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(MIS)INTERPRETING ARTS AND HEALTH:
WHAT (ELSE) CAN AN ARTS PRACTICE DO?

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ABSTRACT

This research project concerns arts practices in healthcare settings and the encounter between artist, researcher, healthcare professional and institution. Rather than understanding arts practices as either therapeutic or recreational services, this research asks instead, what (else) can an arts practice do? This is accomplished by connecting two previously separate bodies of scholarship; health sociology and an art criticism of expanded arts practices. By connecting these bodies of scholarship, this inquiry offers a new conceptual language and orientation for arts and health practitioners distinct from the evidence-based practice model most prevalent in academic and professional discourses and consequently establishes a transdisciplinary trajectory for artistic and research practices. Navigating between polemical art critical discourses and appropriating health discourses the research seeks to follow a generative path, to create a position of affirmation, where art encounters can be understood in the way they produce affects, defined by how they connect and transform, by what they do. Such an approach addresses a lacuna in scholarship created by the almost exclusive academic interest in impact studies and the sparseness of associated critical writing. The research inquiry then makes a contribution to knowledge of relevance to artists, researchers, healthcare professionals and institutions because it offers an expanded conceptual vocabulary and scope for art practices in healthcare settings.

Keyword set: Arts and Health, Medical Humanities, Health Sociology, Expanded Arts Practices, Artistic Research

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Dec 2011 at Rua Red Arts Centre, (CA+HP) supported the *mac* installation at the Faculty of Medicine University College Cork and CIT - Crawford College of Art provided workshop space.

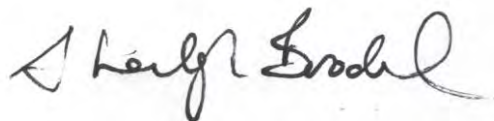
Thanks Eoin, Aisling and Pierce, for what only you can ever know.

DECLARATION

I certify that this thesis which I now submit for examination for the award of PhD, is entirely my own work and has not been taken from the work of others, save and to the extent that such work has been cited and acknowledged within the text of my work.

This thesis was prepared according to the regulations for postgraduate study by research of the Dublin Institute of Technology and has not been submitted in whole or in part for another award in any other third level institution.

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Signature _____ Date 23 February 2015

LIST OF FIGURES

FIGURE 1 LOUISE WALSH <i>EMERGENCY DEPARTMENT COMMISSION</i> (2007-2012)	21
FIGURE 2 ARTS COUNCIL OF IRELAND ARTS PARTICIPATION INFOGRAPHIC.....	27
FIGURE 3 MARIE BRETT <i>THE LOST CHILDREN</i> (2007)	30
FIGURE 4 COLETTE LEWIS <i>TRAINING TO BE A SERVICE USER</i> (2004).....	30
FIGURE 5 SHEELAGH BRODERICK <i>INDEXICAL TRANSFIGURATIONS</i> (2011).....	36
FIGURE 6 JENNY MORAN <i>PERSONAL EFFECTS: INFECTION CONTROL</i> (2010).....	41
FIGURE 7 CLEARY & CONNOLLY <i>BALLYMUN SEQUENCE</i> (2007)	45
FIGURE 8 LAURA FITZGERALD <i>ONCE UPON A TIME</i> (2009).....	51
FIGURE 9 CONDE & BEVERIDGE <i>NOT A CARE: A SHORT HISTORY OF HEALTH CARE</i> (1999).....	54
FIGURE 10 CONDE & BEVERIDGE <i>THEATRE OF OPERATIONS</i> (2000).....	54
FIGURE 11 CONDE & BEVERIDGE <i>ILL WIND</i> (2001).....	54
FIGURE 12 PAULINE KEENA <i>THE NAMED BODY</i> (2008)	56
FIGURE 13 PHARMACOPOEIA <i>CRADLE TO GRAVE</i> (2003).....	66
FIGURE 14 HANLON <i>TOWARDS AN INTEGRATIVE FRAMEWORK</i> (2012)	69
FIGURE 15 HITO STEYERL <i>SEMIOTIC SQUARE</i> (2010A).....	76
FIGURE 16 TIM WAINWRIGHT <i>IAN</i> (2008).....	82
FIGURE 17 SHEELAGH BRODERICK <i>CT SCAN 6 DEC 2011 PANEL DETAIL</i> (2011).....	87
FIGURE 18 SHEELAGH BRODERICK <i>CT SCAN DEC 6 2011 INSTALLATION VIEW</i> (2011).....	87
FIGURE 19 BRETT & MCHARG <i>A QUICKENING</i> (2011).....	89
FIGURE 20 DENIS ROCHE <i>A CLINICALLY USEFUL ARTWORK? PART 1</i> (2006)	94
FIGURE 21 CIRCUS ENGELBREGT <i>PLACEBOS FOR ART</i> (2011).....	97
FIGURE 22 SHEELAGH BRODERICK <i>WORKSHOP DOCUMENTATION</i>	159
FIGURE 23 JOSEPHINE KAVANAGH WITH MARIELLE MACLEMAN <i>SUGAR LOVE</i> (2013).....	185
FIGURE 24 JOSEPHINE KAVANAGH WITH MARIELLE MACLEMAN <i>THE PEAKS</i> (2013).....	185
FIGURE 25 SHEELAGH BRODERICK <i>MAC DETAIL</i> (2011)	190
FIGURE 26 SHEELAGH BRODERICK <i>MAC INSTALLATION VIEW</i> (2011)	190
FIGURE 27 WAINWRIGHT & WYNN <i>ITU VIDEO SCREEN SHOT</i> (2007).....	200
FIGURE 28 EMILY ROBYN ARCHER <i>THE POST ROOM PROJECT</i> (2010).....	203
FIGURE 29 MARIE BRETT <i>HER PINK SHOE (AMULET PROJECT) 2009-2013</i>	233
FIGURE 30 SHEELAGH BRODERICK <i>MAC 2011</i>	238

