory 'resemblances' of reality[63].

Within the context of image production towards a scripto-visual presentation, my ideas did resonate with some elements of Sandra Harding's 'notion of objectivity' as a method of 'transactional knowing' [*owning* the role of 'one's own' position], with the belief systems that have informed a specific choice of 'objectivity'. Such 'background revealing objectivity', as 'one truth among many', positioned my dual artist/holistic practitioner role in the research as perhaps also 'epistemologically determined'. As such I was fusing two worlds – the subjective/artist and the objective/ holistic practitioner, and sought a theoretical position that would allow the merging of the two forms of focus, which might otherwise remain disparate and intransigent. Thus, the visual outcomes of <u>Soma-Series: Somatic metaphors evidenced in a series of patient-doctor transactions?</u> anticipated a way of cutting through and across 'logocentric' viewpoints of the socio-medical paradigm by holding 'specific contentions' that informed both its interpretation and its theoretical analysis.

But this research had also a political stance [I was again reminded of the Russian Constructivists, especially Vladimir Mayakovsky's 1920's poster advertising a 'free health service' as graphic art which addressed the

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[62] Hilde Hein exemplifies the role of aesthetic theory as not being separate from many 'feminisms' in general- but being concerned with 'transformation of media, be it the woman herself, or the pliant matter that she works...it in they are primarily concerned with the deconstruction of phallocratic theory and practice' [p.323] in <u>The Aesthetics of Theory</u>: from <u>Feminism - Art Theory</u>. Hilary Robinson.

[63] Evident in the detail of the image making processes in the Appendices 6.5 – 6.10, the 'bricollage' that made-up the visual metaphors could be seen to render the work a 'polemical statement'. As such the imagery, through its dependence on scripto-visual presentation has been chosen more in a didactic/political way than an aesthetic one.

*status quo of public health*, but also signified a 'challenge' to the inherited viewpoints of medical orthodoxy of the period[64]]. Based on observational fieldwork it could also be more extensively examined through discourse analysis, in relation to my adoption of Foucauldian assumptions about the nature of medical surveillance in terms of how it separates mind from body. I strongly related my Ayurvedic] standpoint to his famous statement about ways in which the body '.... was seen to bear the 'stigmata of past experience upon its surface' and that it was an 'inscribed surface of events [traced by language and dissolved by ideas.... a volume in perpetual disintegration'[65]. Whilst Lois McNay and other writers on the 'processes of domination' always point to the problems of eliding Foucault and feminism, my position as holistic practitioner agrees with the way that he sees the body as needing to *resist* incorporation, and so provided a theoretical discourse that affirms the conflict of interest I saw emerging through my NHS fieldwork.

In this way the research resonated with that of both Borland and Prophet, whose [cited] projects could be seen also to contribute to broadening the cites of contestation between art and aspects of socio-medicinal disciplines. Creating the scripto-visual <u>Soma-Series</u> out of medical transactions observed, has been pragmatic since it metaphorically revealed that observed 'lived-experience', via the pre-surgical interview, might 'ethically' challenge orthodox health-care regimes and notions of 'becoming bionic'. The research has observed 'bodies in transaction' with emphasis on the ethical implications of bodily attitudes to artificial-

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[64] Artistic intervention via early Russian Constructivist Art into all aspects of the social domain 'highlighted conflicting points of view between the old order and the emerging new one after the Russian Revolution of 1917, where it was seen that art would be replaced by "construction"' as stated in David Elliott's <u>New World-Russian Art and Society</u>: 1900-1937. [1986] Unsentimental and scientific, art had taken up the concerns of sociological issues rather than purely personal ones, which I have strongly identify with regard to this research.

[65] Lois McNay, in <u>Foucault and Feminism</u> pointed to the uses of Foucault's statements, from the 1984 Interview with Foucault in <u>The Foucault Reader</u> [Ed. P. Rabinow] pointing to the way medical surveillance, via the medical gaze has aimed to 'take over the care' of the disintegrating body, thus rendering it weakened on many fragmentary levels.

improvements through surgical intervention: as such the body can be said to align itself with a 'disciplined' action that has become a something of a 'habit' and a 'norm' within Westernised health regimes. Like artist Jo Spence, Soma-Series sought to promote 'resistance' to what was seen as 'oppressive' normative standards in attempts to deal with 'dysfunctional' body-parts. It was the procedures through which the medical gaze was evidenced, via observational fieldwork, that 'witnessed' the patient's body as a willing participant in a process that could render it as further 'fragmented', and as such a became a 'disempowered' body. Thus the somatic metaphors findings as www.soma-series.org.uk served as 'suggestion' for a kind of 'corporeal resistance' to what I perceived as an oppressive 'societal norm' that is the remit of the quest for prosthesis[66]. The central question that emerged from looking at the research at this 'base line' level, seemed to be an ethical one in posing the question of whose 'needs' were being met: the patient's or the doctors?[67]. This additional questioning might be said to render the research outcomes as reflexive on some levels, so confirmed the need of audience interaction to respond to different levels the contention that Soma-Series addressed. It was this aspect of the research that indicated a specific difference from the projects of Borland and Prophet, whose medically based narratives did not elicit 'direct' audience participation, since their 'statements' were perhaps complete in and of themselves. With these notions at the forefront of the drawing up of a methodological matrix, and in observing retrospectively the role of the medical gaze [as it contributed to somatic responses of those who were seen to be subjected to it], I have found

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[66] From an Ayurvedic perspective, bodies that suffer any form of physical disability need *a change in lifestyle* to accommodate the disability rather than 'procedures' to fragment and reconfigure the body. Eugene Gendlin echoed this concept and discussed how the body is not only rendered malleable by culture and its discourses: '... Bodies are seen as entirely entities of the situation in which they are embedded, a sensing that enables action that is much broader than the mere five senses allow', in The Primacy of the Body, not the Primacy of Perception: How the Body knows the Situation and Philosophy, [*Man and World*. No. 25. p.341-353. 1992].

[67] Or, as Prophet suggested in Sordid Sites– '... the manufacturing producers of implant technologies? [p.30] Digital Desires, Language, Identity and New Technologies. [Ed]. Cutting Edge: The Women's research Group. See also Appendix 6.10.

feminist aesthetic theory and discourse analysis [as related to the sociological overviews of the medical transactions described], to be the most valuable ways of evaluating core outcomes of this research process. Aspects of these methods of interpretation have been presented against a background of visual art that has responded to similar paradigms.

## 3.2. The Developmental Stages of the Visual Work

### 3.2.1. Hospital Fieldwork: rationale.

a. Investigative practice took the form of photographic recording of body-language and noting of informal comments from patients and doctors who had volunteered to be observed in interview **[See: 3.2.4].** The recordings took place over a four-week period [February-March 2001] at the Northern General Hospital in Sheffield in the Department of Orthopaedics.

b. Orthopaedic Surgery was chosen as an area to investigate because of the concerns about prosthesis women patients had articulated whilst they attended my Ayurvedic practice, especially in relation to attaining prosthetic 'joint replacements'. I viewed this problem as being in part reflective of how Orthodox practices enforced the 'fragmentation' and subsequent 'objectification' of the body, because of their focus primarily on physical 'evidence' alone, rather than the whole person, who always has a specific narrative to express.

c. Female patients who participated expressed an interest in the project, stated how they anticipated giving voice to their concerns as to their 'chances' of obtaining prosthetic 'repairs' and the fear that this uncertainty brought about. The process was viewed by many as 'something of a lottery'. Surgeons agreed to participate to dispel 'bad-press' on aspects of NHS practices, by revealing to me that they were confident in all levels of their practice.

**d.** Consultants were male was because there were no female Orthopaedic Surgeons at this hospital.

**e.** After formal negotiations a panel of consultants and administrators had been satisfied that no *medical confidentialities* could be compromised and that the resulting visual research would be presented to all participants as an 'art' exhibition in the hospital.

**Practice for observing the patient-doctor interviews:**

Observations occurred in near identical Interview Rooms and a Waiting Area, purpose-built in 1970. The clinical environment was bland, claustrophobic, chaotic and overheated, contributing to high tension levels in all parties; photographic 'recording' was extremely restricted and fragmented due to room size and the fast pace of events that were often running hours behind schedule. **[see: sketchbooks; 3.2.4.]** Aspects of social Inter-Actionism were applied to investigate elements of body-language and the results were considered in the context of patient's anecdotal 'comments' about their concerns as to the outcome of their medical prognosis. This occurred in the Waiting Areas near the interview rooms.

**3.2.2. Findings**

The following observations are prime examples, photographically recorded and collated as images for sketchbooks and charts, to be re-considered and re-interpreted for completed artwork as the Pilot Video as 'Experiments'; Soma-Series: Ten Constructs and www.soma-series.org.uk

Eleven out of twenty three patients indicated a 'negative response' to the prognosis offered by the consultants. Non-verbal communication via body-language was photographically recorded during five- ten minute consultations, using the social-interactionist methodology. Verbal

anecdotes were: "He just doesn't care…. He's a wolf in sheep's clothing… I'll be waiting for another ten years before I can get a hip-replacement…" **[see: Sketchbook 2 in 3.2.4.]** Physical behaviour included neutral/ unfriendly facial 'expressions' and the following movements and motion:

1. Entering the interview either slowly with reluctance or moving quickly and anxiously, as if attempting a level of 'frozen' resistance to medicalisation. **[see: Construct 1 in 3.2.7.]**
2. Avoiding the consultant's gaze; looking into the middle distance, retaining fixed expression. **[see: Constructs 5 & 8 in 3.2.7.]**
3. Displaying no interested in their own 'X-Rays'; gazing beyond administrative staff who were pre-occupied by paper-work procedures and timing. **[see: Constructs 2 & 3 in 3.2.7.]**
4. They shuffled around uncomfortably in their chairs: an indication of being at the 'effect' of discourse, not its 'cause', whilst their case histories were discussed. **[see: Construct 4 in 3.2.7.]**
5. Attending with friend or partner acting as silent 'witness' to proceedings: an indication of insecurity/uncertainty of the 'emotional' response to their prognosis **[see: Construct 3 in 3.2.7.]**
6. Displaying no emotional 'outbursts' [related to the disappointment about their diagnosis/prognosis], until after they had left the room: then revealing intense emotional distress, with tearfulness. Tension in the body was portrayed as an arm separated from the body but reaching up to it. **[see: Construct 5 in 3.2.7.]**

Post-interview statements included: 'You're pushed around by the system …What does he care? … He doesn't care about my pain… The system's crap… He's a "monster"… You're used by the system for their research purposes'.

### 3.2.3. Conclusions of fieldwork

**a.** Patients considered themselves "under surveillance" by the medical gaze. **[see:  Pilot Video Stills: 3.2.6. & Construct 6 in 3.2.7.]** They appeared often 'disappointed' by 'the system', and were mostly unrestrained in their verbal anecdotes outside of the interview room, in contrast to the interview where they assumed an acquiescent submissive pose in terms of body-language **[see: Charts 1 & 2].** Metaphorically each 'persona' went into a type of role-play, and I interpreted the gaps and omissions in the transactional exchange as indicating significant fear about truthful and self-revealing communication to their consultant. Three out of eleven patients, 'physically' expressed a depressed and 'cynical attitude' towards their interview and their dependency on it. **[see: Construct 7 in 3.2.7.]** I interpreted this critical stance, and others that revealed how patients were not viewed holistically as 'people with their own specific narratives', as part a larger 'pattern' of response, displaying somatic fragmentation and unease at subjecting themselves to the disciplining scrutiny of the 'Orthopaedic' medical gaze. Thus the quest for prosthesis, to replace worn-out body-parts, was overall seen to be based on 'tangible' but ambiguously manipulated 'models of response' within the *triad* of patient, doctor and hospital management, that appeared as the critical point between the securing of an operation for prosthesis or as definitive 'cut-off point' between the patient and prosthesis: hence my interpretation of colourful and contrasting 'nuanced' moods of high drama in each transactional event.

**b.** Twelve out of twenty-three patients indicated a 'positive response' to their treatment and their consultants. This was portrayed by the relaxed, submissive and assumingly 'friendly' manner, and even a sense of 'flirtatiousness'. Some wore 'seductive' clothes; asked few or no questions about prospective treatment but smiled 'demurely',

indicating agreement with their prognosis, even if they were not offered what they had wanted. Examples were: a patient presenting the consultant with photographs of herself, stating: "Mr K...., you have answered my prayers!" Several patients stated openly: "He's an angel... He can do what he likes with me.... I put myself entirely in his hands" **[see: Sketchbook 2 & Constructs 2 & 10]**. I interpreted this behaviour as an attempt to create a synchronised exchange between patient and doctor, to bring out the 'invisible human-side' of the all of consultants: but 'conversation' as such was always cut short, to which the patient acquiesced. This deference to the omnipotence of the doctor was pictorially interpreted as 'figure-head' with 'angel's wings': whilst the 'model' patients selected by hospital administration responded through varying degrees of compliance. **[see: Constructs 1-10 in 3.2.7.]**

c. Where informal statements indicated 'total trust' of the procedures of the medical gaze, a patient's body-language was compliant and yielding; expressive of acquiescence and being a 'model-patient', indicating an unassailable 'belief' in their consultant [and inherently in the medical gaze]: **[see: Charts 3 & 4 and Constructs 2, 9 & 10]**.

The following bodily/behavioural attributes were evident in these instances:

1. Patients were confidently entering the room, attempting to retain eye contact with the consultant.
2. NHS staff presence as the management team, appeared unobserved by the patient, although they were silently controlling the whole event : this became a central 'motif' of the culturally learned discipline that held all participants in a state of suspense and anticipation, which in turn appeared to 'freeze' all behaviour.

3. Walking into the interview with crutches did not prevent instances of 'flirtatious behaviour' where, once seated, patients legs were frequently 'crossed and re-crossed' to reveal 'tops-of-thighs', interspersed with moving the feet towards the consultant to the point of touching 'their' toes **[see: Sketchbook 2 and Construct 9].** I interpreted this ambiguous behaviour as a way of possibly 'currying-favour' in anticipation of 'favourable' prognosis to the transaction, but behind it may have been the idea it might have been necessary to employ devious behaviour to avoid disappointment. But this was also an expression of underlying fear.

4. Patients' engaging in a 'cultural/verbal exchange' [e.g. holidays, the consultant's health/family], whilst the medical gaze remained focused on patients files/X-Rays: indicating 'information seeking' to create a 'friendly' response, despite it being ignored: **[see: Sketchbook 1 & Construct 6].**

5. Being 'passively' compliant, by 'unquestioningly accepting' the prognosis given without comment or change of posture: the facial expression remaining neutral and reflecting a seemingly 'learned social and cultural history' of 'keeping up [polite] appearance, and not asking awkward questions. As such they became 'model patients': **[see: Pilot Video Stills: 3.2.6. & Constructs 1-10].**

6. Expressing no displeasure at travelling two hundred miles for the appointment and waiting for four hours in the Waiting Area, thereby *keeping their stressful condition to themselves,* which was frequently in evidence indicating a fear of being 'openly' truthful about their disappointment: **[see: Constructs 1-10].**

7. Allowing 'orthopaedic clamps' to be re-positioned without complaint, despite obvious pain [not evidenced in the interpretative work, as ethically inappropriate].

**The consultant's response at the interviews:**

1.  The seven consultants' responses to patients remained consistently uniform; their focus was on the physical 'presentation' as sole evidence of the medical condition rather than the patient themselves. Consultants consolidated their diagnosis/prognosis via X-Ray photographs and hospital files. Some decisions related to 'treatment' were made in patients' absence in consultation with management: **[see: Construct 8 in 3.2.7.]** No interviews were private since hospital staff always attended.

2.  Few patients were even partially 'examined', following the pre-surgical transaction, since the focus remained on the X-Rays and paper-work. Consultant's mannerisms were polite/official; technically astute and ready to question and connect prognosis to their referenced clinical costs and timetabling, thus maintaining their dominance within the medical hierarchy. In this way the medical gaze 'appeared omnipotent', since 'it' determined whether a patient had access to a prosthetic joint replacement [thereby appearing to alleviate their joint-pain], or were considered too young or too old to make this financially viable [since the replacement joint would require further replacement within a ten year period].

3.  Consultants were formal at all times, remaining seated when patients entered. Central to all proceedings was the financial viability of a replacement prosthetic-joint - 'prognoses' in consideration of expenditure and age of patient. Consultants were mostly behind schedule for appointments, so were *'economic with discussion'* both prior to a patient's presence and during discussions with NHS management. Whilst I was aware that I could have adopted an attitude of 'ethno-methodological' indifference to this factor, from my holistic perspective it provided further evidence that the transaction had its own 'hidden agenda', that in itself contributed to the mechanical nature of interviews- hence my response that they had a

commercial current that turned the medical gaze into a deceptively controlling one. This was critically responsible for creating physical tension and stress into those parties who were dealing with seemingly 'invisible' financial restraints.