ABBREVIATIONS

AHRC	Arts & Humanities Research Council (UK)
AOD	Alcohol and Other Drugs
APG	Artist Placement Group
CA+HP	HSE South Cork Arts + Health Project (CA+HP)
BMJ	British Medical Journal
BwO	Body without Organs
CAE	Critical Art Ensemble
CHH	Centre for Health & Humanities
CIT	Cork Institute of Technology
Create	Create the National Agency for the Development of Collaborative Arts in Ireland
DIT	Dublin Institute of Technology
ESRC	Economic & Social Research Council (UK)
EBM	Evidence Based Medicine
HIQA	Health Information & Quality Authority
HSE	Health Service Executive
KCL	Kings College London
NCAD	National College of Art and Design
IMMA	Irish Museum of Modern Art
QR	Quick Response
WHO	World Health Organization

TABLE OF CONTENTS

ABSTRACT	i
ACKNOWLEDGEMENTS	ii
DECLARATION	iv
LIST OF FIGURES	v
ABBREVIATIONS	vi
TABLE OF CONTENTS	vii
PART 1	1
1 INTRODUCTION	2
1.1 RESEARCH PROBLEM	3
1.2 RESEARCH TRAJECTORY	5
1.3 SITUATING THE RESEARCHER	7
1.4 THESIS OUTLINE	9
2 RESEARCH CONTEXT	15
2.1 SPECIFYING A FIELD OF INQUIRY	16
2.2 SITE SPECIFICITY	22
2.3 BOUNDARIES TO RESEARCH INQUIRY	25
2.4 ACADEMIC CONTEXT	32
2.5 INSTITUTIONAL CONTEXT	37
2.6 RECAPITULATION	47
3 LITERATURES	49
3.1 THE SOCIAL TURN	49
3.2 EVIDENCE BASED STUDIES	59
3.3 HEALTH LITERATURES	67
3.4 ARTISTIC RESEARCH	71
3.5 RECAPITULATION	76
4 DISCOURSES	78
4.1 PROHIBITION: A DOUBLE EXCLUSION	80
4.2 BETWEEN REASON AND MADNESS	88
4.3 BETWEEN TRUE AND FALSE	93
4.4 RECAPITULATION	98
5 THEORETICAL FRAMEWORK: THINKING TOOLS	100

5.1	THEORETICAL NOMOS	101
5.2	THINKING WITH IMMANENCE	106
5.3	STRUGGLING WITH ART, SCIENCE AND PHILOSOPHY	114
5.4	DIFFRACTING HEALTH	118
5.4.1	AETIOLOGY, ETHOLOGY, AFFECT	122
5.4.2	CREATIVITY AND HEALTH	129
5.5	WHAT CAN ART DO?	131
5.5.1	AESTHETICS OF AFFECT	136
5.5.2	CRITIQUE OF CREATIVITY	140
5.5.3	FROM INSTITUTIONAL CRITIQUE TO INSTITUENT PRACTICE	143
5.6	RECAPITULATION	149
6	METHODOLOGY	151
6.1	QUALITATIVE RESEARCH	151
6.2	THE RESEARCH ASSEMBLAGE	153
6.2.1	COLLABORATION.....	156
6.2.2	ETHICS	159
6.2.3	POLITICS	160
6.2.4	VIRTUALITIES.....	161
6.3	ESTABLISHING RIGOUR /AUTHENTICATION	164
6.4	INTERTEXTUALITY	166
6.5	DISCIPLINARY PRACTICES	172
6.6	RECAPITULATION	176
PART 2	177
7	ART ASSEMBLAGES	178
7.1	THE MAGICIAN AND THE SWALLOWS TALE	179
7.2	MAC	187
7.3	UNFOLDING SPACES	196
7.4	RECAPITULATION	204
8	WORMHOLES: CONNECTING ART HEALTH AND RESEARCH	205
8.1	THE DIAGRAMMATIC FUNCTION OF ART	207
8.2	CREATIVITY AND ART	211
8.3	DETERRITORIALISING RESEARCH	220
8.4	RECAPITULATION	224
9	TRACING THE MAP: AFFECT, TRANSVERSALITY, CONSISTENCY	226
9.1	AFFECT	228