4. Their actions, other than looking through patient's files and discussing them with the management, were restricted to '*hand-eye-speech*': frequently returning *their* gaze to X- Ray material and paper-work. Consultants manoeuvred the clinical transactions with apparent military precision and calm, indicating total ease with their own decision-making procedures at all times. A mere fragment of an interactive encounter contained an elaborate exchange of signs, such as a glance; focus on hospital apparatus or avoiding eye contact.
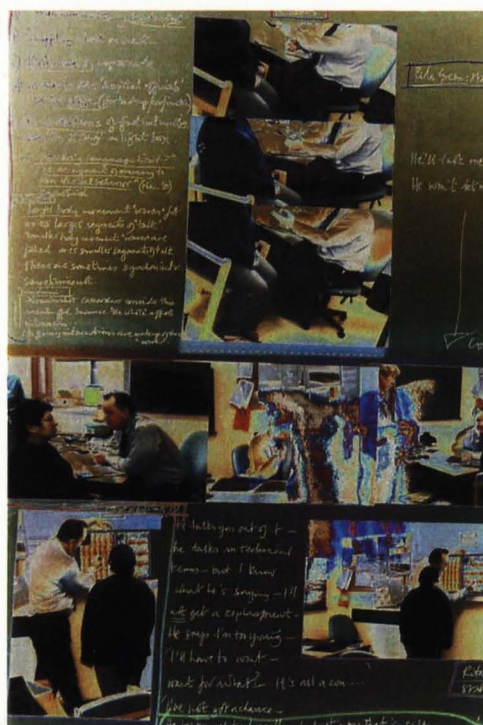
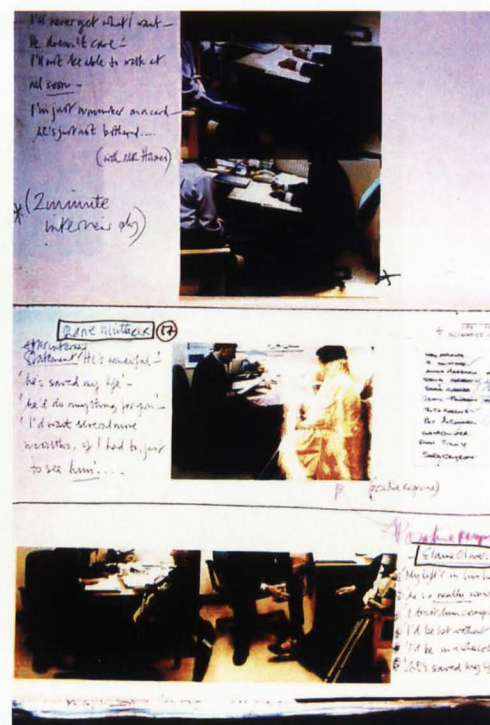## 3.2.4. Investigative research material: sketchbooks and charts.
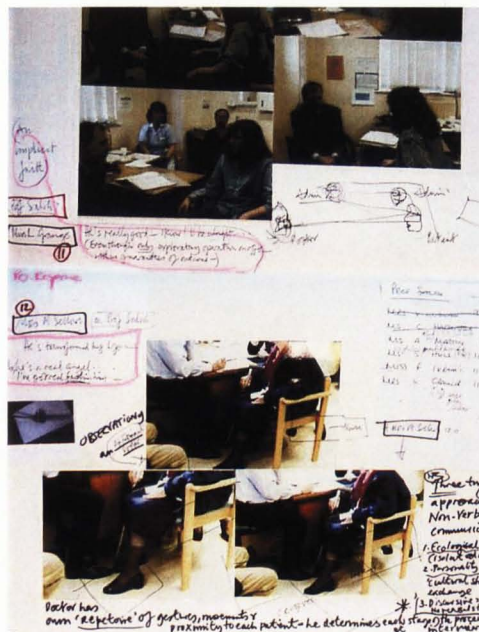


**Visual Example: Sketchbook 1**
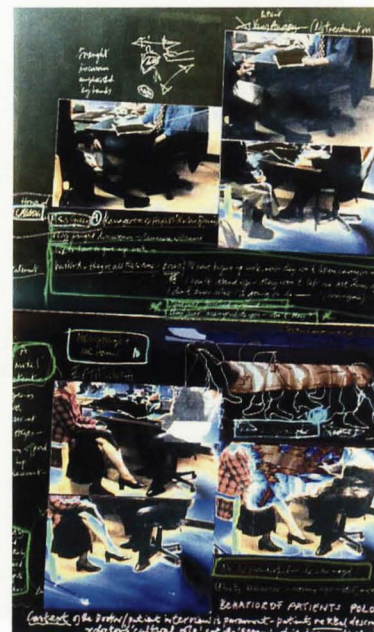


**Visual Example: Sketchbook 2**



**Visual Example: Sketchbook 3**
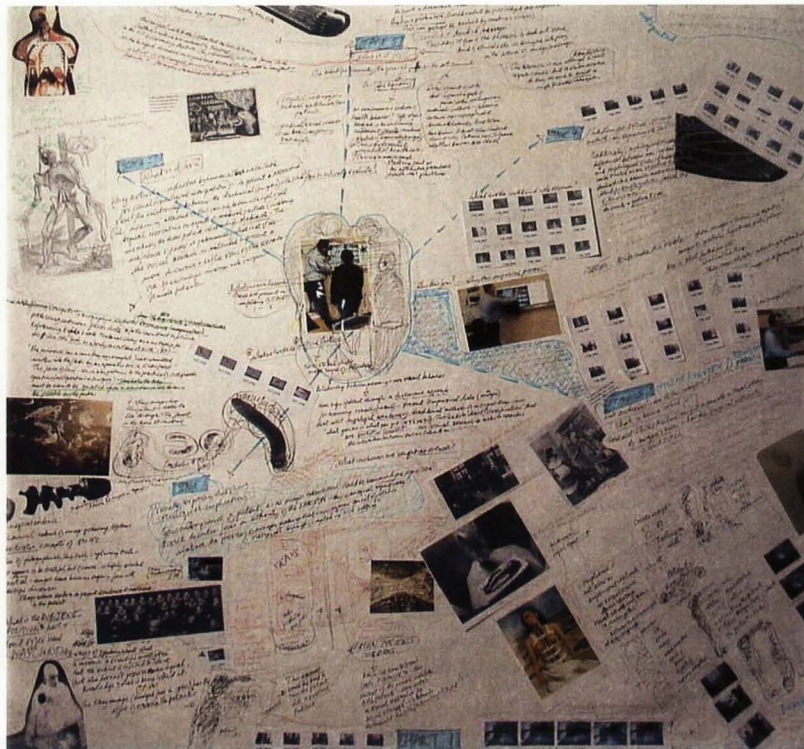


**Visual Example: Sketchbook 4**

**Chart 1** Primary responses via Concept Mapping, starting with a single analogue image from the Investigative DATA of the patient-doctor interviews, responding to the Literature Review.
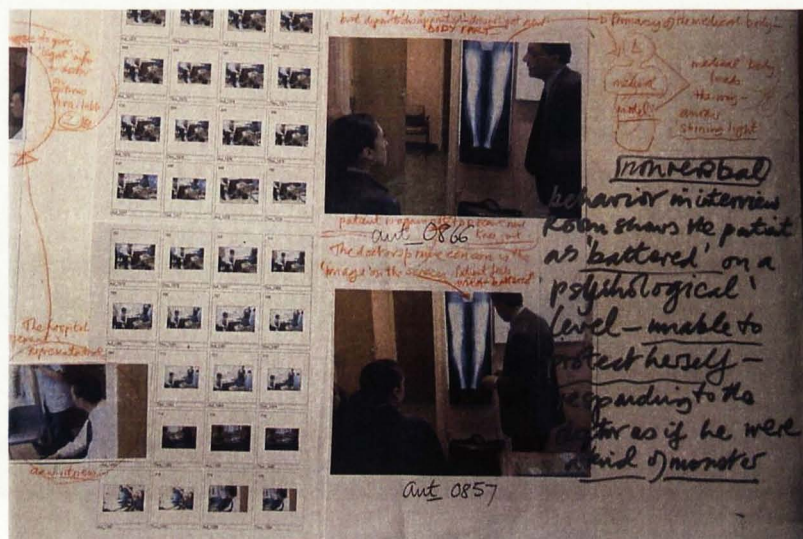


**Chart 2** Secondary responses via Concept Mapping linking psychological and physiological ideas on the 'body' of medicine, merging 'theory' and 'practice'.

**Chart 3** Investigative images from fieldwork in the Orthopaedics Department.



**Chart 4** Examples of Interpretative images based on Fieldwork and first production of 'props' for Pilot Study.

**Chart 5** Interpretative images further developing into **'Soma Series'**.
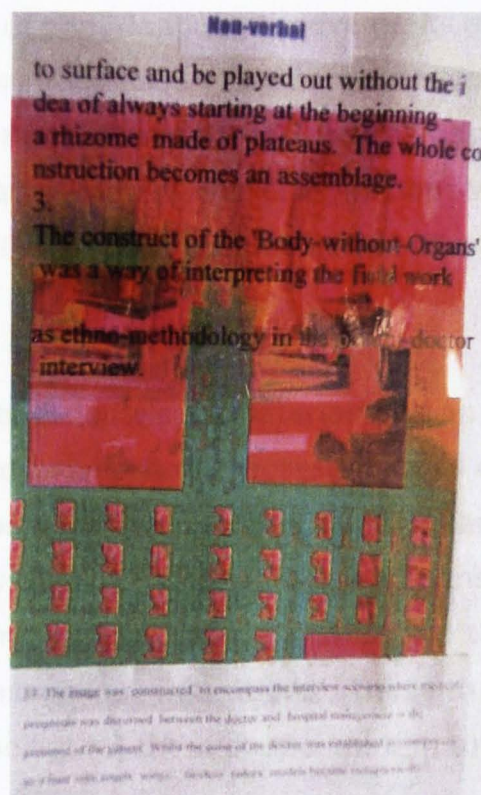


**Chart 6** Planning links for text/image for the Website.

### 3.2.5. The Pilot Study as experiments

**Rationale:**

Incorporating 'encoding/decoding' practices and aspects of 'simulation' of the transactions I had observed I engaged the following processes to move the investigative fieldwork to the interpreting methods in the studio:

1. Recorded analogue and digital photographs annotated with summarised patient's comments were collated onto five large Charts and visually explored in six A3 Sketchbooks.

2. The interpretation of 'body-language' via significant aspects of non-verbal communication was based primarily on the kinetic expressions as stated in fieldwork practice via social-interactionism[68]. By 'Concept-Mapping' aspects of body-language movements and facial 'expressions', drawings and figurations began to emerge: these were then reconfigured into three-dimensional 'models', assembled in the studio and set into repeated 'metonymic' compositions with ready-made three-dimensional 'figurines', purchased specifically for this research. **[see: Chart 3]**.

3. At this stage the encoded visual material took on new dimensions of interpretation, and moved from 'representations of reality' to become new visual compositional 'simulations' **[see: examples in Constructs 6 & 7]**. 'Bodies-without-Organs' as 'three-dimensional mannequins', 'tailor's models' and various 'props' were set up to metaphorically re-construct the transactional 'figurations'. These three-dimensionally constructed compositions in the studio were in turn digitally

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[68] See Appendix 6.6. All the major tenets of social interactionism that were used in this research have been listed, since they were also integrated into the completed website www.soma-series.org.uk

photographed and then transposed onto the computer via 'Adobe Photoshop 6/Macromedia Director 8' software programmes to be further developed as experimental 'moving' and 'still' sequences **[see: Charts 4, 5 and** www.soma-series.org.uk **+ Experiments].** Creating a fusion of several processes led to editing chance/choice 'fragments' of images to reflect the hospital paradigm encoded by a variety of 'expressive' processes. It was at this stage that I had created the first stage of experimental work that reflected the idea of "the quest for a prosthetic body-part" as a somatic metaphor as a form of idealised transformation. I was responding to the idea of 'bad joints' from an Ayurvedic perspective [indicating that bodily conditions reflect emotional attitudes, and that illnesses such as arthritis should be treated for their *underlying* emotional causes[69]]. The quest for prosthesis was seen as analogous to a malfunctioning machine that replaces 'spare-parts' but in so doing avoids other problems, so was a move towards a further fragmented bionic body that could result in total dislocation.

## 4. Limitations of this study.

The imagery focused too much on either the hospital environment or not enough on ways the core issue of the medical transaction: however, all participants appeared to take on an artificial level of role-play, becoming kitsch 'comic-book' constructs. Seeking artificial body-parts rendered the body as 'consumer' and so removed the nature/culture barrier[70]. From my specific perspective this continuous metamorphoses appeared to be created by the omnipotence of the medical gaze, objectifying the issues to do with prosthesis as though it were in was promoting a mechanical body, but in fact can be said to

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[69] In The Language of the Mind-Body Connection, [1991] Barbara H. Oberman-Levine examines how 'dis-ease' needed to be cured by *self-understanding*, which corresponds to the Ayurveda.

[70] Joanne Finkelstein in The Fashioned Self [1991] has noted about dysfunctional body parts: 'They are a commodity which can be upgraded and modified in accordance with new interests and greater resources' [p87].

not be separate from broader perspectives to do with identity and life style [which remain beyond the remit of this research paradigm].

At the stage of the Pilot Study/Experiments I had perceived only a generalised idea of the 'blurred boundaries' between bodies and synthetic bodies, [as patient and medical practices] so *omitted* the fact that such a vast and complex transaction was entered into by all concerned in the deployment of prosthetic surgery in a 'culturally learned fashion'. **[see: 3.2.6.]** Making artwork that might discursively reveal the unspoken power struggle that could be evidenced behaviourally and somatically between patient and doctor was clearly an ambitious task. The Pilot Study as an 'experiment' did not begin to show the underlying fear, distress and physical alienation that the transaction brought about in all engaged with it, but acted as a useful starting point to see where the major omissions lay. [Elements of the Pilot Study as moving sequences have subsequently been added to www.soma-series.org.uk as 'Experiments' in the form of continuous random choice- chance presentation].

## 5. The 'somaesthetic' processes in relation to the pilot study:

Having 'witnessed' the medical interviews as primarily much more dramatic than I could have anticipated, I set about 'abstracting' the notion of the omnipotence of the medical gaze in what, in retrospect, was a 'mix' of 'romanticised' imagery, based on my fieldwork data, contrasted with minimalised and oblique perspectives of impersonal and seemingly endless hospital environment as corridors with people in constant motion. I metamorphosed the patient into a 'glamorous/ heroic' role and the doctor as a mix of 'demon and angel' – the two metaphors appeared to glide about in space as though transfixed, but interspersed with continuous 'unknowable' styles of hospital architecture. I had at first interpreted each transactional body as taking on an adopted persona that resembled elements of Film Noir, but with an Italian Futurist style ambient colour to enhance a mood more, where

the hospital scenario was portrayed like a dance, and the figures within it glided in it like marionettes moved by something mechanical in a type of surreal waltz. Whilst this was interesting aesthetically, it distracted me from the more poignant task in hand of showing how the role-play dictated transactionally via the imposing of the omnipotent medical gaze, transformed all those engaged in its perspective into life-size puppets/marionettes/mannequins and models. These 'figurines' did not become synthesised into specific constructions until I had time to reflect on how the social-interaction I had collated from the hospital became the real force behind the subsequent imagery which developed out of repeated analysis of my primary fieldwork data. But it seemed that there was something already 'bionic' about the bodies engaged in these processes.

### 3.2.6. Pilot Video Stills as visual examples in experiments

**Examples of Video Clips**



**Video Clip 1**



**Video Clip 2**

### 3.2.7. The contribution of the Pilot Project towards a synthesis in the Ten Constructs

Utilising the most poignant elements from the Pilot Study as Experiments towards the final outcomes as Soma-Series: Ten Constructs, involved abandoning the video constructs almost entirely since they had not 'worked' in terms of revealing the degree to which social-interaction had contributed to the somatic experience in the medical interviews. In the light of the Transfer Report, too much had been omitted, so it became necessary to utilise images which had a direct metaphoric 'correlation' to the interpretation of fieldwork evidenced in the Charts and Sketchbooks. This meant a specific "return to the drawing board" to reconsider details of social-interactionism and create new metonymic 'props' and compositions to begin a reconfiguration process. I developed a selection/inclusion set of procedures with diverse newly acquired '3-D props'. I created a three-dimensional vocabulary that directly correlated with what I interpreted as the artificial prosthesis of hospital transactions. They included a parodic 'pseudo-Russian Constructivist "style" assemblage' of: Red 'punch-ball' head + 'stands'; clocks and 'headless' tailors-models; white mannequins; assemblages of cables/lighting and X-Ray light-box; chairs; tables; fabric; wooden plinths; stands; columns and paper.

Repeatedly reconfiguring this visual material, with close reference to fieldwork Practice, and 'encoding' these findings with the newly considered aspects of the 'unsaid' elements of the medical interviews; recomposing selected 'props' became an intense three-way activity that in itself 'mimicked' processes of 'surveillance' and ersatz re-construction: several of the new 'props' contained symbolic and indexical qualities such as the 'punch ball'; the lights within the cluttered interior space that could be observed from a semiotic perspective. Additionally, close compositional proximity of these artificially encoded 'signifiers' focusing on the

mannequins as metaphorical 'patients' with their 'positive/negative' body-language response during the interviews, indicated the observed 'patterns of response' that I perceived as 'manifest' in a somatic manner. The major visual correlation was that patients were unavoidably 'manipulated' and persuaded [either to receive or not be granted prosthesis] when under the scrutiny of the medical gaze; perceived primarily as 'objective/evidence' for surgical/technological intervention; subjected to ambiguous administrative 'time/money' procedures without powers of redress.

The task at this stage was to develop these 'enigmas' through further 'encoding' allowing for all aspects of the investigative and interpretative practices to merge visually as the completed <u>Soma-Series: Ten Constructs</u> that were to become central 'motifs' of the hypertext/website material within <u>www.soma-series.org.uk</u>. But there were some difficult questions to be addressed here: what constituted the boundaries of the self that I transformed into model body-in-bits 'stylised' forms? How had I elected to illuminate the idea of the 'bodies-in-transaction' that forms the medical interview process? Implicit in the ethical framework that was my starting point for this research, was specific opposition to the idea of the 'mind-body split': however, because I was working with metaphor, I had at this stage decided to include, parody and pastiche to emphasise notions of somatic experience into pure 'plastic form', so ideas of body-boundaries and gender were perceived in a futuristic and still [unavoidably] idealised and so exaggerated way[71].

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[71]  I was reminded at this point of the work of Georgina Starr: <u>The Bunny Lake Collection</u> [2000] at the Venice Biennale, where the artists used mannequins in portraying women as fashion 'victims' and ending up as 'dead' mannequins, which appeared like a 'double-parody'.

## 3.2.8. Developing new three-dimensional constructions and preparing them for digital transformation.

At this stage of making work in the studio it would have been possible to proceed with purely sculptural form, as Borland had done with her responses to findings at the Medical Research Council. However, this would not meet the tasks I had set for the research as a whole which was to make work where an audience response through inter-textual action could significantly contribute to the work's final outcomes. Whilst sculptural form was complete in itself, work placed on a website continues to develop conceptually due to growing audience feedback, since for a viewer, 'hyper-real' work on the 'screen' offers the same environment to the artist/author as the viewer and requires no specific venue to be exhibited[72]. Spectators become participants in the growth of the continuing outcomes of the work since 'feedback' allows for re-evaluation of both art work and its sociological basis, thus contributing to it topicality. Remembering the work of again Borland I had elected to make the 'body-constructions' as they emerged out of my quest for appropriate metaphor, in the studio, as particular forms of 'inscripted surface'. But there were two 'opposing forces' to portray: one related to the women patients' fragmentary view of 'themselves' as a result of the medical transactions – the other was the more oblique viewpoint of medical orthodox procedures as it is manifested via its 'gaze', which further dislocated the way patients were perceived to undergo their medical surveillance in the quest for prosthesis.

Fieldwork revealed that specific patterns of physical behaviour emerged: the images I had created still 'romanticised' the patient-doctor dichotomy, with the inclusion of mannequins, tailors' dummies and ersatz 'baroque'

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[72] Landow, G.P. pointed out how on the web 'images are caught up in a system of references to other images and a network of references'. The Convergence of Contemporary Critical Theory and Technology. [1997] p.143.

plaster-cast angels, photographed against pastel coloured backdrops, reminiscent of the hospital environment. Thus, groups of 'figures and props' turned the patient-doctor interview into deep parody, resembling Surreal sculpture, Expressionistic painting and Absurdist theatre[73].

To attempt to explore further this new dichotomy, I recalled that the 'perspectives' available to me in the hospital interview rooms remained almost as restricted at that in André Brouillet's 1879 painting[74]. Whilst the Transfer Report suggested that I consider the psychoanalytical implications of the interview paradigm, [to aid my quest for seeking out "new visual pathways" into questioning the medical paradigm to reveal unspoken aspects of its discourses], I was more focused on transforming the practical contents of my studio into a series of replica 'mock-medical interview rooms': this transpired through applying metonymic uses of my collection of 'bricollaged' figures and 'props' in mimetic poses to the fieldwork 'picturing'. The 'constructs/compositions' that emerged out of this process of addition, subtraction and experiment aimed to disturb a viewer, in the way Prophet's imagery had done in The Internal Organs of a Cyborg [1996]. Each element of these new visual metaphors contained likenesses to 'everyday 'objects trouve' [already culturally 'available' in shops, and charity shops, so in no way innovative in themselves] so once they were transposed into a website screen, a viewer might transfer their own 'notions' of the patient-doctor interview, as they in turn had experienced it. But I was making artwork, not creating a hospital 'promotional campaign', so in this respect, as with Borland and Prophets' work, a viewer would need to decode the apparent 'myth-making' of my production.

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[73] This conjured up images from Martin Karmitz' film shown in the 2001 Venice Biennale of Samuel Beckett's video Comodie [1966], where three 'unnameable' characters were enclosed in open topped large jars each communicating with a different agenda, thus making a mockery of social interaction and so-called purposeful communication!

[74] Une Leçon Clinique à la Salpetriere: [1879] See Appendix 6.10.

The problem, at this stage, was that without inclusion of specific explicatory text, the imagery would still, at best, be seen as amusing or romantic. Juxtaposing social-interactionist related text would establish a stable point of entry by which to view the imagery. These could act as 'codes' to indicate that the imagery had a specific sociological basis, and that the work, when viewed as a whole was an *antithesis* to the comedy of the pictorial simulations of the created 'hyper-reality'. I chose the use of 'body-in-bits' as 'figurines', purified and so 'clinicalised' [with a coating of white paint] 'made-to-metamorphose' into symbolic components according to the *roles they had personified* [and so metaphorically somatised] in relation to the fieldwork findings. With this in mind, groups of figures formed experimental new compositions in the studio, which itself became like an NHS interview room, but was 'decorated' with paper to reflect a mix of both the ordinariness and the surreal aspects of interview room apparatus. The 'constructed' assemblages thus seemed to hold a new significance in terms of how the artwork made each artificial [prosthetic] element to transform the transactional experience into hybrid/synthetic plastic form. Whilst they had been arrived at by repeated concept-mapping produces: consultants appeared to be those highest in dominance in the real fieldwork scenarios, so metonymically their hierarchical stance place them into a position of 'superiority' within the team: the doctor's 'gaze' was shown as either above or beyond the rest of the 'group'. This had been seen to *systematically* move from patient to written notes/records, and remained mostly fixed either on the X-Ray material or the part of the body that required surgical intervention in the patient, as seen in the fieldwork.

These completed compositions were photographed and placed in the computer software as still images for 'manipulated' to enhance overall effects. This process revealed a procedure that reminded me again of Christine Borland's The Dead Teach the Living. Working on the computer at this stage was like *bringing to life genetic material found in a disused*

*laboratory* in the way that Borland had made three plaster busts by 'decoding her data' for specific characteristics and facial features, but unlike Borland commenting on a medical narrative raised again my antipathy towards the 'material' I was responding to as a site of conflicting annotations and an amalgam of diverse thoughts[75].

### 3.2.9. The interplay of the fieldwork and the studio 'props':

All the three-dimensional simulations can be seen to has thus been encoded as 'icons' and 'props' composed in my studio. As such they became a 'gallery of signifiers'[76]. These encoded referents were composed to exemplify patterns of interaction that were evidenced in the fieldwork, and further modified on the computer to enhance the quality of tone, lighting and colour contrast. The following characteristics were cited to be the main focus for the website, alongside elements of preparatory sketches and social-interactionist texts as:

A. Individual patients in the hospital appeared to be involved with preserving autonomy but not resisting 'objectifications' in the face of the orthodox medical gaze: they were 'represented' as fragmented mannequins.
B. The 'Doctor' was presented as 'fashion-bust/ model' incorporating 'ersatz wings' and medical stethoscope and, or electrical light. Within the patient-doctor interview, fragmentation and scientific objectivity were the main constructed 'manifestations' of medical observation: the task of this research has been to find visual expression for this dichotomy **[see: images B + E].**

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[75] This also reminded me of Jo Spence's <u>Cultural Sniping: The Art of Transgression</u>, because of its transgressive qualities.

[76] In <u>S/Z – An Essay</u> [1974] Roland Barthes discussed the 'connotations' of imagery as being '...classified according to its value' [p.7]. With the additional refinements of connotions and dennotions, Barthes indicated how reading images, through the complexities of the subjective and objective responses they require, is best seen as a 'lexeological act,' [p.10] where meaning is always differently interpreted and so 're-created' by each individual viewer. I see this aspect of the image making for this research much as Barthes described, but also arrived at not as 'raw' material, but as popular ready-made 'icons', used parodically.

C. Hospital 'management' and 'nursing staff' were created as two 'tailor's dummies' with interchangeable 'heads' in the form of 'light bulbs'; 'punch balls' with attached 'dark-room-clocks'. I remembered how Foucault had observed how orthodox medical discourse, since the Enlightenment, *forms* the 'object/subject' of which it speaks: it was thus a means of disciplining the body in institutional settings and I represented via the doctors gaze [the white 'face' on the plastic bust, with no colour to distinguish different features, were intended to indicate the head/mind/vision apparatus were all as one]: the 'objects' chosen here were contemporary 'items' that could be moved about to point the 'gazing head' in different directions, as in a display for a commercial shop window-dressing **[see: image C].**

D. A Victorian pedestal as ersatz Greek column: metonym for the continued 'tradition' of the superiority of 'the platform' of the medical gaze .In attempting to normalise a subject's ill health medical practices exert a level of power/knowledge that can result in a deep level of 'alienation' on the part of the patient, due to the learned hegemony of the medical gaze **[see: images D + H + I].**

E. 'Pseudo' Doric column, metonym for the basis of tradition of Western Culture Gallenic practices, referencing the idea **[see: image A].** A 'real' laboratory stool: metonym for biomedical research and its historically handed-down practices.

F. A 'saucepan' storage-rack: metonym for 'stacked-up' patients on 'waiting lists', with the portrayed patient at the top of it.

G. Electrical cables and plugs: redundant and contemporary technologies, imitative of those used in the hospital interview rooms.

H. An electrical hospital X-Ray viewing box, from a disused hospital, and part of an orthopaedic crutch: material aids to both patient and doctor.

I. Miscellaneous tables, chairs, sheets, paper rolls, wooden boxes, sheets and table lamps: some of the paraphernalia of the hospital interview room collected from a disused hospital in Sheffield.

J. The studio: a 'stand-in' for the hospital interview room as seemingly 'neutral' space, potentially metamorphic in its usage.
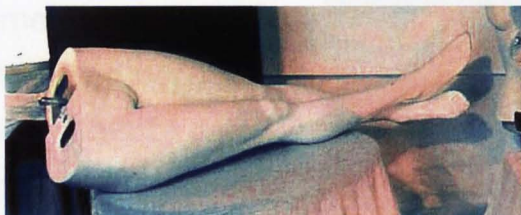
# Key image examples.



**A**



**B + E**



**C**



**C + I**



**D**



**F**

### 3.2.10. Summaries of compositional components of the <u>Ten Constructs.</u>

**Construct 1:** *A negative response from the patient:*

Imagery developed out of observations of patient-doctor transactions where the patient remained compliant to the doctor but retained a negative response to the prognosis: [that they were not eligible for a prosthetic joint replacement for reasons to do with cost effectiveness]. The 'patient -torso' was posed submissive, visually suggestive of how they appeared 'dislocated' as a result of the 'doctors gaze' [bust with angel's wings on a plastic Doric column]. The 'wings' and 'elevation on the column' were metonyms for the patient's metaphor of 'the doctor was an angel' or in some instances a 'monster'. The plastic Doric column, plastic bust and ersatz wings all signified the artificiality of these 'sublime' metaphors. Fieldwork indicated that there was a separation of patient and 'illness': patient being a vehicle for technical or financial intervention towards 'cure' or processes of cure within Orthopaedics. However, fieldwork revealed that a patient could not be certain how their condition would be responded to by an NHS Hospital, since political aspects of surgical practice were not known to have been available to them. All these 'elements' contributed to the alluded 'artificial and deceptive mode' of the interview – hence its 'artificial' and 'prosthetic' components, and 'shadowed' atmosphere.

**Construct 2:** *A positive response from the patient*:

Quoting the Deleuzian 'Body-Without-Organs' construct, the gaze of both 'patient/ mannequin/torso' and 'doctor/bust/wings' were composed temporarily to 'meet each other'. The 'meeting of gazes' represented a 'positive response' from a patient during the interview with the consultant. Two 'tailor's dummies' with attached 'electric-light –heads', were metonyms for the perceived 'managerial automatism' of hospital management, that was seen to preside permanently during each transaction. This apparent 'theatre' reflected the interview scenario as concerned with *singular* issues of bodily malfunction, since the focus was on replacing 'one' joint 'prosthetically'. Disparately composed torso and limbs, metaphorically indicated that *only part, not the whole*, of the patient would undergo the diagnostic observation of the doctor's 'objective' gaze. Various scattered 'objects' represented the 'constructed environment' of the interview room and acted as signifiers of the patient's fragmented and transient experience of it. In this sense all the 'props' in the composition 'acted' as metonyms for prosthesis, and the fragmentation and dislocating of the body that had elected to become part of this artificial process. Were they already bionic?
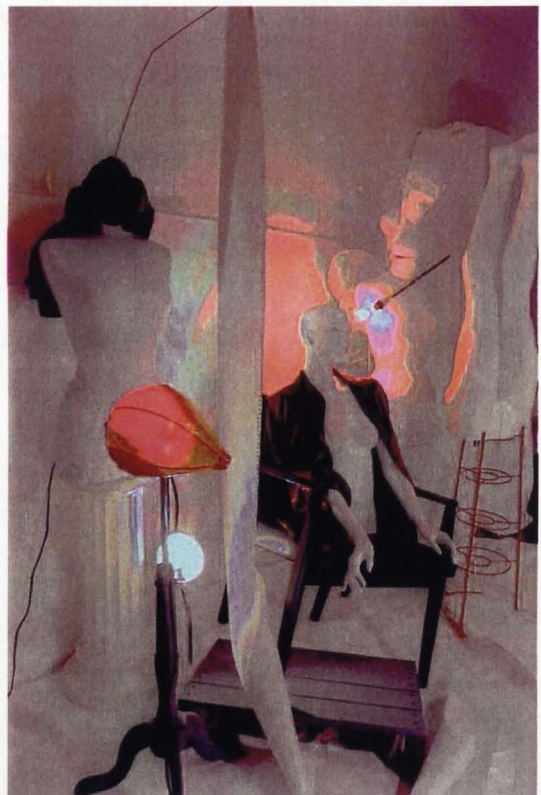
**Construct 3:** *A positive response from the patient*:

Within medical discourse the subject 'as patient' was seen not as the *cause* of discourse but the *effect of discourse.* There is no evidence of the doctor's presence in this image, which was created to indicate that the power of such discourse was seen to take a similar effect on a patient, even in its immediate absence from the scene. [The doctor had momentarily left the room in this instance to view another patient, but their absence made no difference to the overall dynamic]. In this way the patient and their anticipated prosthetic joint replacement become *equal objects* of the medical gaze, since they were seen to be inseparable. Two 'horizontal arms' positioned between intermediaries of 'hospital management and bureaucratisation' suggested the *fear* that underlies patient-doctor interviews, even when the patient had confidence in the prognosis. Fieldwork indicated that when the patient's demeanour was strong and assertive their gaze was directed beyond the interview assembly. The body language presented resistance to becoming an 'effect' of medicalisation but not of *its process* which was a

central determinant of the patient's somatisation. Therefore all participants in the interview were seen to involuntarily 'take part' in this process: thus their 'persona' became synonymous with the processes of prosthesis itself -in this instance the image is broken down the centre by a strand of the endless 'flow' of paperwork that was seen to dominate all transactions at the pre-surgical interviews and illuminated their bureaucratic aspect.
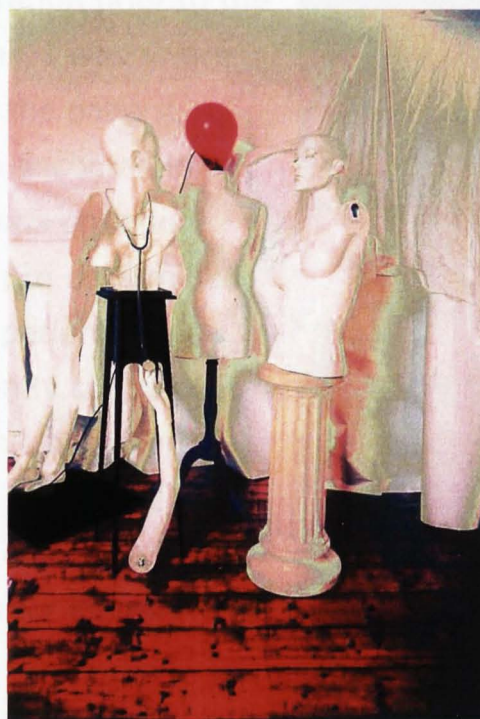
**Construct 4:** *A negative response from the patient:*