9.2	TRANSVERSALITY.....	230
9.3	CONSISTENCY	234
9.4	RECAPITULATION.....	242
10	CONCLUSION.....	243
10.1	LIMITS TO AND TRAJECTORIES FOR RESEARCH.....	245
10.2	A PEOPLE YET TO COME OR A LITERATURE YET TO EMERGE?	248
11	GLOSSARY	253
12	APPENDICES.....	258
12.1	TWO VOICES.....	258
12.2	ARTS & HEALTH: TABLE OF CONTENTS.....	263
12.3	VITAL SIGNS ARTWORKS.....	264
12.4	ETHICS CONSENT FORM.....	266
12.5	RESPONSE TO ETHICS COMMITTEE.....	269
12.6	ETHICAL APPROVAL.....	276
12.7	DATA PROTECTION	277
12.8	CONFERENCES / SYMPOSIA ATTENDED.....	278
12.9	TEXT ABSTRACTS.....	282
12.9.1	ILLUSTRATING GREY MATTERS : ARTS PRACTICES IN HEALTHCARE CONTEXTS	282
12.9.2	SENSE AND SENSIBILITY : ARTS PRACTICES AS MODES OF INQUIRY IN HEALTH, ILLNESS AND DISEASE.....	283
12.9.3	FROM AESTHETIC TO ANAESTHETIC : TRAJECTORIES FOR ARTS PRACTICES IN HEALTHCARE SETTINGS.....	284
12.9.4	MEDICINE IN ART.....	285
12.9.5	INTERPRETING ARTS & HEALTH:.....	286
12.9.6	mac AN ARTS PROJECT FOR HEALTHCARE PROFESSIONALS?.....	287
12.10	CHH FUNDING BID	288
12.11	WORKSHOPS: PRACTITIONERS IN PRACTICE.....	291
12.11.1	PLANNING.....	292
12.11.2	WORKSHOP 1.....	294
12.11.3	WORKSHOP 2.....	299
12.11.4	OUTCOMES	302
12.12	WORKSHOP FEEDBACK.....	304
12.13	SOURCES OF EVIDENCE.....	321
12.14	CORPUS OF EVIDENCE.....	322

12.15	CRITICAL SOCIAL SCIENCE PERSPECTIVES ON PUBLIC HEALTH	
	COURSE OUTLINE.....	330
13	PUBLICATIONS.....	334
13.1	UNREASONABLE DOUBT	334
13.2	HALE & ARTY	350
13.3	WITNESS WRITER	352
13.4	TO EVIDENCE OR NOT TO EVIDENCE?.....	354
13.6	SOMETHING HAPPENS.....	356
14	REFERENCES	359

PART 1

1 INTRODUCTION

This thesis concerns arts practices in healthcare settings and related research. It originated in an interest in why healthcare professionals would go beyond their clinical roles to commission and implement arts projects in their healthcare settings. From this starting point the research morphed through substantive, discursive and speculative forms. The research took place in health, art and academic institutions in an approach where theory and practice meld as tactics to move past accepted figurations to explore future vocabularies.

The inquiry accomplishes this by connecting two previously separate bodies of scholarship; health sociology and an art criticism of expanded arts practices. By connecting these works, this inquiry offers a novel conceptual language and orientation for arts and health practitioners. Such an approach addresses a lacuna created by the dearth of critical writing on arts practices in healthcare settings created by the almost exclusive academic interest in impact studies whereby arts practices are solely understood as therapeutic or recreational interventions.

This thesis has been developed within the frame of practice-based doctoral research. It takes as its initial point of departure a concern with how participatory arts practices in healthcare settings were being understood as clinical interventions. The research sought to address this concern through an engagement with healthcare professionals who commission and implement arts projects in healthcare settings. My questions did not concern whether there is a causal relationship between arts practices and health outcomes rather they concern how these practices are understood. The objective was not to arrive at some specific correct interpretation instead it seeks to offer an alternate conceptual language commensurate with practices. So I was not only interested in the practices themselves, but also how they were being spoken of and written about. These encounters led to an understanding of discourse through participation in it and ultimately to a re-orientation of the

research. Hence the subsequent adoption of a speculative turn and the engagement with a literature that could provide a different lexicon for these practices. Thus there are distinct phases to the research. Such an approach is consistent with contemporary arts practices in the way they adopt diverse strategies of execution. In doing so, I am adopting an approach that specifically addresses arts practices in healthcare settings as a 'problem idea' (Kwon 2002).