The central figure of the partially clothed 'patient/mannequin', engulfed in an amorphous grey-pink 'entourage' of abstracted 'props', was developed as a metonym for those patients whose disposition toward the interview was cynical or depressed and therefore [apparently] uncooperative. Such patients remained somatically 'in shadow' despite being in the 'spot-light' of the doctor's analysis. The gap between what was spoken or visible via body language became the vehicle for creating imagery as a series of fragmented disparate objects. The prominence of the central *instability* of the chair, on which the 'patient- torso' was placed, reflected a level of ambivalence within the transaction. The fieldwork had revealed that when the patient's stance was submissive, since they remained doubtful that the forthcoming 'treatment' was either attainable or desirable: they appeared 'frozen' and isolated. The fieldwork also indicated that a patient's body-language could work to reduce verbal exchanges: in these instances the medical transaction proceeded by avoiding direct eye contact with a patient, whilst the administrative team became pre-occupied with their own procedures, thereby leaving the patient momentarily 'suspended'. Witnessing a kind of corporeal 'resistance' in the patient to the clinical activities, the transaction ended abruptly when prognosis denied the patient the desired prosthesis: had diagnostic technology demonstrated its 'artful' objectivity?
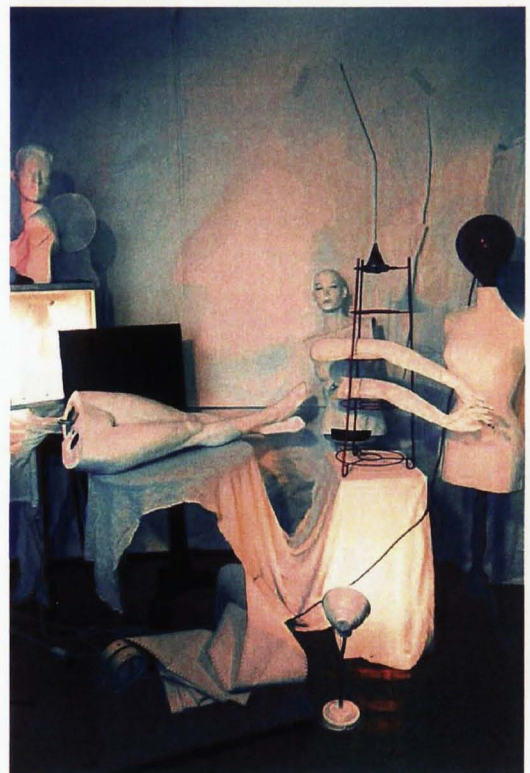
**Construct 5:** *A negative response from the patient*:

This composition was constructed to exemplify a very concise 'verbal exchange' in the patient-doctor transaction. Appearing clinical, straightforward and direct the 'patient/mannequin' was presented for inspection by the attendant hospital management to the doctor's medical gaze – as in many instances in the fieldwork. Metaphorically each 'persona' played a specific role, but the 'patient' was presented as 'dismembered' to draw attention to the power play in medical practices where 'gaps' and omissions 'in communications' served as *signifiers* for patient 'acquiescence'. The 'patient' became evidence for medical observation *only* through a series of 'fragmented symptoms', symbolised here as segmented 'body-parts': thus the patient was the vehicle through which the doctor's medical gaze viewed only objective knowledge via its technical expertise so the subject/patient, was not viewed *holistically* as holding their own specific and unique health related narrative. This construct suggested metonymically that the procedures of the transaction were 'synthetic' to begin with, thus the somatised experience of *all* participants in the interview.



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**Construct 6:** *A positive response from the patient*:

Echoing **Construct 4**, the strong horizontal 'arms', the lower half of the 'torso and limbs' were placed casually on a table. The 'bust' [doctor] was placed above it on top of the empty X-Ray box. On the floor were clocks; computer paper and a table lamp: typical contents of an interview room with a decentred office desk. On top of the 'rack' holding the patients' 'arms' was an empty 'paper-bills' holder: each object was presented metonymically as elements of the hospital interview room. Within this chaotic and sometimes frenzied environment some patients' unconsciously used the sexual dynamics of the patient-doctor power structures in an attempt to gain the 'true object of desire' [the prosthetic]: could the 'lack' within the patient be sated by the possession of 'the phallus' [prosthetic] from the doctor? The patient appeared confident in their 'flirtatious' responses within the transaction, since they departed from the pre-surgical interview with the knowledge that they would receive the desired prosthesis. Remembering how the fieldwork was restricted mainly to the observation of body-language and that

patients had been carefully 'screened' by hospital administration prior to the observed transactions, I was aware the unsaid aspect of the patient-doctor interview was anchored in different manifestations of patient 'acquiescence'. As a pre-determined 'characteristic' of all patients observed, it significantly contributed to the 'ersatz' dynamic of the pre-surgical transactions where the 'medical gaze' could orchestrate procedural outcomes for its own ends.

**Construct 7:** *A positive response from the patient***:**

Placed in an elevated status [metaphorically at the 'top' of the 'stack of patients'] the 'patient/mannequin' focused forward beyond the doctor to the middle distance. During the fieldwork this 'stance' conveyed the confidence by which certain 'positive-response' patients ceded autonomy to the expectations of the doctor. This manifest confidence indicated that the patient's 'medical' expectations had been met: subsequently these interviewees became 'model' patients for the diagnosis/prognosis. The 'doctor', next to the 'X-Ray light- box' and 'clock', remained unchallenged on any [visible] level, retained undisputed control. The critical task of the medical team had been to decode the patient's symptoms to their biological referents in order to diagnose a disease 'entity', but these had only been sought through measured clinical facts, not the patients discourse or personal narrative relating to their illness. Disease, therefore was attributable only to objectively demonstrable

physical changes in the body's structure or function, which as symptoms and signs made up a 'clinical picture'. This picturing via the medical gaze resulted [in this instance] in a prosthetic prognosis, contributing to the seemingly undisputed desirability of creating inroads towards the bionic.
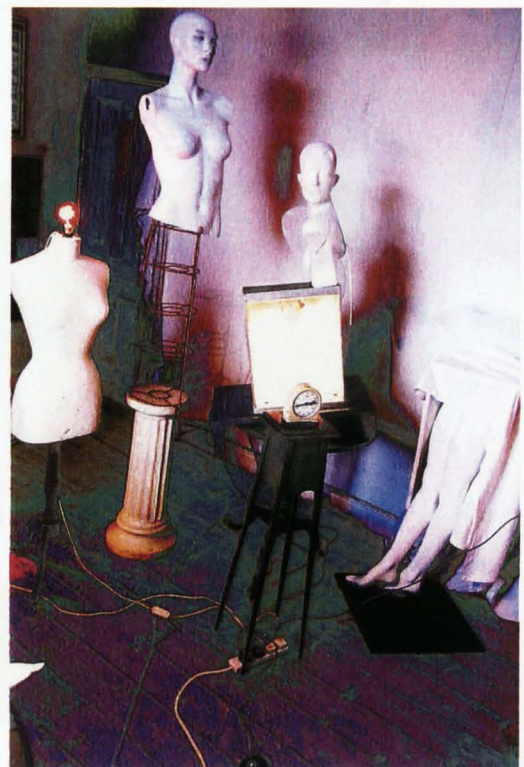
**Construct 8:** *An 'interpretation' of body-language of doctor and 'management' in the absence of patients*:

The doctor and the hospital management in the momentary absence of the patient discussed the prognosis of the patient. While the 'doctor' stance [as the bust] remained unaltered due despite the absence of the patient, the 'models' [representing management-hierarchies], were presented as separate and aloof. This stance related to the 'routine-ness' of the task in hand, but omitted the often dominant 'double-voiced' edge of medical/financial discourse. Social-interactionism revealed a level of vulnerability within patients [that I spoke with briefly in the Waiting Areas, prior to observing them during their medical transaction]. They were extremely concerned as to how their individual case-histories were discussed in their absence; this in itself created a high level of stress and anxiety in them, which remained invisible to the medical team, who discussed the 'patho-physiological' process of treatments available for each patient based on single causal strains of scientific knowledge, in some instances deciding on procedures towards multiple prosthetic implants.



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**Construct 9** *A positive response from the patient*:

Reflecting aspects of **Construct 4** the patient/mannequin was centrally positioned and observed via the medical gaze metonymically 'up close' via a 'probe-light' at an oblique angle. This 'scene' was a drawing together of instances in the fieldwork where the doctor's demeanour indicated a lack of ease with patients 'personal remarks', so found ways of 'distancing themselves' paradoxically by close-up examination of the patient's facial demeanour. This was not met as a rebuff by the patient, but a profuse embarrassed response that seemed to increase the manner in which they acquiesced to the routines of the transaction. By remaining placid and vulnerable to the cohesive co-ordination between the management team and the doctor, they became ostensibly manipulated, which in turn portrayed them as fragmented and only 'partially' able to represent their 'case'. This scene also 'demonstrated' a false sense of intimacy to the transaction, heightened by the overall clutter and interior chaos of the interview room, in which the patient was seen to attempt to 'fit in'. Despite their confusion such patients left the interview with the knowledge they would receive the desired prosthesis.
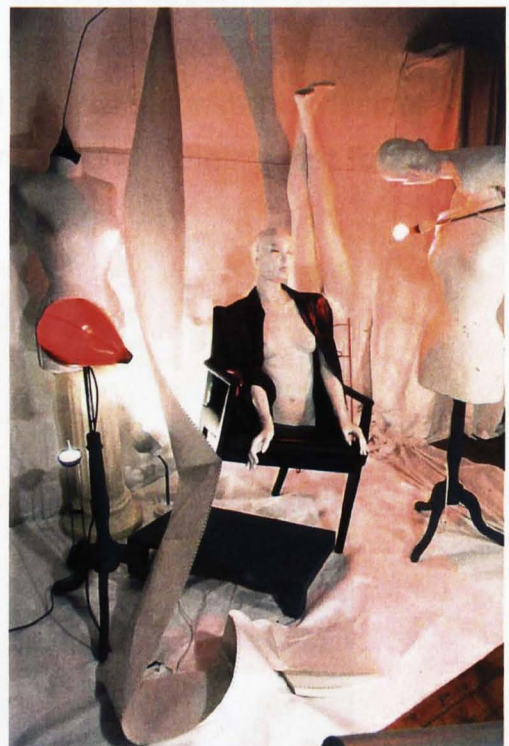
**Construct 10:** *A positive response from the patient*:

Extending the oblique angle of **Construct 9**, but with the dual gaze of the 'doctor' and 'management/model' positioned high above the patient/mannequin/torso'. The 'downward' medical gaze and the oblique presence of the 'management/models' indicated that while socio-medical attitudes, hierarchies and behaviours did not adversely affect all patients, they were central to the invisible processes of 'objectification' which was always seen as the remit of the medical gaze. Careful monitoring of the patient, during the interview via administrators ensured the patient perceived that they were under more than one layer of surveillance. The fieldwork indicated that the patients were complicit to these 'rules of medical discourse' in anticipation their acquiescence would lead to freedom from debility. This factor diminished the patient's autonomy in dealing with their own health-care and facilitated the doctor's omnipotent gaze and ensuing diagnosis. The drapery served as a reminder to the fact that patients remained fully clothed during the pre-surgical interview, and thus had the outward appearance of being autonomous and 'non-scrutinised': they are presented as partially clothed as metonymic with the observed patient's constant physical vulnerability throughout the medical transaction in their quest for prosthesis.

**Conclusions:**

Soma-Series: Ten Constructs became the penultimate interpretation of the fieldwork; recorded from the studio built 'compositions' and transposed into the two dimensional images that were then integrated as central 'motifs' for the final stages of presentation in the www.soma-series.org.uk. Utilising aspects of the early concept-mapping through the Charts and Sketchbooks and extending the three-dimensional compositions of the Pilot Study, the outcomes reflected patterns of observed behaviour attributable to the medical gaze and its attendant practices, as the central 'image' focus for interactive hypertext. Placed randomly within the maze-like structure of the 'artwork-as-website', it was anticipated that a viewer would gain insight into the creative and interpretative procedures involved in the processes that led to the making of images and its social-interactionist basis: as such they were then additionally inscribed with texts related to the hospital interviews, which was not possible within the limits of an exhibition of framed work.

# Chapter 4

## Reflections on the three stages of the formative findings.

### 4.1. Fieldwork into studio practice.

Reflecting how the medical interviews contained aspects of material that
was reminiscent of the Enlightenment art, I had recalled that Gilray and
Hogarth among others of this period, had also been sceptical about the
efficacy of the orthodox regimes of their times so had developed ways of
satirising what were austere occasions, thus turning the patient-doctor
transaction into an ironic or satirical event. Despite the obvious pathos
evident in the quest for prosthesis, as encountered during the time spent
gathering visual data from hospital procedures, there was a contradiction
at play within my quest to harness the most poignant signifiers and
dominant codes of interaction between the professionals and the
layperson. From a visual perspective the twenty-three observed pre-
surgical interviews held within them a great deal more than could be
rendered through purely 'retinal art', since there were many layers of
meaning to interpret within the transactional 'theatres' I had observed[77].
My presence in the interviews suggested that the transactions had to an
extent been 'stage-managed' and 'role-played'[78]. From my specific
aesthetic/feminist position I had witnessed subtle series of masculine
'command and control' paradigms, as dictated by the strategies of the
medical gaze, since they occurred without access to or engaging with the

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[77] I recalled the conceptually based photography of Victor Burgin, which was described by Peter Osborne in
Relocating [2002] as: '... Burgin's move to a politicised photographic art practice is best understood as
the practical pursuit of its expanded conception' p.63]. My digital response to the hospital imagery
needed also to find ways of *expanding* the form and content of what I had perceived, so similarly
engaged the practice of a scripto-visual presentation to 'expand' its context.

[78] This was due to the NHS Ethics Committee screening procedures to agree only to compliant patients
being observed and photographed.

patients' or the medical staff's 'self-defined specificity'[79]. So I had been very much a spectator of this apparent 'theatricality' which away from the hospital revealed a type of more abstracted idiom from my specific standpoint, as I recalled the stories from my Ayurvedic patients. I had a series of photographs observing transactional body-language, and I had planned [as Victor Burgin had done in diverse scripto-visual exhibitions throughout the 1990's] to present the completed images in juxtaposition to social-interactionist 'language'[80]. I recalled the task of the medical team had been to decode a patient's somatic and biological referents [relying directly on diagnostic technology to collate their visual evidence as x-rays, and reporting them]. Since the patient was seeking prosthetic surgery, the factor of the cost-effectiveness of prosthetic implant was critical to the transaction. The patients remained intense, anxious and fearful awaiting their prognosis: would they receive the desired prosthesis? Could the medical team process patients efficiently? Out of the initial photographs came drawings of these postures; glances; gesticulations and interactive movements and textual description that began to form significant compositional 'patterns' of transactional behaviour. But after investigation of this dichotomy, and by standing back from it and 'reconstructing' it [remembering the Ayurvedic 'knowledge' I had brought into the hospital arena], did possible visual/textual compositions and new questions arising from them come into play[81]. Focusing specifically on the 'information seeking' and social-interactionally observed 'signalling' behaviour between patient and the medical team, examined in conjunction with notions of the disciplining 'medical gaze'

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[79] In Explorations in Feminist Ethics, Care and Respect [p73] Robin S. Dillon discusses why respecting persons [within medicine] requires seeing things also from *their* point of view: this did not occur during the observed interviews.

[80] Hilde Hein in 'Where is the case for Feminist Theory? The Case of Aesthetics' [in Feminism-Art Theory. Ed. Hilary Robinson] discussed the need for aesthetic innovation 'which represents genuine alternatives to a *totalising theory* which advances knowledge only at a cost of diminishing what is knowable'. [p.317]. This seemed to confirm the idea that there were many idioms within the 'transactions' I had observed from my fieldwork and studio practice without having to arrive at one specific viewpoint only: hence the development of the work towards a hypertext.

[81] Chaplin, E. [1994] Sociology and Visual Representation discussed this process '*of arriving at visual outcomes after time has sufficiently lapsed....*' [Chapter 2].

[was this replicating my 'artist-researcher gaze'?], I recalled how Deborah Lupton had indicated that medical interview practice operated as a 'series of loosely linked assemblages' in a way that allowed little scope 'for real lived experience'[82]. As this concept resounded with the reflection of events I had perceived in the hospital: I saw how the exercise of power/knowledge procedures, and the *artificial behaviour* aroused by it, became central motifs of interview transactions out of which the visual 'somatic metaphors' emerged.

Outcomes to my initial visual data showed that the body/bodies I observed became bio-mechanical, since each interview had a type of rhythmic-mechanical movement built into it, which in itself *negated* any 'individuality' and suggested instead series of stylised pathologised 'figurines' each holding a certain functional readiness to move 'towards the bionic'. The interview paradigm suggested a learned collective and collaborative response, which I perceived as an aspect of the participants simulated, hyper-real and thus somatised response to their medical experience[83].

## 4.2. Interpreting the scripto-visual outcomes.

Expanding this reflective and 'simulated' practice encouraged an interpretation of the seemingly mechanical transactions as physically dislocating [in terms of health-care] and essentially 'hyper-real'. The patient had been observed as both subject and object of the symptoms she had arrived with: their 'health experiences' through the transaction of the 'quest for prosthetic replacement' could best be reconstructed as

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[82] Deborah Lupton: Foucault and the Medicalisation Critique [1997] indicated how *docility* became a necessary 'manner' for a patient to present themselves for medical surveillance since it was 'essential' within the exercise of disciplinary power.

[83] In Culture, Health and Illness [1985] Cecil Helman stated '...in most illnesses there is some interplay between voluntary and involuntary in the expression of illness... cultural factors determine *which* symptoms or signs are perceived as 'abnormal', since they *shape* the diffuse emotional and physical changes into a pattern which is evident to both the sufferer and those around them' [p.71].

simulated 'models' of what I had seen, as in a comic-book with added 'comments'. Recognising the pre-surgical interview as the first stage in a process towards artificial 'metamorphosis' [which my standpoint view interpreted as transactionally taken into the body 'somatically'], the interview paradigm took on a surreal quality, which I needed to translate into 'visibility'. Thus each body/bodies, via the removal of 'individuality', became rendered as 'body-in-bits' with repeatable 'patterns' and permutations. I drew this into the sketchbooks and charts, and came to perceive each figure as simulated and so 'artificial' [through their 'investment' in the world of artificial implants]. Together these ideas became visual metaphors and so 'impersonal' and 'collective' and to me suggested the 'Deleuzian construct' of the 'Body-Without-Organs' since it was how metonymically the medical gaze 'constructed' the patient as 'object' from 'subject' or perhaps as a more of an [already] bionic or Cyborg construct [84]. But did the patient see herself as in a process of metamorphosis towards a 'bionic being'? This notion of a 'protean being' as a ready-made facsimile was thus utilised as an outcome of these particular interpretations of what I had seen, providing 'analogous structure' to the metaphor it held for the women I observed in Orthopaedics seeking prosthetic health-care solutions.  But in the broader perspective the research's focus on the 'body-in-transaction' [under what I had perceived from a pragmatic feminist standpoint as *repressive* medical regimes], served to reinforce notions of a larger dimension that were at work both within the pre-surgical interview and beyond it in a world where increasing uses of prosthesis are the norm. The most poignant motif that I aimed to construe was based around the observed tensions, stress and fear within both patients and medical staff: fear that hospital management would not grant them a new prosthetic part; anxiety on the part of the medical team for not being able to offer

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[84] In A Manifesto for Cyborgs: Science, technology and Socialist Feminism, Donna Haraway sited a 'body-without-organs' as science/art; machine/human – a hybrid that cannot achieve wholeness since it is a sublime 'image' exiled from utopia. [See also: Glossary of Terms on: Subject/Object].

unconditional prosthesis to all who requested it[85]. This was seen to be the central transactional response in each series of medical interviews: the quest for bodily rejuvenation via prosthetic replacement 'therapy'[86].

With these ideas in the forefront of my interpretative studio practice and through engaging layers of 'encoding/decoding'[87] into what had emerged [in determining how these bodies 'somatising patterns' of 'conformity' and 'acquiescence' could be integrated into 'body-in-bits' motifs], I could perceive 'practices of rupture' whereby prospective bio-technology, literally, was seen to 'disengage' humans from their sentient form. Thus perceptions and evidence had jointly created visual parallels for the way the women in the medical interviews related to the maintenance of their own bodies 'somaesthetically'. My visual quest, allied to social-interactionism, hospital fieldwork and my own Ayurvedic perspective indicated that the visual/textual outcomes, anticipated contributing to a broader gender/health-care related debate within socio-medicine from a pragmatic feminist standpoint. It was from this perspective that the research outcomes formed a contentious political and ideological agenda, since they were critical of an aspect of 'cultural practice' that many subscribers to medical orthodoxy was viewed as 'sacrosanct'. Reminded again of early Russian Constructivist imagery, where all parts of a concept/observation/construct were perceived as equally consequential to the type of work that could be made, my 'socio-visual' work also sought vehement response to public notions of what constituted health-care within the remit of prosthetic advancement. But could images, juxtaposed with social-interactionist based texts as a

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[85] Patients aged between twenty-thirty years, would have to wait for their body to age as much as twenty years, because they may have been too young to be considered to be *cost effective* for prosthesis to be financially viable.

[86] In Power, Bodies and Difference [from Destabilising Theory: Contemporary Feminist Debates] Moira Gatens noted that the notion of 'somatophobia', being closely related gynophobia and subsequently misogyny, were part of a deeper alienation of the self, which corresponds to the Ayurvedic perception of the current trend of bio-technologies as an apt health-care strategy.

[87] Hall, S. in Cultural Representations and Signifying Practices presented a critical feature of this research tool: decoding referencing what a viewer brings to interpreting an artwork/text; and encoding indicating how the producer of a work had deconstructed it prior to presenting an artwork/text. See also Glossary of Terms.

scripto-visual hypertext, contribute to audience perceptions of orthodox health-care regimes? As was the case with Constructivist artists, I hoped that the outcomes of the hypertext work would not be separate from the [hospital] context in which it was produced, since it was here that 'plastic' form was given to ideas and concepts evidenced in the fieldwork thus forming a creative, public domain based 'synthesis'. I had anticipated a challenge to seemingly invisible 'patterns of dominance and subordination' within the transactional practice of the interviews as dominated by the medical gaze. The 'three-dimensional studio re-constructions' of my interpretations when photographed digitally and further enhanced [in terms of colour, composition and geometrical perspective] to parody the 'constructed' yet surreal theatricality of hospital 'regulatory practices'.

## 4.3. Merging 'sociology' and 'art' in hypertext form.

Anticipating that these outcomes would receive diverse interpretations from [future] audiences, I made the decision at this stage to juxtapose both image and [selected] texts *with* preliminary sketchbook work. I wondered if I had taken on an interpretative stance that was overly demanding/exploitative of the subject I had observed. Ten Constructs became sequences of 'coded messages' with specific signifiers and surreal images [perhaps augmented by the contrasting 'rationality' of the inserted texts]. Recomposed through nuanced digital transformation as 'figurative/geometric assemblages' inter-constructed with 'bric-a-brac-props', they emanated a slick and synthetic quality. Reduced to a small, digitised two-dimensional surface; rendered as 'synthetic and artificially constructed' photographs, they became the chosen coinage of communication that was ready to be launched into the next [hypertext] stage[88]. Had I taken the subject matter of my artwork to an unacceptable

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[88] The Ten Constructs were also framed as an exhibition, in May 2002, as requested by the Hospital Ethics Committee. See responses to it in Appendix: 6.8.

degree of parody? Imagery originating in socio-medical discourse, whilst perhaps poignant in itself, did not offer a viewer information as to *how* I had arrived at the Soma-Series *as* metaphor. Whilst I had devised a creative process of systematising my visual presentation, I anticipated a viewer could be 'guided' through the website by discursive clues derived from social-interactionist texts, but with much of early stages of the fieldwork practice included as part of its presentation to reveal that the findings were not based on pure fantasy.

Presented specifically as non-linear and non-hierarchical, I wanted the site to metonymically replicate the uncertainty of the interview outcomes and draw attention to the dangers of accepting the 'unassailable side' of what I saw as a level of unquestioning acceptance of the move towards the bionic body. Working through a website, transactions/negotiations might be 'formal' or 'guarded'; informed by a specific prejudice and already 'learned response' [of clicking on to the next underlined component] or awaiting the next cue to 'move on'. But through these procedures an audience was invited to look 'inside' and 'outside' of the purely visible "retinal-art" kind of response, to engage their own pragmatic and personal processes. This had been a central anticipation of the research. Reflecting on the hypothesis as to whether visual metaphors could be created out of 'somatised experience', I recalled that Susan Bordo discussed how somaesthetic experience served to limit, rather than expand bodily strength. My research has been concerned with how the medical gaze could be shown to physically affect those subjected to it in the quest for prosthesis. But I had not addressed what counts as 'beneficial to body maintenance' or the larger complexities of the processes whereby somatisation takes place or any specific connection to the more subliminal aspects within notions of 'bodying' and its interconnections of mind and body. My intention was to produce artwork that sought out a paradox of the medical gaze paradigm, and thereby render visible aspects of the physical anxiety aroused in those subjected

to it. From my holistic perspective, artificial surgical implants via the practice of prosthesis, has been seen to offer nothing of *lasting benefit* to the sentient body: subsequently, I made light of it, by presenting all bodies participating in the medical transaction, as 'man-made/body-in-bits' replicas[89].

Relating these ideas to those of observed by Shannon Sullivan, I recognise that my research paradigm has examined the notion of the somatisation 'process' in only a very cursory way[90]. I recognise that my research paradigm has examined the notion of the somatisation 'process' in only a very cursory way. But remembering my specific hospital observations [which in themselves contained diverse power/knowledge regimes emanating from the medical gaze] and creating artwork as hypertext from it, I anticipated that my interpretations, as such, could at least open up possible future debate. Through having a specific feminist standpoint that informed this research, I observed that the practices of the medical gaze appeared to exploit those who were subjected to it: the pre-surgical medical interviews were 'frightening' since they created an environment where personal individual identity was seen to collapse. Patterns of identity, through outward behavioural manifestations, seem all that remain, and finally it was these patterns I aimed to evidence and present through www.soma-series.org.uk. But these 'patterns' have been only indirectly and discursively *alluded to* throughout the website, which was intricate and complex to set up with a total of eighty different components placed in it.

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[89] Additionally, I anticipated that any obvious/look-a-like reference to an actual 'living body', would become ethically questionable, so ensured its total 'absence' from the images for hypertext [although these were partially visible' in the sketchbook and chart investigations].

[90] Shannon Sullivan examined how critical the effect that *others* can be on one's own somatic experiences, through numerous examples in Chapter 6: Transactional Knowing in Living Across and Through Skins: Transactional Bodies, Pragmatism and Feminism

Ironically, on reflection, it is this sense of incompleteness, but subsequent 'open-endedness' that could be seen as a 'strength' in the research production as whole, yet as artwork marks another specific contrast to the work of both Borland and Prophet, whose [cited] projects have allowed audiences to remain conventionally distanced from 'direct contribution' to a synthesis of their projects' outcomes. As in The Internal Organs of a Cyborg [1997], the process that the [female] body has to go through in an attempt to find this wholeness can be extremely traumatic for both the medical staff and the patient[91]. The medical 'industry' depersonalised a patient's body by observing *fractions* of it at any one time: the resulting 'dislocation' replicated this complex and fraught process throughout the Soma-Series website. A possible outcome, from a feminist perspective might be that a patient's sense of identity and completeness becomes significantly compromised.

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[91] This was evident throughout the fieldwork observations, since patients who had either a 'positive' or 'negative' attitude to the doctor they were interviewed by, all sought wholeness from their 'incompleteness'. The interviews have subsequently been presented metonymically as a series of body-parts that remain mechanically 'in pieces'. The patient wanted to arrange for the implant of a prosthetic body-part, but was not informed directly as to their success in obtaining this [the request was always 'deferred'].

**Chapter 5**

**Conclusions and action plans**

## 5.1. The hypertext collage: from 'audience' to 'evidence'.

As I attempted to create links between the examination and analysis of the core issue of how the somatic metaphors became parodied within www.soma-series.org.uk, I was aware of a level of vulnerability in myself as holistic practitioner and artist/researcher. I had elected not to 'make it known' on the website that Soma-Series arose from 'specific interests and biases': I wanted to create artwork as hypertext that sought to dissolve power divisions that exist between researcher and researched; artist and audience. Because the research as hypertext could be said to be a 'substantive work' [in so far as it has been created for a reason 'beyond' the purely 'aesthetic'; has a 'hospital-context of production' and is grounded in a specific standpoint towards medicalised transactions], it anticipated a particular type of critical response from a prospective audiences.

The outcomes of my investigations, viewed from a feminist perspective as artist/holistic practitioner anticipated echoing a level of 'ontological' holism[92]. However, notions about how the pre-surgical transaction could be seen to somaesthetically render those involved in its transactions as 'already' artificial and that prosthesis could be viewed as a move towards a bionic body was only hinted at in www.soma-series.org.uk A viewer was offered only small portions of my findings about the patient-doctor transactions: engaged in one/two 'frames' [out of eighty inserts, the other seventy-eight parts remain unseen at any one viewing] 'randomly

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[92]  In Breaking Out Again, Liz Stanley and Sue Wise discuss why they see the inclusion of emotions [all levels of 'feeling'] as an intrinsic part of the feminist researchers' role [p.193]. However, viewers may not share such levels of empathy to the project, and those who are in disagreement with its negative viewing of prosthesis might decline to respond at all to the project.

connected links' encouraged a viewer to click onto the 'next' step in the perception process out of a myriad of information that could alienate further following through the whole website. [Perhaps this fragmented process specifically indicated why there have not been more than about thirty 'feedback entries' to the site, and as such is[93] an indication of the research being of less 'public' interest than I had anticipated, since I had hoped it might become something of a 'liberatory' project[94].

But engaging ideas pursued in <u>Life on the Screen, Identity in the Age of the Internet</u>, where Sherry Turkle argues that it is through our confrontations with technology, as it 'collides with our sense of identity' that we think we already know about ourselves[95], I have taken some comfort from this statement since it confirms to me that *new ideas* can begin to be articulated on the web, without having to present absolutely transparent and known concepts. The <u>www.soma-series.org.uk</u> feedback[96] although limited, has shown that this genre of cultural 'response' [to which Turkle referred], is still culturally comparatively new. Offering 'responses' on a website, has been shown to change the relationship we have with ourselves, our bodies and our own histories: since the artwork as hypertext has anticipated challenging notions of identity in relation to both medical ethics and in so doing was diminishing boundaries between art, life and technology. As such, it is perhaps less surprising that audiences might have been uneasy or unwilling to respond enthusiastically.

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[93] 'When every connection requires a *particular level of effort* [my italics].... availability and accessibility become essentially equal, as they are for a skilled reader in a modern library'. [p.286]. George P. Landow in <u>Hypertext 2: The Convergence of Contemporary Critical Theory and Technology</u> [1997]. <u>The Convergence of Contemporary Critical Theory and Technology</u> [1997].

[94] It is also a marked contrast to the amount of 'purchases' there have been for the framed printed versions of the <u>Soma-Series: Ten Constructs.</u>

[95] 'In the real-time communities of cyberspace, we are dwellers on the threshold between the real and the virtual, unsure of our footing, inventing ourselves as we go along'. [p.10].

[96] See: Appendix: 6.8.

However, despite the formalism and rationality of 'art-from a-machine' it has remained appropriate to place work based on 'somatic metaphors evidenced in a series of patient-doctor transactions' as constructs and texts visible on the 'screen'. The website might have been challenging viewers with new discourses, presenting 'persons' and 'objects' that have been 'reconfigured', thus pursuing new boundaries that in themselves present ' the computer' as an extension of bodily needs, since the computer in itself can be said to offer a transactional mix of biology and technology[97]. In this way the viewing of www.soma-series.org.uk is in itself a metaphor for the desire for technological enhancement: perhaps a prosthetic [hypertext] 'replacement'?

That there has been predominantly a female 'feedback entry', could be said point to women developing and responding to new views of what counts as 'objective' in art and science, since hypertext remains culturally coded by some as male[98]. However, from my [holistic] perspective website feedback has provided interesting responses indicating the 'research-on-line' in the form of www.soma-series.org.uk has presented insights into some critical observations of orthodox medical practices. Comments evidenced this by statements: ".... doctors still see themselves holding power over others"; that the medical gaze had "been better understood" as a result of manoeuvring through the site; and conclusively, that "the site was like a church hierarchy ... 'god' [as the doctor/medicine] being something separate and outside ourselves... so we feel disembodied". Viewers responded quite strongly to the 'puppet-like' figures and 'synthetic hospital environment' that had led others to point to the site's apparent "chaos" to be in itself a 'good metaphor for the NHS environment'. More poignant was a viewer who observed "the 'nature' of the disciplined patient", and that the site 'idea' offered multiple

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[97]  Susan Sontag in On Photography [1979] saw this happening well before its time.