This inquiry is important because it is a novel approach to research in this field, which is more usually characterised by case study and narrative. The research inquiry then becomes a contribution to knowledge of relevance to the field because it gives an expanded vocabulary and scope for art practices in healthcare settings (and related research) and presents practitioners with an expanded territory within which to locate their practice. It is timely finding resonance with a broader artistic project in which 'retooling our conceptual vocabulary has become a crucial task' (Wright 2013, p.36). Wright (2013) acknowledges how such work can be disorienting as self-evident terms and the institutions, and practices which they name, are retired. In undoing such 'apparent self-evidences', Wright (2013) claims that emergent concepts are repurposed within the shadow of expert cultures. Art, health and academia are the expert cultures overshadowing this inquiry's retooling of a lexicon for practices.

1.1 RESEARCH PROBLEM

The research inquiry was originally conceived as an address to healthcare professionals; to understand why they would go beyond their specified clinical roles in commissioning and implementing arts projects for their health settings. After two years of research the inquiry upended itself, as I realised the limits to academic discourse through participation in it. Arts and health research itself then became the focus of my inquiry.

The question whether arts interventions should be subjected to clinical trials depends largely on what kind of arts intervention is at stake. The

clinical evaluation of arts therapies is logically consistent as they are conceived of as clinical interventions, but clinical evaluation of contemporary arts practices is to misunderstand them. Expectations of positive clinical outcomes place an unbearable burden on artists who are not clinically trained and impose an unreasonable doubt on contemporary arts practices. These arts practices are concerned with issues such as power and knowledge, spectatorship and participation, institutional and public spaces, technology and embodiment, through diverse art forms including digital media, sculpture, performance and painting. They are not intended as clinical interventions and present clinical researchers with substantive and ethical impediments in research design. Scholarship on arts and health however, is limited through the exercise of knowledge and power in discourse. As Foucault puts it we are 'reduced to the monotonous act of an endlessly repeated foundation' (Foucault 2002b, p.207) as discourse creates and perpetuates itself.

The encounter between arts and health is yet another iteration of the rift between what CP Snow referred to as the two cultures: science and humanities (Snow 1993). This rift returns relentlessly in disputes over knowledge claims, leading to an irresolvable conflict between different ways of knowing the world. Arts projects struggled to provide evidence of health benefits and academics worked hard to provide them with methodological toolkits that would meet required standards of rigour. The value of arts and health had become an indisputable premise, but what remained to be found was a way to prove it. This urgency and zeal dispelled alternative perspectives in which critical voices were less silenced than ignored. Displacing emphasis on answering the urgent question of method, Foucault invites us to think problematically, to go beyond problem resolution through dialectical question and answer (1980b, pp.185–186). The Foucauldian understanding of knowledge/power relationships operating within contingent regimes of truth opens up the possibility of arts and health discourses being considered their own problem, in the way that research is inhibited in

asking questions beyond the limits of its discourse(s) and in the way that it infers a critical awareness of what is being said and done, and by whom (see chapter 4). This research then seeks to question the way in which these evidence-based research discourses normalise arts practices, understanding them as either therapeutic or recreational services.

My challenge as an artist researcher was not to represent back the recognisable idioms and manners of the clash in cultures between science and humanities, because in recognition our knowledge, beliefs and values are reconfirmed. What compels us to think is not an object of recognition, but an object of encounter that forces us to thought, challenging our systems of knowledge and disrupting our habitual ways of being (Deleuze 1994; O'Sullivan 2007).¹ Rather than repeat what is, this project seeks out difference eschewing logocentric views of the world that assert an unmediated truth. Acknowledging that 'neither research nor practical experience can ever provide a single or universal "truth" about the world' (Fox 2003, p.7), liberates the inquiry to pursue research and practice as intertwined. Such a practice if confined only to refusal and dissent, is reactive rather than creative. Instead, dissent conjoined with the production of new forms and possibilities offers affirmation through resistance (O'Sullivan 2007).

1.2 RESEARCH TRAJECTORY

What I say ought to be taken as 'propositions', 'game openings' where those who may be interested are invited to join in – they are not meant as dogmatic assertions that have to be taken or left en bloc (Foucault 2002a, p.224).