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possibilities of discourse plus "a feeling of being able to separate these". Other viewers and medical sociology students commented on the patient-doctor interview as it matched their own experience[99]. These responses, and others available in the appendices, indicated that, to a degree, a viewer of the site could be seen as having metaphorically, an opportunity to 'return the *medical* gaze' via a digital one[100].

The production of the interpreted fieldwork 'as website' anticipated that a long-standing hypothesis of medical hegemony-via the medical gaze, be challenged: contemporary 'virtual' communication thus enabling both the production and reception of discourse with the potential to reconfigure social attitudes to it. Thus viewers have begun 'sequences of narratives' that can reframe the interpretation of imagery [initially composed by myself] and in turn challenge my network of references in a continuum. It is this inter-active aspect of the research outcomes that holds the greatest difference to the [cited] work of either Borland or Prophet, whose work did not seek audiencing as part of its public presentation.

## 5.2. Notions of self transformation within the limits of the website art of www.soma-series,org.uk

The premise from which the fieldwork in an Orthopaedic Department in an NHS hospital began, has revealed that I have not engaged in this research from a viewpoint that praises interventionist orthodox medicine, especially in relation to prosthesis. From my feminist standpoint, and as

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[98] In A Feeling for the Organism [1999] Evelyn Fox Keller, discussed at length why females use virtuality to move beyond 'local' knowledge to 'global' concerns, especially when a 'biological metaphor' is involved; "She can forget herself.... hear what the material has to say" [p.198].

[99] Second year BSc. Students at Sheffield University's School of Health and Related Research, Faculty of Medicine, where I had co-ordinated lectures on Representations of Health, Illness and Disease.

[100] In Foucault and Feminism: Power, Gender and the Self, McNay pointed out how the unspoken responses of the medicalised female serve only to legitimate medical hegemony in all branches of Orthodoxy, so the opportunity to 'comment' publicly at least allows a level of scepticism about the benefits of medicalisation. [This is not meant in the same way that Laura Mulvey uses 'returning the gaze' in feminist reception theory, since I am using the idea metaphorically in this context].

an Ayurvedic practitioner I have been long concerned about the way such practices 'rupture' the body in relation to its 'maintenance'. Because of this bias to the primary investigation, the research outcomes have been intended to open up debate to centre towards sociological investigation, rather than the purely aesthetic concerns of Fine Art. From this dual perspective Soma-Series as website could be seen as a metonym of degrees of alienation from ethics of the 'self' that might be experienced within patriarchy[101].

As 'artwork' it was hypertext 'theatre' in which 'models and props' portray different modes of sociality and subjectivity. Within this dichotomy I saw www.soma-series.org.uk reiterating aspects of art that, beyond the limited ideological and stylistic links to early Russian Constructivism, already referenced is not specifically 'Eurocentric'. In Art as Technology: The Arts of Africa; Oceana and Native America Zena Pearlstone examined art of 'other cultures' as having utilitarian and transactional function inherent within it, and as such contain ideas that operate as 'persuasive/ instructional' devices[102]. Whilst I do not claim any similarity with my responses to the body to those discussed in Pearlstone's study, I have great respect for the powers of communication that exist in, for example, Native American Art. Within Western culture viewers as ' individuals' may respond in a myriad of ways, 'decoding' and reconstructing culture as it is experienced through their own individual viewpoints, encoding a 'project' from their own culturally learned perspective. From this standpoint I ask: might *different* cultural viewpoints open up future debate?[103] Were this

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[101] In Foucault and Feminism Lois McNay points out how Foucault linked the idea of self transformation to the wider political transformation, where contemporary life becomes governed by the discovering of self against the task of "endless self-production".[p.99]

[102] Much non-European art contains an integral technological function that is often concerned with healing and interaction with the environment. In Western culture we are used to dividing function–what an object does in its social context – into' transactional' and 'utilitarian'. I see this project as having elements of both within it.

[103] By scrutinising the website viewers can: '... form a continuum of discursive [written] practices which in turn enables a level of 'appropriation' of the work and its sociological basis'. Andrew Darley examines this idea in Visual Digital Culture:  Surface Play and Spectacle in New Media Genres [Chapter 6].

the case, future responses to www.soma-series.org.uk might reshape the ideas presented on the site to open up audiences new levels of response, which could be considered as a potential 'liberatory' outcome of the research.

## 5.3. How far the aims of the research have been achieved.

Considering again how Shannon Sullivan has emphasised that feminist thinking about the 'body in transaction' has contributed to re-thinking the "living processes of existence", I am aware that my study has been restricted to focusing on concrete 'physicality', rather than a more expansive or inclusive psychological study in relation to my fieldwork outcomes. I have acknowledged 'bodily somatic experience' without placing it in opposition to its psychological experiences, because of the limited scale of this research based primarily on 'visible' evidence through body-language[104]. In making artwork that explored this 'somaesthetic' type of experience [the patient-doctor transaction being only a small example of it], I have wanted to communicate a complex idea about the body 'becoming' mimetic of the experience that it engages in, which on reflection I consider to have merely broached upon. I see, through encountering art making processes and a small degree of feminist epistemological methodology, that much research remains to be undertaken in this area [both as 'evidence' and as 'art']. I am very much at the beginning of a longer research process, so I consider the research to have been only partially successful, but with many ideas emerging out of its shortcomings and limitations. Notably, through focusing more on the patient's perceived experience of the medical transactions, there has been a degree of asymmetry between my detailed responses to both genders

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[104] It has been assumed within this reading of the body that there is no Cartesian mind-body split: Shannon simply uses the term 'body-mind' in her view of somatisation processes, and it is one that I have adhered to throughout the research.

[doctors and hospital management being male][105]. Whilst this point has not been mooted via any audience feedback, I am aware that gender related issues will become a central focus in future research based on transactional somaesthetics within the patient-doctor transaction.

What might also be appropriate to follow up as a result of the research processes described, could be to discover how far website viewers themselves become 'somatised' through their hypertext 'responses'. I recalled a passage of Sadie Plant about notions of viewers becoming themselves "cyberflesh"[106]: '…. the pixilated window caught her eye…. cameras had given her the chance to explore the technical potential of imaging machines, but she wanted her pictures to dance and scream, taste and smell, touch and contact senses still to come' [p.192]. In this respect, placing some of my sketchbook drawings and research data images on a website as 'components' within the project together with elements of 'social-interactionist texts' [interspersed with the Ten Constructs], seemed a comparatively small undertaking on the logistical level of the website's design. [In future technologies there may be facilities for offering sensation and reading beyond the purely visual and textual interface of current cyberspace]. Because hypertext offered a means of democratic empowerment, both to the maker of work as well as audiences, technological new infrastructures will later exist as Sadie Plant has suggested, which future research on somaesthetics could fully exploit.

However, currently www.soma-series.org.uk remains a type of 'intellectually teasing' game, where there is only narrative, image and interaction between the two. There is a level of 'kinaesthetic performance', as in computer games, but the viewer has no real control

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[105] In Metamorphoses, Rosi Braidotti discussed the problem the idea of imaging t'Bodies without-organs' as molecular and beyond gender [p.80].'Politically, it implies that the identification of points of exit from the phallogocentric mode takes dissymmetrical forms in the two sexes'. [p.81]

[106] Sadie Plant: from Zero's and One's: Digital Women and New Techniculture: Plant shatters the myth that women are victims of technological change, since she asserts that unprecedented patterns of communication and exchange can now emerge.

as to what will happen next, since the site operates like a maze. The virtual artwork therefore frustrates a viewer, with its glimpsed representations of time and space, and a possible simulation of the orthodox hospital paradigm, as a type of 'motionless voyage'. But a disparity here also exists in the 'simulation effect' that hypertext offers: as I remembered Darley had pointed out: '.... the ability to *act* within a "given scene" does not necessarily increase aesthetic depth' [p163][107]. My work as website was not sensually rich – so a kind of 'sensational numbness' sets in after a while on the site. So how might spectators be said to be somatising the computer experience? Kevin Robins pointed out how digital expressions are 'semantically shallow' so have no power to undermine ideologies: '... at their most extreme they may be used to construct alternative and compensatory realities'[108]. Perhaps this is as much as I have only touched upon through www.soma-series.org.uk. However, whilst an artwork as website might be conceptualised as a mere sequence of 'by-products' of the computing world genre, the somatic metaphors that were its core theme, might suggest there to be a type of 'larger' picture to be found in the site as a whole, in that there is a deliberate transgression of old separate hierarchies of Fine Art and Medicine[109].

So could the 'work as website' be said to contribute to the 'anti-aesthetic' of current popular taste? I recalled something Pierre Bourdieu revealed: '.... popular works embody a conditional and utilitarian aesthetic; that is to say that their choice of images is powerfully determined by their conception of social needs'[110]. Recognising a

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[107] From Visual Digital Culture:Surface Play and Spectacle in New Media genres. [2000]. Andrew Darley. [p123].

[108] From Kevin Robin's Into the Image: Culture and Politics in the Field of Vision'. [1996].

[109] Hayward Gallery Exhibition. [2000] in the historically based exhibition Spectacular Bodies emphasis was on the mutual interest of both disciplines on the bodily aesthetics rather than the sociological implications that this gave rise to.

[110] From Bridget Fowler's The Popular and the Periphery [p.161] in Pierre Bourdieu and Cultural Theory: Critical Investigations.

response to this dynamic through the 'sometimes playful' and parodic nature of www.soma-series.org.uk. I reflected on how I had wanted to situate the work in the domain of popular culture via the web. As such it had a reflexive 'style' that perhaps inadvertently demanded self-consciousness on the part of a viewer, who may be more interested in the style and conventions of the site than any suggested 'content'. Perhaps this was another shortcoming of the website as a whole, in so far as audiences may just *not want* to respond to the issues that the site raised. Did the website suggest a hyper-real playfulness and seriousness simultaneously, and thus a rejection a 'single' concept of truth and a blurring of boundaries between sociological narratives and expressive imagery, which seems something quite beyond what I had anticipated from my specific standpoint perspective. The site, by default could be said to some extent to have 'fused' theoretical and artistic responses to socio-medicine and digital technology.

I am here reminded how Haraway did not want audiences of cyberspace to experience technology as solely 'external' or oppressive: given the already 'bodily relationship' that currently exists for many with technology "... perhaps we are all cyborgs", was one of Haraway's paradoxes! In Scientific Looking, Looking at Science Marita Sturken and Lisa Cartwright pointed out how pseudo-scientific narratives have increasingly come to figure: '... in the techniques and topics of entertainment and leisure: we may dissect medically accurate and detailed simulations of bodies in CD-ROM games... practices like institution surveillance show us how permeable are the boundaries between science and culture'[111]. Towards this type of genre-merging www.soma-series.org.uk has made only very a partial contribution.

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[111] Marita Sturkken & Lisa Cartwright in Practices of looking - An introduction to Visual Culture [2002], [p.312].

## 5.4. Ideas of developments towards future research and reflections on how this research might have been pursued differently.

Recalling how Nietzsche suggested there was no need for bodily improvement stating that 'decadence is nothing to be fought'[112], I was somewhat reaffirmed in my 'holistic standpoint' for making this research/ project in the first place. With this idea in mind, I can empathise with Shannon Sullivan's statement: 'attention to the body in order to improve it would be an example of idealistic mendaciousness that demonstrates that a "person is not strong enough to love what she is"[113]. Whilst this concept seems highly provocative, it echoes the overview of much holistic /Eastern thinking about the body and concepts relating to non-surgical-intervention practices [that I have endorsed as an Ayurvedic practitioner]. I anticipate researching further into the notion of corporeal 'improvement' and contrast it to the Ayurvedic viewpoint of working within the body [to alleviate pain and physical disability] through 'natural remedies' and 'lifestyle' adaptations[114].

By working closely with a 'biomedical' anatomist, I would research the transactional-body between the two distinct paradigms of allopathic and non-allopathic treatment, [where prosthesis might have been considered]. As a visual artist/researcher I would create imagery and text related to my findings, again in a rhyzomatic manner. It might well manifest very different visual and textual outcomes than those observed in www.soma-series.org.uk, given that I would attempt to utilise the newest 'cyberspace

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[112] Referencing Frederic Nietzsche's The Will to Power, Elizabeth Grosz in Nietzsche, Feminism and Political Theory, endorses the idea that Western culture and biomedicine fictionalise bodies via social relations [p.51].

[113] In Living Across and Through Skins; Transactional Somaesthetics [p.115]

[114] An American based Aid Agency has recently agreed to sponsor me to work in Kyrgystan to promote the "re-introduction" of natural medicines to people living in its rural areas who want to use locally grown herbal medicines to use for healing purposes instead of importing expensive allopathic medicines, which it cannot afford. I shall visually and textually record aspects of this process.

developments' to communicate the outcomes. The Wellcome Trust is continuing to promote the 'Sci-art' Project[115], whilst the Health Foundation[116] is promoting, through the King's Fund and the Nuffield Institute visually interpreting areas of interaction between Eastern Science with Western Orthodoxy which could extend the domain of feminist praxis, were it to allow development of the scripto-visual means of communication and experimental hypertext technology.

Within the Soma-Series visual research I would like to have found more concrete and diverse ways of communicating the idea of bodily 'obedience' to the coercive persuasion prevalent in the quest for prosthesis, within devising imagery to parody 'the fears' that were evidenced in fieldwork observations. But, because of what was feasible as research 'from an artist' [in terms of the NHS Ethics Committee] I recognised that I could not approach the primary fieldwork from a deep psychoanalytical perspective, so chose not to relate notions of 'medical obedience' with notions of 'repression'[117]. From a pragmatic feminist standpoint, and an Ayurvedic one, the research as a whole has perhaps indicated that there is no such thing as the self as a 'stable entity': perhaps there is always a 'transactional self' that invisibly 'somaestheticises' everything. So I would have liked to have found more explicit ways of showing that the quest for prosthetic surgery and its bodily transformative processes, is perhaps symptomatic of Western phallocratic ways of avoiding or digressing from the inevitably sentient life-cycle.

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[115] The Wellcome Trust Public Interest Project 'Engaging Science' is a charity whose mission is to promote research with the aim of improving human health. [www.welcome.ac.uk]. The aim of improving human health. [www.welcome.ac.uk].

[116] See www.pppfoundation.org.uk. This means that there will be grant money available to apply for art-based related   projects, which I am applying for.

[117] Earlier in the research process I had though of utilising a level of feminist related psychoanalytic theory related to the idea of the body as responding to its own sense of 'lack', as shown by many Lacian based writers, but have subsequently realised that this perspective was not feasible within the remit of this research.

On a more practical level, were I to undertake the same research again in an NHS Department of Orthopaedics, I would work with ultra-violet film instead of analogue and digital 'film' to see 'through the body' in a quasi-X-ray manner. In that way physical somatisation could be 'visualised directly' through the body, and images of it further enhanced by digital manipulation. I would wish to work 'three-dimensionally' to recreate the clinical environment of the hospital, to which I did not give great attention [beyond that of the Pilot Study shown in the website as the 'Experiments'], in the sense of reflecting the Foucauldian andocentric impersonal forces that contain medical orthodoxy within hospital architecture[118]. In this way I could re-evaluate culturally learned behaviour, that is part of medicalisation and inherited bodily identities and values, to challenge received interpretations of healthcare regimes[119]. As a feminist, I would also want to expand and explore gender differences within the broader orthodox medical patriarchal domain, and pose questions about apparent healthcare freedoms and oppressions, since many who are engaged in it on both sides appeared seemingly unaware of the hidden nature of the orthodox regime in which they work. The area of body transformation through prosthesis involves many complex issues, and not simply those of 'oppressed and oppressor'. As Jana Sawicki stated, in relation to researching similar seemingly invisible 'grey areas' of cultural experience: '... feminist praxis seems caught between appeals for a free subject and an awareness of victimization'[120].

Overall, the research hypothesis: Somatic metaphors evidenced in a series of medical transactions? has been shown visually to be very

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[118] I have not significantly utilised ideas, for example, from Foucault's Birth of the Clinic: An archaeology of Knowledge [1978].

[119] I am reminded here of a work I saw in the 2001 Venice Biennale called Women on the Waves: it was created by Joep van Lieshout in 1995 and consisted of a transport unit that can be carried on ships and acts as a mobile gynaecological clinic. It was designed as art/sociology project to allow women from all cultures where abortion is illegal to terminate their pregnancy; the operation being carried out in international waters. Whilst my current research has evolved into a website, I would like to create some kind of 'parallel clinic to van Lieshout, where women substituted non-prosthetic treatment for holistic treatment! See: Guide to La Biennale di Venezia [2001].

[120] Jana Sawicki, in Disciplining Foucault: Feminism, Power and the Body [1991] p.104.

partially 'revelatory' because in itself it is such an immense socio-medical domain. This research has been paradigmatic, in so far as it has oscillated between two levels of response/intervention and a 'critique' of how it happened. Reflecting on the completion of each individual stage of the research points only to the limitations each specific discipline engaged in its completed matrix [as an inter-disciplining work] contains as a vehicle for communication simply "on its own". As a visual artist I have been more confident with image-making than with compiling textual information; but as an Ayurvedic practitioner I have been aware that the diverse disciplines that the research has engaged have become aesthetically inseparable. In conclusion, each aspect of this research paradigm has opened up possibilities for future thought about the body in transaction and its susceptibility to somatisation that is always contextual and never absolute.

## 5.5. Innovative outcomes of the research: conclusions.

The research sought to make new artwork in response to the complexities of how those caught up in orthodox health-care regimes could be unwittingly transformed by its processes. It was innovative in so far as much emphasis was placed on the undertaking of observational fieldwork, usually associated with purely sociological surveys. As its starting point, the research paradigm was motivated by a feminist aesthetic in response to women [Ayurvedic] patients' quest for prosthesis: it findings and outcomes, relayed by interactionist hypertext, moved towards a broader audience response. Within this dichotomy the presentation of social-interactionist text and new digital imagery, aimed to challenge assumptions about the outcomes of engagement with orthodox health-care regimes, and open debate about ways in which the medical transactions, in and of themselves, control patient responses.

Because the research outcomes as hypertext [via audience 'feedback'] sought to engage public response to attributes of the medical gaze, its innovative use of fieldwork evidence sought to use text and image as a 'substantive work' beyond purely aesthetic considerations of art practice as referenced in this thesis. As a Feminist work it evolved from an investigated context that rendered it a 'liberatory' project, in so far as it engaged artwork to challenge the status quo of medical hegemony. It sought to merge different disciplines through discursive scripto-visual practice, to render visible a 'grey area' of cultural experience, where the transaction of the quest for prosthesis was revealed to hold inherent dangers within it, at the point of engagement in the pre-surgical interview with its transformative powers to render desirable artificial 'body implants'.

However, the presentation of the work as hypertext was doubly ironic as it was a 'simulation' of fieldwork evidence *not* an imitation of it. The website was conceived as a mirror of reality with the appearance of a scientific 'truth claim' but it did not contain the type of 'documentary' function that chemical/ analogue photography contains. It did not hold up directly as a 'window on the *real* world': instead it presented that world as a parodic dystopia through the 'sculptural reconstruction' of fieldwork. But did the work as a whole suggest some level of 'breaking with the past'? The hypertext work presented the 'loss of the real' as a simulacra of the quest for prosthesis which in itself was one of the overall parodic effects of its existence as an 'art work.' Soma-Series was not presented as a work disengaged from a specific type of social reality: the patient/doctor/prosthesis triad. It, 'artwork as hypertext', attempted to break 'new ground' as an interdisciplinary work dependent not just on its 'form of presentation' and specific content but to the extent to which it remains an 'open text' for future audiences. I hope the work as a whole contributes to interventions in the cultural hierarchies that currently exist in relation to Fine Art practices. As an interdisciplinary work with a sociological basis I hope that the work will move audiences beyond the 'aura' of pure perception, and allows for a level of distance between was is

presented as ' subject matter' in www.soma-series.org.uk and towards reflection on their own experiences of the sentient body beyond that observable within a medical transaction. Digital imagery and its inherent 'hyper-reality' thus holds the potential for increasing audience awareness of the 'real' conditions of existence, so can be seen as empowering tool for personal development and awareness of the 'processes of the body' and '.... an opening to aspects of reality which until then had been hidden to the viewer'[121].

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[121] Michelle Henning in Digital Encounters: Mythical Pasts and Electronic Presence [p.232] from Lister, M.[Ed] The Photographic Image in Digital Culture.

# Appendices

## 6.1. Ethical Approvals: summaries of the Ethics Committee of the Northern General Hospital, Sheffield and the Ethics Committee of De Montfort University.

*The procedures for access to the Patient-Doctor interviews and summary of the empirical data collated:*

## 1. Rationale and Introduction:

That the patient was 'female' and the 'consultant' male in this research needs to be acknowledged: it was poignantly constructed to draw attention to continuing ambivalence of the treatment of women's health within Orthodox medicine - historically patriarchal in structure. All participants became collaborators by virtue of having 'volunteered' to participate, after receiving letters of information about the project patients and doctors understood that it would take its primary perspective from a feminist perspective. That the research was visual/textual and would relate to aspects of visual culture and post-structuralist feminist discourses was evident since it was the 'unsaid' aspects of the interviews that were to be photographed and interpreted, via the ensuing body-language interpreted as 'somatised' experience.

*[An outline of this was stated in the original Patient Information Sheet and the forms agreed to by the NHS Ethics Committee].*

**2. Outline of procedures that took place prior to and during the seven clinics attended for observation and visual recording of the patient-doctor interviews during February 2001 at the Northern General Hospital, Sheffield, U.K:**

Visual data was collected over a four-week period in the Department of Orthopaedic Surgery, after complex negotiations with the North Sheffield Ethics Committee over thirteen weeks for this research programme to be approved. It was then decided that ninety female patients would be approached by letter, and sixteen surgeons; dates for clinical observation had been organised by myself with many weeks of clerical work with the hospital management. Examination of body-language and patients own comments to myself were cited as the context of the research: no 'medical' dialogue was permitted by the Ethics Committee. I was permitted to speak to patients about themselves [but without 'confidential' medical disclosures for socio-legal reasons], with the proviso that comments would be informal and available to me only whilst patients attended the Waiting Areas immediately prior to or after their pre-surgical interviews. Patients and doctors were informed that they would receive a CD Rom or details of the work when published as a website, and that a public exhibition would be held at the NGH Hospital's Clock Tower Gallery in May 2002.

**3. Ethics Committee at De Montfort University**

The research project was also approved by this committee in February 2001.

**6.2. Transfer Report: summary of the recommendations:**

1.  It was stated that 'scholarly work' sought to determine the 'unsaid' in all situations to be researched. An extended definition of the 'unsaid' was required in relation to 'gendered issues in medicine under

patriarchy'. This factor was further considered and became the basis for further clarifying the issues of power relations evidenced in the fieldwork.

2. That Lacanian psychoanalysis would be appropriate in the interpretation of body-language within the patient-doctor interview was recommended to be in evidence in subsequent stages of the research. Clarification of the use of a feminist interpretation of Lacan was also required. However, this proved to be inappropriate since I was focusing of the way the physical body was seen to respond to the omnipotence of the medical gaze, and not from a mind/ psychoanalytical perspective[122].

3. That André Brouillet's painting <u>Une Leçon Clinique à la Salpetriere</u> [1879], [see: Secondary Source Images: 1] was of art historical and current research related interest [since an 'observer/artist' of a patient-doctor interview in 2001 could still only *observe from outside'*, the closed domain of the medical gaze], was poignant and useful. While the Pilot Study as 'Experiments' was completed at the time of the Transfer Report this critical evaluation led me to attempt to expand the parameters of Brouillet's perspective, and so emphasised further 'unsaid' dimensions of the fieldwork. [It was this factor that led me to see how audience response to my research as a possible - at this early stage - hypertext presentation].

4. It was suggested that I include aspects of the ethno-methodological observations of the patients, but this proved to be unworkable since I was not spending long periods of time with a specific group of people. [I would think, instead, about the idea of 'parodying' the medical gaze as part of the artwork's completed 'presentation' thereby expanding Brouillet's original perspective as 'significantly representational' artist observing the medical gaze under medical patronage. This led me to consider that my studio based work, with

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[122] From the holistic perspective that I approached this research paradigm, the mind/body split does not exist; therefore the body manifestly contains the psychological as [psycho-somatic].

its processes of deduction, was mimicking the medical gaze and replicating it with a 'digital-artists-gaze'.

5. At this stage I was caught up with the idea that 'objects of the medical gaze might *become* subjects of the digital gaze.' This was true in so far as processes of the visual research were re-creating in *the studio,* what I had observed in the hospital, but they did so in a satirical way.

6. Selection and inclusion from my 'ready-made 3-D props' from the experimental Pilot Study involved utilising only those images which had direct metonymic correlation with the 'unsaid' aspect of the patient-doctor interviews. So after considering the response to the Transfer Report, the materials/props of the studio compositions were considerably minimalised to signify their metonymic role-play within the 'interview' paradigm, and not the 'romanticised' role as props for a video film that I had first endowed them with. Interpreted from a holistic viewpoint, I needed to focus on a combination of my fieldwork charts and sketchbooks and the discourses responding to social interactionism and the 'transactional–towards–the–bionic' body *as* consumers engaged silent manoeuvres.

## 6.3. Exhibition at the Northern General Hospital's Clock Tower Gallery, 24-31 May 2002 as <u>Soma-Series: Ten Constructs</u>.

Each Construct was presented as a framed A3 mounted image and separate A4 text beneath it. In this way image and text formed a conceptual artwork: an exhibition viewer was invited to consider the context of the imagery presented. Additionally, viewers also had access to the completed website: <u>www.soma-series.org.uk</u> prior to attending the framed exhibition: this information was sent out as Private View Invitations to all patients and hospital staff involved in the project. <u>Soma-Series: Ten Constructs</u> was viewed in-situ by over three hundred people, and work was purchased as combined framed image and text.
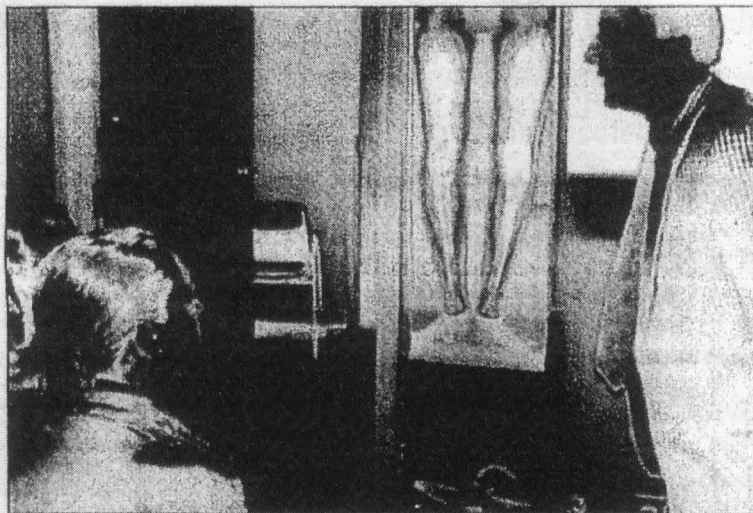
## 6.4. Exhibit and Invitation Examples:
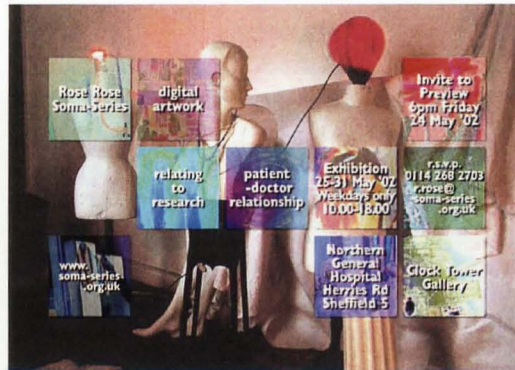


**Example of exhibition invitation**



**Example of one exhibit at Clock Tower Gallery**

## 6.5. The Sheffield Telegraph response to the Northern General Hospital Exhibition.



**SHEFFIELD artist Rose Rose** studied the body language between patients and doctors and then translated it into a piece of digital art which is now on view at the Clock House Gallery at the Northern General Hospital.

"It's a different way of art from normal observation, interpreting the ethnological background of the patient-doctor relationship," she explains.

The original research for Soma-Series took place in February 2001 in the Department of Orthopaedics where 23 women patients and seven consultant surgeons agreed to take part.

Rose Rose was originally a painter who has gradually introduced new technology into her work. Soma-Series: Constructs 1-10 + Texts evolved from photography, sketchbooks, concept-mapping charts, sculpture and digital imagery.

She is also a complementary medicine practitioner and the project will form a thesis in health and art studies at De Montfort University.

Soma-Series is on view at the Clock House Gallery until next Friday, but can also be viewed on an interactive website www.soma-series.org uk which invites response.

## 6.6. The hypertext/website construction as www.soma-series.org.uk

While the digital stills acted as the central 'motifs' for the website, selected sketchbook and charts 'examples' were juxtaposed with them. Thirty examples of the investigative images were selected, for inclusion as links to the website, as were forty 'social-interaction based text examples' extracted from the fieldwork practice and related practices – such as parts of letters inviting participants to contribute to the fieldwork. Seventeen significant *key-words* were additionally selected to form *links* between image and texts as and formed underlined links within the website as:

Non-verbal; Signs; Fragment; Patient; Doctor; Methods; Context; Agenda; Friendliness; Gaze; Hostility; Dominance; Behaviour; Constructed; Constructs; Image; Fieldwork and Signifiers.

The following forty 'texts' were also included to extend and amplify and parody the 'surveillance' procedures of the research processes, and became the scripts of the scripto-visual work:

1. *A researcher examining the non-verbal communication aspect of social interaction can find that a mere fragment of an interactive encounter contains such an elaborate exchange of signs, that a study can be only systematic when passed through a 'semiotic analysis of signs.'*

2. *Since non-verbal language cannot be studied in isolation, the human 'signalling systems' that emerge are always co-structures in a number of universal, but culturally specific situations.*

3. *Whilst touch, smell and sound were present as evidence of social interaction within the observed patient-doctor interviews, the research observed the visual only, which in itself provided evidence of the*

aesthetic/feeling side of subjects observed, and hence provided a glimpse of an inner psychological side: but this was possible only because of the already 'known' socially acquired <u>signs</u>.

4. The basic assumptions are that human beings act toward things on the basis of the meanings<u>/signs</u> that things have for them.

5. The meaning of such things<u>/signs</u> is derived from, or arises out of, the social interaction that one has with ones fellows.

6. The meanings are handled in, and modified through, an interpretative process used by the person in dealing with the things/<u>signs</u> encountered.

7. In order to uncover the <u>methods</u> through which interaction is organised the researcher must adopt an attitude of ethno-methodological indifference. However, it is crucial to understand the role of the <u>context</u> in which interactions take place.

8. All the preliminary studies related to the historical and political made prior to the visual research of the <u>patient-doctor</u> interviews, had to be temporarily 'put on hold', so that photography in the Consultation rooms, was not entered into in a preconceived or ideologically biased way.

9. The recognition that subjects to be studied have both a personal subconscious disposition, which will affect the manner in which they present themselves in any given situation, in addition to the one which is culturally learned, has been a critical part of the research conducted in relation to the <u>patient-doctor</u> interview.

10. The different ways in which individuals invest objects, events, experiences etc. with meaning form the central starting point for <u>non-verbal</u> research. The reconstruction of such viewpoints becomes the instrument for analysing social worlds.

11. That there was a subconscious '<u>agenda</u>' present in both the doctor and the patient had to be given consideration when looking at the visual '<u>body-language</u>' evidence in the research at an interpretative level.

12. The visual research carried out in an NHS Hospital necessarily omitted any in-depth discussion with any of the twenty-three women _patients_ or the seven _doctors_ who had agreed to be photographed. It was not necessary to rely on interpreting the _body - language_ from a pre-dominantly psychoanalytical viewpoint. However, the 'hospital - experience' has a specific history, which had been considered from a Foucauldian perspective and so specifically informed any psychoanalytical interpretation of behaviour of both the _doctor_ and the _patient_.

13. 'Factor analysis' of social behaviour in _non verbal_ communication has generated two main dimensions – friendly versus hostile and _dominant_ versus submissive. All social behaviour is governed by rules, specifying the behaviour which is appropriate in different relationships and situations.

14. In most working and professional relationships the rule is for a, friendly attitude to be expressed, together with the appropriate status relations: the most important dimension of attitudes to other people is how much they are liked or disliked. How does the _patient-doctor_ relationship fit this paradigm?

15. The main aspects of _friendliness_ are:

- Proximity - closer, forward leaning if seated.
- Orientation-more direct, but side by side for some situations
- Gaze - more gaze and mutual gaze.
- Facial expression - more smiling.
- Gestures - head-nods, lively movements.
- Posture - open with arms stretched towards other versus arms or hips folded.
- Touch - more touch in an appropriate manner.

When these cues are used in combination, a total impression of 'friendliness' occurs. When more than two of these are omitted, a sense of neutrality or even _hostility_ is experienced.