¹ Here I am referring to Deleuze's claim that 'everything begins with misosophy ... The conditions of a true critique and a true creation are the same: the destruction of the image of thought ... and the genesis of the act of thinking in thought itself' (1994, p.139). The thing that forces us to think lies in an object of encounter - that which can only be sensed in diverse affective tones such as for example love, wonder, hatred, suffering. Drawing from this, O'Sullivan in his introduction explains, that not only is his book a personal archive of his encounters in the expanded field of contemporary art but that art 'is the name of the object of an encounter, ... also the name of the encounter itself, and indeed of that which is produced by the encounter' (2007, p.2). This is discussed further in section 5.5.1 as the aesthetics of affect.

This research operates as a game opener, switching from analysis to speculative inquiry. How would a shift in orientation of these practices affect our relation to them? Rather than representing antagonistic knowledge claims, the inquiry deploys Deleuzo-Guattarian concepts to understand health not as a state, but as a process, as a 'healthing';² and art as an expanded and complex practice, coined 'aesthetics of affect'. Each is concerned not with what a body *is*, but with what (else) a body can *do* (Fox 2012b, p.205; O'Sullivan 2007, p.20).³ It offers a perspective in which health and art are seen as an affirmation of potential. When taken together these writers open up the possibility of thinking about and talking about arts practices in healthcare settings free of the bonds of fixed, institutionally-bounded categories of health and art, resistant to codified ways of thinking and acting.

Such narratives can provide alternative positions from which to think about and talk about arts practices in healthcare settings, consistent with practices as they are implemented. They also provide the possibility to think about arts practices within the health institutional setting as instituent practices, resistant through invoking a constitutive power.⁴ The literature referred to moves between theoretical and practice-oriented texts, troubling the way in which language is used to find an analytic consistent with practices. It provides both a perspective and an impetus for art practice. The inquiry then seeks to generate and infiltrate networks to decentre discursive practices through the dissemination of a series of statements.⁵ It aligns itself with recent developments in the UK Arts and Health Research Network in which theoretical resources are being tapped in order to support the elaboration of experimental research practices. It also finds resonance with recent moves made by BAK Utrecht who are

² The WHO defines health as a static ideal type. 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (World Health Organisation 1948)

³ The (else) refers to Spinoza's injunction 'No one has yet determined what the body can do' (1959, p.87 cited in, Brown & Tucker 2010, p.3), a project which is less about figuring the body and more about its configuration, a theme which will be developed in chapter 5.

⁴ Raunig et al (2009) are referring to the 'strategies and specific competencies of art ... deployed to spur on a general reflection on the problems of institutions ... {and} ... the predicaments of critique' (2009, p.xvii). These instituent practices are an approach to renew and reinvent institutional critique relevant to contemporary circumstances and will be discussed further in section 5.5.3.

⁵ A statement can be a word, a sentence, a paragraph, an article, a book, or an artwork that can appear in many different places and be presented to many different audiences.

engaging with the Deleuzian scholar Professor Rosi Braidotti in their current project *Future Vocabularies* (2014).⁶

The artwork is conceived not as object but as a process (Stewart 2012). The concept of process can be understood in a variety of ways, not only as a material exploration but also as a theoretical investigation and negotiation of a model of art distribution working outside traditional sites of art production and reception. The research inquiry becomes a contribution to knowledge of relevance to the field because it gives an expanded vocabulary and scope for art practices in healthcare settings (and related research) and presents practitioners with an expanded territory within which to locate their practice. As Pink suggests:

Theories are vocabularies necessarily underdetermined by empirical facts, which allow us to enter, at an abstract level, a world of social realities and imaginings, providing us with a way in which to understand our encounters in them (Pink 2012, p.15).

To be clear it is not my intention to set myself apart to express the 'truth of the collectivity'. Rather this inquiry has become the site of my own struggle against disciplinary forms of power that seek to transform me 'into its object and instrument in the spheres of "knowledge", "truth", "consciousness" and "discourse" (Foucault 1980a, p.208). This thesis then is concerned with a negotiation of theoretical connections to think about and talk about arts projects in healthcare settings.

1.3 SITUATING THE RESEARCHER

The idea that the researcher can maintain a distance from their research inquiry no longer holds sway in qualitative research, 'observation not only *disturbs* and *shapes*, but is *shaped* by what is observed' (Lincoln & Guba 1985, p.98 italics in orig.). Rather, the researcher 'is always already enmeshed within complex transversal social-material spaces where we must act as *bricoleurs* using whatever effects we believe are possible and desirable' (Kamberelis & Dimitriadis 2005, p.888). In a very real sense there

⁶ See www.artsandhealthresearch.ac.uk/artshealthandwellbeing/index.aspx and BAK (Basis Voor Actuele Kunst) www.bak-utrecht.nl

is a continuous unfolding, a series of iterations in which the researcher and the inquiry shape and are shaped by each other. My attention is turned inwards towards myself deploying a disturbed and disturbing role in the inquiry (Lincoln & Guba 1985, p.100).