16.  The main signals for dominance are:

  •  *Spatial position – height, facing a group or taking up more space.*

  •  *Gaze – in an established hierarchy, less gaze, but relatively more looking while talking.*

  •  *Face – non-smiling, frowning.*

  •  *Touch – asymmetrical touching of other, rather than direct face-to-face contact.*

  •  *Posture – relaxation in established hierarchy.*

  •  *Spatial behaviour – men approach less closely or retain a distance from others, where possible. Unsmiling and frowning faces are interpreted as dominant; the gaze can indicate annoyance, puzzlement or boredom or contempt.*

17. *Several levels of explanation are needed to understand the implications of the 'categories' of non-verbal communication since they all reflected 'learned social and cultural history'.*

18. *In the patient-doctor interview the doctor appeared to employ a mix of all of all aspects of non-verbal communication in his efforts to be persuasive over his patients.*

19. *Whilst it was evident that the most important dimension of attitudes people in general have to each [to] other [people] is how much they are' liked or disliked'. The way that non-verbal communication has been evidenced in this survey provided an insight into why the patient-doctor interview could be artificial and stressful.*

20. *For patients seeking information: non-verbal communication played a considerable role in the power relations that medical practices were able to assume.*

21. *Those high in dominance look more at other 'competitors' in a competitive situation. Looking-away in a competitive situation can imply a negative response which can work to undermine the dominant 'competitor'.*

22. Controlling by silence was a characteristic present in the _patient-doctor_ interview and were useful markers in indicating the play of power relations that medical practices are able to assume.

23. Shifts of the _gaze_ are usually co-ordinated with the timing of speech and help with synchronising. Generally in a dominant situation of one party against another there is less _gaze_ directly to the 'other'/audience, when there is a monologue rather than a conversation.

24. Mutual Gaze and Intimacy experiments suggest that _gaze_ is used as a cue for intimacy, and that both _gaze_ and mutual _gaze_ decline with proximity, which is in itself another cue for intimacy.

25. Inhibition of _gaze_ – avoiding undue intimacy: the avoidance component of _gaze_ falls more steeply with distance, but conversely it can equally do so with too much proximity, in an 'inappropriate' non-intimate situation.

26. Distraction through avoiding excess _gaze_: when a dominant speaker does not want to be distracted, he/she deliberately looks away from the other/audience at the beginning of an utterance, and may or may not only glance quickly at an audience whilst focusing on specific information delivery.

27. That _patients_ have been seen to experience a sense of dominance by the avoidance of _gaze_ as much as through too much 'close eye - to eye' contact.

28. Dear Patient.... For research purposes...... I would like to be present for a few minutes to take digital images of yourself speaking to your _doctor_ at your forthcoming appointment...... No information will be available to me in terms of _patient_ files or names and no sound recording will be done..... I will not be present during the physical examination.....

29. What _patient-doctor_ 'procedure' that is being tested?

30. The mannerisms and postures via the _body-language_ that occur

*during the formal interview between twenty three female <u>patients</u> and seven orthopaedic surgeons who have agreed to be photographed in the presence of the 'management team'.... Some results have been conceptualised and interpreted as visual metaphors....*

31. *The ambiguities and problems of socio-<u>medical</u> attitudes, hierarchies and behaviours did not necessarily affect all <u>patients</u> or all <u>doctors</u>.*

32. *The <u>patient</u> remained 'focused-forward' seemingly content with the outcomes and inputs to the interview which was never private, being witnessed by the hospital management team.*

33. *The <u>image</u> was '<u>constructed</u>' to encompass the interview scenario where <u>medical</u> prognosis was discerned between the <u>doctor</u> and hospital management in the presence of the <u>patient</u>. Whilst the guise of the doctor was established as omnipotent as a bust with angels' wings, 'faceless' tailors' models became metaphorically <u>constructs</u> of management hierarchies.....*

34. *Placed in an elevated status [metaphorically at the 'top' of the 'stack'] the <u>patients</u>' [mannequin] <u>gaze</u> focused beyond the 'accessories' of the scene.... This stance was <u>constructed</u> to convey the confidence by which certain 'positive-response' patients engaged with the requirements of the doctors....*

35. *Because this confidence indicated that their '<u>medical</u>' expectations had been met, they became 'model' <u>patients</u> by unquestioningly accepting the prognosis given. The '<u>doctor</u>', juxtaposed closely to a prosthetic X-ray box and clock, was unencumbered with the usual administrative routines for an instance....*

36. *Sometimes the <u>patient</u> was in desperate need for the <u>doctor</u> to accept that they were deserving of new prosthetic body parts such as hip joints and knee joints...*

37. *Metaphorically each role became a 'persona'.... but the '<u>patient</u>' was presented as 'dismembered' to draw attention to the power play in <u>medical</u> practices where 'gaps' and omissions served as <u>signifiers</u> for acquiescence on the part of the patient....*

38. Some _patients_ remained psychologically 'in shadow' through the interview. Throughout the _fieldwork_ their stance was submissive, since they remained doubtful that the forthcoming 'treatment' was either attainable or desirable..... The _image_ sought to reflect how a 'subject's pessimism' could work to undermine communication...

39. The '_patient's_' pose was presented as strong and assertive: the gaze was directed outward and two horizontal arms were shown to intersect the figure of 'hospital management'; the empty 'rack' and the 'paperwork'. This obviously 'surreal gesture' was constructed to act metaphorically as a 'defiant' gesture 'in unconditional defence' of _medical_ orthodoxy and its attendant practices.

40. The pose of the '_patient_' was specifically passive, indicating a level of 'submission' to the _gaze_ of the '_doctor_', who, transposed on the 'pedestal' was presented with combined 'technological and seemingly supernatural powers via the 'angel's wings'. The latter served to exemplify the idea expressed by some _patients_ that 'the doctor is an angel' and by others that he was a 'monster'... **[see: images A, B].**

All forty selected texts were juxtaposed on **Chart 6** to appear randomly against thirty randomly selected Sketchbook and Chart Images.

**Conclusions:**

A www.soma-series.org.uk website viewer was thus 'invited' to read and observe major components that made up a social-interactionist survey of the series of patient-doctor interviews, whilst engaging simultaneously with conceptual aspects and interpreted imagery that were the foundation of the research practice as a whole. Viewers, selecting links could move between different aspects of the research and create unlimited new interpretations of the investigative and interpretative input.

Selecting strategic images **Charts** and **Sketchbooks**, prior to composing the site via the computer, images were digitally 'enhanced' to avoid physical-likeness or direct representation of all aspects of the hospital **Fieldwork,** and subsequent interpretative responses to it. In total, thirty images were selected from all observed sources to link up randomly with texts with the aim of creating a continuum of referent juxtaposition.

### 6.7. Outcomes of website 'Feedback'.

Through presenting key words from the research investigative practices, a sequence of 'textual-links' was established to the images. The links would indicate a viewer's potential 'path' through the whole website. Using the Deleuzian 'rhizome' method to view the site, a viewer might move through the visual/textual information, repeating a Concept-Mapping procedure that was used in the research from the start. There was also an element of 'chance-choice' so that any textual link could potentially meet up with any one of the forty images, including the digital stills as <u>Ten Constructs</u>.

A viewer would be engaged in observing a hypertext 'art-work' responding to the 'processes' of Orthodox medical surveillance, thereby creating and returning their own gaze to the 'subject' of the website. Working through the forty texts and images [a 'journey through the website' both 'predictable' and 'unique'], a viewer can be said to be 'simulating' visual 'material' presented in a way that enabled the 'gaze to be returned' thereby engaging with a major aim of this research project. With hypertext 'closure' is non-existent, which allows for a decentring of the 'subject', has been apt for the outcomes of this research. The 'subject' can become whatever a viewer wants it to become – their gaze in conjunction with the choice-chance aspect of the hypertext 'journey' allows a level of co-authorship with myself as artist: at the end of viewing

the site these boundaries and a 'feedback' category area invites written response.

## 6.8. Audience responses to the exhibition and website.

Whilst affirmative statements were placed on the site 'Feedback', in so far as viewers apparently 'identified' with the 'dislocations' depicted within the hospital scenario, there were no 'suggestions' relating to how a patient might maintain personal autonomy in the face of medicalisation or how 'medicalisation' as such, could be otherwise. Perhaps it is taken as inevitable that institutions 'structure' themselves 'over' their patients? Comments such as "doctors still see themselves holding power over others"; that the medical gaze had "been better understood" as a result of manoeuvring through the site; and conclusively, that "the site was like a church hierarchy... God being something separate and outside ourselves...so we feel disembodied". Comments about the 'puppet-like' figures and synthetic environments led others to point to the site's apparent "chaos" to be a good metaphor for the NHS environment. More poignant was a viewer who observed "the nature of the disciplined patient", and that the site 'idea' offered multiple possibilities of discourse plus "a feeling of being able to separate these". Other viewers, including medical sociology students commented on the patient-doctor interview as it matched their own experience. These responses to www.soma-series.org.uk indicate that to a small degree a viewer might be said to have had an opportunity to 'return the gaze'[123].

The production of the interpreted fieldwork 'as a website' anticipated that the long-standing hypothesis of medical hegemony, be inter-textually

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[123] In Foucault and Feminism: Power, Gender and the Self, McNay pointed out how the unspoken responses of the medicalised female serve only to legitimate medical hegemony in all branches of Orthodoxy, so the opportunity to 'comment' publicly at least allows a level of scepticism about the benefits of medicalisation. [This is not meant in the same way that Laura Mulvey uses 'returning the gaze' in feminist reception theory, since I am using the idea *metaphorically* in this context].

challenged; since contemporary 'virtual' communication [enabling both the production and reception of discourse] has the potential to reconfigure social attitudes. The viewers, via some of the comments alluded to here, have begun sequences of narratives that can reframe the interpretation of imagery [as composed initially by myself] and in turn challenge the whole network of references that contextualise it. It is this aspect of the research that holds the greatest difference from the work of either Borland or Prophet because in their [cited] projects there is no direct way of engaging with their work, or discovering what others think about it, outside a gallery based exhibition.
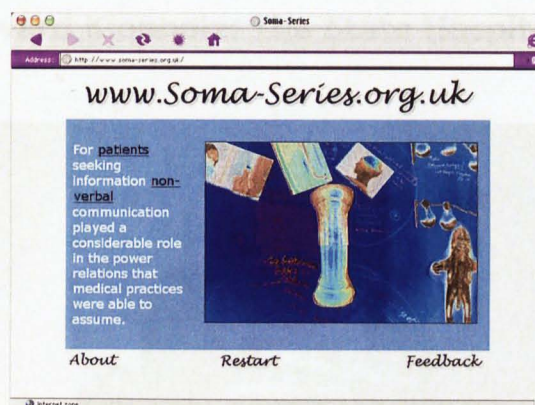
## 6.9. Examples of website as www.soma-series.org.uk
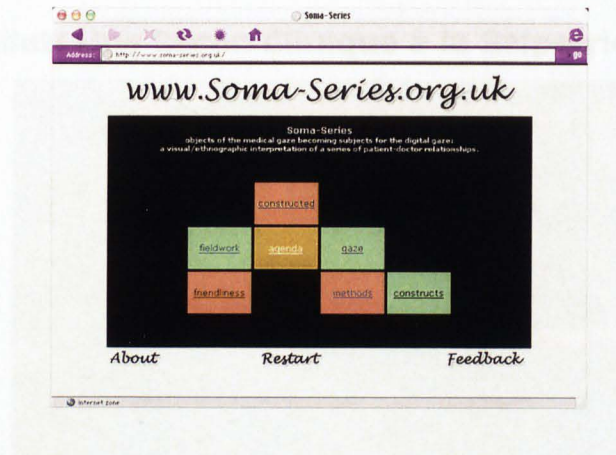


**Hypertext 1**



**Hypertext 2**



**Hypertext 3**

### 6.10. Secondary source images.

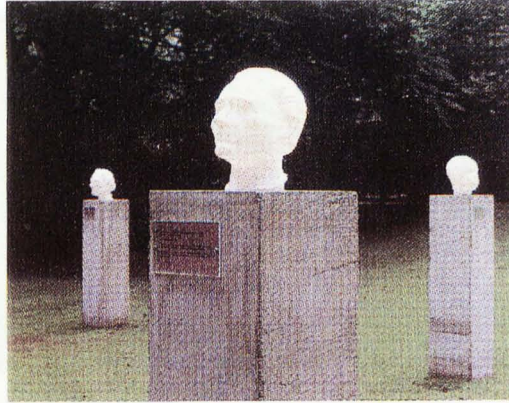**1. André Brouillet: Une Leçon Clinique à la Salpetriere [1879].**



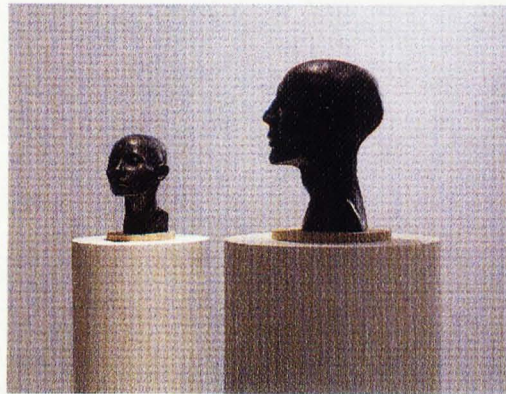**2. Natalia Goncharova: Pillars of Salt [1908].**



**3. Nancy and Edward Kienholz: The State Hospital – The Birthday [1964].**

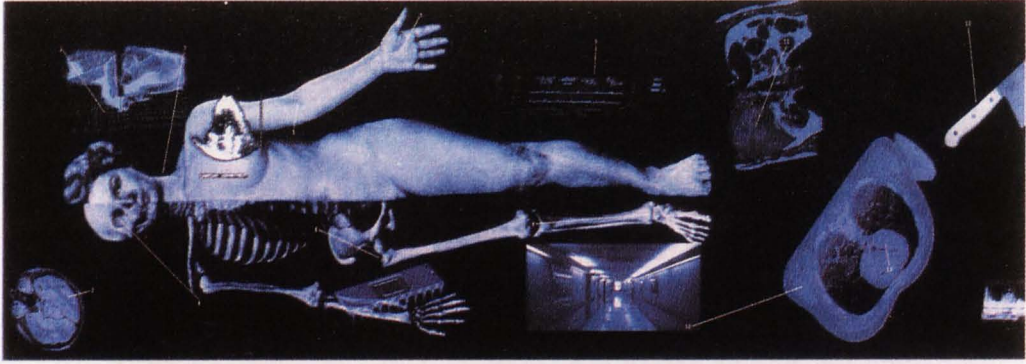**4. Christine Borland: The Dead Teach the Living [1997].**



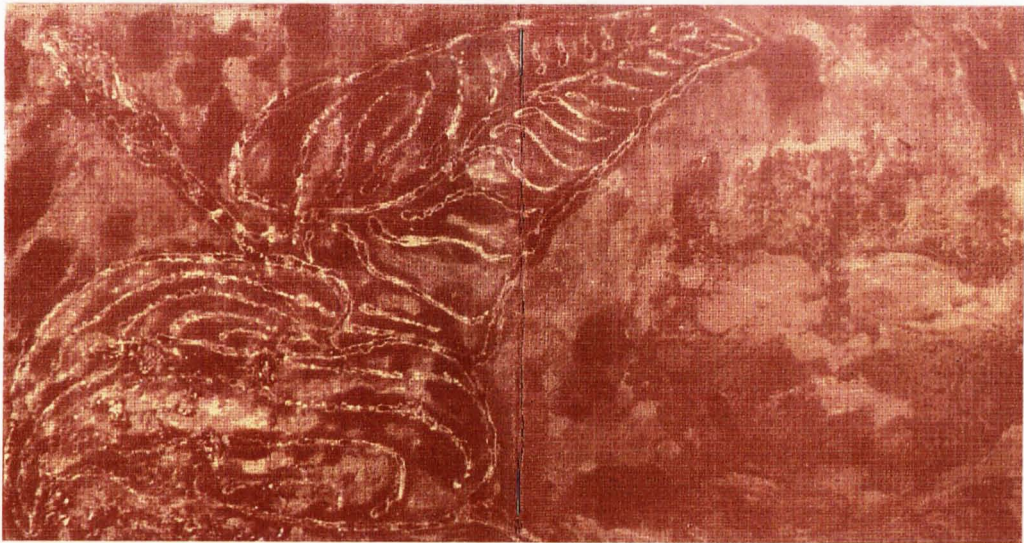**5. Christine Borland: Second Class Male, Second Class Female [1996].**



**6. Christine Borland: Cet être lâ, c'est à toi de la créer! Vous devez la créer! [1996].**

**7. Jane Prophet: The Internal Organs of a Cyborg [1996].**



**8. Rose Rose: Sig/nature [1996].**



**9. Rose Rose: Epigene [1999].**

# 10. Rose Rose: Volaptuary [2000].

Allison, ... London. Kegan Paul ...

Argyle, M. ... Methuen. ...

Bachelard, ... London. Routledge Press.

Bann, S. [...] ... Documents of Twentieth ...

Barrett, M. ... Contemp...

Barthes, R. [1974]. S/Z. New York. Hill and Wang.

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