Many of the life experiences that bring me to this inquiry equip me with a situated knowledge: through working as a University Hospital Arts and Health Coordinator: through academic research and through experience of implementing collaborative arts projects. I had been working on a part-time basis for the Health Service Executive (HSE) in a variety of roles since 2001. However, this research was carried out distinct from my professional role in the HSE as my request for support was declined. Links to personnel in the HSE involved in the research project, were made through the HSE project advisor, located in the HSE South Cork Arts + Health Project (CA+HP), however pre-existing knowledge of the institution was inevitably of benefit. In 1997 I completed a Masters in Sociology, which aided significantly when faced with the task of scholarly work. Technology changed so much in the intervening time; the academic research largely took place in my own home using the Internet to connect to online library databases and listen to podcasts from a variety of sources.⁷ Technology helped too with reference management software such as Zotero. An Abbest scholarship, assisted with financial support, affording me the opportunity to circulate in places where researchers met and shared their work as well as attending artists talk, exhibitions and professional development days. When I started the research inquiry in 2009, I had just finished a durational collaborative project with the support of a Create artist in the community research and development award, followed by a Create artist in the community project realisation award. During the research I was able to draw on mentor support through the Arts Council Connect professional development training programme managed by Create and Common Ground. These were all key elements in contributing to how the research took place and how I would rethink my practice and modes of collaboration in terms of time and space. Nothing could have

⁷ I accessed University of California, Berkeley online courses in philosophy and medical sociology.

prepared me for the way in which I could lose myself in the research project repeatedly, proceeding determinedly on intuition and with reference to a core community of practitioners.⁸ These practitioners may indeed find themselves lost upon first reading this text, but it is my hope that they will find enough to consider a reorientation, not of the particular practices themselves, but of the way in which we relate to and understand those practices.⁹

1.4 THESIS OUTLINE

The thesis is divided in two parts. Part 1 refers to content as a tracing and Part 2 to expression as a map. Deleuze and Guattari distinguish between 'tracing' which describes existing relations, and 'mapping', as an experimental future oriented activity (2004b, p.13). Tracing, refers to the world 'as-it-is', providing a specific orientation by drawing attention to problems and inconsistencies within relations. Mapping, on the other hand, refers to experimental processes anticipating new trajectories and connections. Mappings act upon the world producing new ways of thinking and acting.

What distinguishes the map from the tracing is that it is entirely oriented toward an experimentation in contact with the real ... The map is open and connectible in all its dimensions; it is detachable, reversible, susceptible to constant modification ... It can be drawn on a wall, conceived as a work of art, constructed as a political action or as a meditation ... the map has to do with performance (Deleuze & Guattari 2004b, pp.13–14).

Inevitably the tracing reduces the chaos of the world to a single image of 'reality' or 'truth', and so Part 1 should be read accordingly with this in mind. It was necessary to begin with a tracing however to start the

⁸ Such self-confessed following of intuition is not inconsistent with the knowledge creation required of a PhD. Indeed Deleuze and Guattari specifically foreground the operation of intuition; 'But there is no reason to oppose knowledge through concepts and the construction of concepts within possible experience on the one hand and through intuition on the other. For, according to the Nietzschean verdict, you will know nothing through concepts unless you have first created them-that is, constructed them in an intuition specific to them: a field, a plane, and a ground that must not be confused with them but that shelters their seeds and the personae who cultivate them' (Deleuze & Guattari 1994, p.7)

⁹ A public expression of this being lost can be found in the *Witness Writer* text commissioned for the National Dialogues in Arts & Health Conference (see section 13.3).

process of making a map. This will become evident as the reader moves into Part 2 of the thesis equipped with tools of navigation from Part 1. This text begins in the middle, as processes are already in play, connections previously made, relations already formed and transformed.¹⁰ This text assemblage then operates in actual terms in its production, distribution and reception, as content and expression, and, in virtual terms as a line of flight.

The adoption of a Deleuzo-Guattarian approach made possible an experimental propositional engagement with arts practices in healthcare settings simultaneously an act of resistance and an act of creation. These enactments are carried in the title of the thesis *(Mis)Interpreting Arts and Health: What (Else) Can An Arts Practice Do?*. Parentheses are deployed as a framing device, as 'each parenthetical modification alters perception of the en-framing gesture' (Dick & Wolfreys 2013, pp.112–113), to prompt multiple readings of the title, rather than insinuate any foundational claim.¹¹ The self-understanding of the project title can be read in many ways by readers of different dispositions and remains open to future readers.

This chapter has introduced the research problem, the research trajectory and myself as a situated artist researcher. The chapters that follow are presented as autonomous units in terms of research context, theoretical orientations, methodological considerations, transdisciplinary literatures, discourses and practices until they are brought together in Part 2, disclosing their webbed connections.

Chapter 2 establishes the research context in terms of specifying a field of inquiry. It begins to introduce a wide range of practices by referencing arts projects in healthcare settings both nationally and internationally.

¹⁰ The difficulty in starting from somewhere is acknowledged by Deleuze and Guattari 'It's not easy to see things in the middle, rather than looking down on them from above or up at them from below, or from left to right or right to left: try it, you'll see that everything changes' (Deleuze & Guattari 2004b, p.24).

¹¹ Such notation is in common usage for example, *(Mis)Understanding Photography: Works and Manifestos* is the title given to an exhibition at Museum Folkwang, Essen, Germany, 14 June – 17 August 2014.

Boundaries to research are established in relation to adjacent practices of arts therapy, recreational arts and other cross platform participatory arts contexts (albeit with a caveat referring to the permeability of these boundaries). The academic context of scholarship on arts practices in healthcare settings is explored introducing knowledge conflicts concerning validation of practices. A specific characterisation of the Irish institutional context is presented to indicate the embedded nature of practices in the Irish institutional landscape.

Chapter 3 refers to transdisciplinary source literatures that shape this project. It is divided in 4 sections concerning;

1. The social turn in arts practices and attendant critiques,
2. The dominance of evidence-based research,
3. Alternative narratives for healthcare practice and
4. Disputes arising from the academic disciplining of artistic research.

These four areas are important to this project, as they set a context for practice, identify a critique of approaches to evaluation, foreground the curiosity within healthcare practice for alternative narratives and detail the uncertainty within artistic research concerning its newfound identity as an academic discipline. Linking these texts together and applying them to arts practices in healthcare settings makes it possible to depart from prevailing logocentric perspectives to reorient the scope for these practices.

Chapter 4 substantiates the claim already made (section 1.1) asserting that scholarship in arts and health places a limit on its discourse. In order to do this I analyse a regime of practices that have prescriptive effects concerning what is to be done and what is to be known, what is taken for granted and what is imposed, what is said and what is done (Foucault 2002a, p.225). Specific conferences, seminars and artworks are referred to as emblematic instances through which discourse operates. Particular

emphasis is given to themes not typically heard in scholarship and practice, disclosing limits to the conditions of its possibility. This chapter concludes that foregrounding dissent neglects the probability of being caught up in the same terrain as that which is ostensibly opposed (O'Sullivan 2010a), necessitating a new direction for research.

Chapter 5 is presented in five parts; Firstly, I outline the movement between theoretical positions adopted in an attempt to open up practices to discussion, briefly mapping shifts from; Gadamerian phenomenology, Foucauldian discourse and ultimately to the pragmatic philosophy of Deleuze and Guattari. Secondly, it draws on the work of Deleuze and his precursors to understand his deployment of immanence and the implications for thought. Thirdly, I distinguish between art, science and philosophy as each are centrally implicated in this inquiry (Deleuze & Guattari 1994). Fourthly, I attend to the ways in which health is reconceptualised as a process rather than as a state, as a 'healthing', in terms of what it can do. A trajectory of health technologies from aetiology to ethology is traced and a link between creativity and health established. Fourthly, I elaborate an understanding of art in terms of what it can do and in which the work art is figured as an aesthetics of affect (O'Sullivan 2001; 2007; 2011a). Finally, I elaborate art critical concepts in terms of art's own self-understanding of itself in the critique of creativity and institutional critique.

Chapter 6 discusses methodological concerns that permeate both domains of health and art. It attends to the research assemblage as a posthumanist approach to understanding research of, and within immanence, which includes a specification of my own practice. This is followed by reflections on rigour in research. I discuss the deployment of intertextuality, as a collaborative construction of narrative connecting literatures and practices. This chapter ends with a consideration of the parameters of interdisciplinary and transdisciplinary inquiry.

Chapter 7 moves on from the tracing of previous chapters in Part 1, to

commence an experimental mapping in Part 2. The concept of assemblage is used to think through two different art projects. The first, *The Magician and The Swallows Tail* (MacLeman 2013), is set in the dialysis unit of Galway University Hospital. The second, *mac* (Broderick 2011d), was installed at a University Medical Faculty. I consider how spatial contexts modulate the capacities of bodies to affect or be affected and how an arts intervention might change these capacities in discussion of a UK arts project with transplant patients, *Transplant* (Wainwright & Wynne 2008) and a project based in Waterford Regional Hospital, intended for healthcare staff, *The Postroom Project* (Archer 2011) .

Chapter 8 builds on previous chapters discussion of the health assemblage and the art assemblage. I revisit *The Magician and The Swallows Tail* (MacLeman 2013), to explore the diagrammatic function of art, healthing and the BwO (Body without Organs). I seek to extend the work of Fox (2012a) by bringing an art sensibility to the discussion on creativity and health. I consider how art and health may be connected without becoming the same. I turn to Balkema's 'concept of multiplicity or multiple connected space' with it's capacity to analyse figures of thought and its capacity to connect various worlds (Balkema 2004, p.60).¹² What is at stake here is a connection between the world of health and the world of art, and the consequences of making these connections for deterritorialising research practices.

Chapter 9 presents this inquiries self-understanding as an attempt to contribute to a minor literature through the unlikely encounter between artist, researcher, healthcare professional and institution. This encounter holds the potential for instituent practices, yet is overshadowed by polemical art critical discourses and appropriating health discourses. Rather than engage, this chapter turns away seeking to navigate to an ethological understanding of health and art, to a position where machinic connections can be understood in the way they produce material effects, defined by how they connect and transform, by what they do, rather

¹² Balkema indicates that she uses the word 'world' where Deleuze would use the word 'plane'.

than being a means to an end. Deploying concepts of affect, transversality and consistency I shift attention to the evolving relation between healthcare professional, institution, researcher and artist as a site for instituent practice in which collaboration creates the conditions of possibility for imagining new forms of instituting, suggesting they are the people yet to come.

Chapter 10 concludes the thesis with claims to knowledge and anticipating future research trajectories.

The text has been illustrated with images throughout, but I wish to caution that these images are not the subject of visual analysis. They are included as documentary material only. Participatory practice as Bishop points out, is almost impossible to grasp from images alone. Images 'tell us very little, almost nothing about the concept and context of a given project ... and convey nothing of the affective dynamic that propels artists to make these projects and people to participate in them' (Bishop 2012, p.5). Furthermore, the particular works that I have developed myself are dispersed throughout the thesis. There are two reasons for this; 1. The works themselves were never intended to exist autonomously, instead they emerged from a context in particular relational configurations and are presented as such, 2. To foreground the visual aspects of this research over and above this written text would be to favour ocularcentric bias in contemporary art and be counter-intuitive to the claims being made.

2 RESEARCH CONTEXT

This chapter establishes the research context in terms of specifying a field of inquiry, outlining boundaries to research, adjacent contexts in terms of academic scholarship and a specific characterisation of the Irish institutional context. It begins to introduce a wide range of practices by referencing arts projects in healthcare settings, both nationally and internationally. Throughout the text particular examples of arts projects are introduced to further specify the range of practices of interest to this inquiry.

Interpreting arts and health, as the research project was originally conceived was an inquiry that would explore how healthcare professionals that have commissioned, mediated and implemented arts and health projects understand these practices through a collaborative arts practice. By this I mean that the inquiry was conceived of as artistic research deployed through the framework of a practice-based PhD (see section 3.4).

The Guidelines for Good Practice for Participatory Art Practice in Healthcare Contexts, states that 'the term 'practitioner' ... refers not exclusively to artists but rather to anyone who has a professional role in the preparation, delivery and evaluation of the work' (White 2009b).¹³ Consequently healthcare professionals are designated arts and health practitioners.

The period of research coincided with the emergence of official and institutional positions in relation to practices. The Arts Council of Ireland published its policy and strategy (Arts Council of Ireland 2010) and the HSE South published Good Practice Guidelines (White 2009b). It also coincided with a growing academic interest in arts and health practices with the

¹³ The Guidelines for Good Practice were commissioned from the Centre for Medical Humanities at Durham University by the Waterford Healing Arts Trust and the Health Service Executive South (Cork) Arts + Health Programme with financial support from Arts Council Ireland/An Chomhairle Ealaíon.

establishment of topic specific journals.¹⁴ I was interested in the way that in these journals, and in an immense grey literature of project evaluation reports (of variable quality), claims were being made for arts practices attributing them with health gains (Mirza 2006; Raw et al. 2011).¹⁵ Despite these claims being made it was never clear how artists who had no clinical training could claim health benefits for their practice or how healthcare professionals would allow such claims to undermine their professional role. The purpose of the research then was to pursue a line of inquiry that was consistent with practices as lived experiences. The route this took was circuitous, unanticipated, experimental and speculative.

2.1 SPECIFYING A FIELD OF INQUIRY

The areas of interest in this inquiry are participatory arts practices which can occur in residential care, day care, acute hospital, maternity hospital, community hospital, and, community and primary care contexts within the following service areas; Mental Health, Acute Hospitals, Child and Family Services, Public Health and Health Promotion, and Eldercare. Arts practices in healthcare settings are extra gallery practices that are institutionally embedded. That is, they take place in institutional contexts with institutional support; without these institutional partnerships to fund and manage projects, it would not be possible to mediate and implement projects in healthcare settings. Furthermore, the negotiated collaboration between institutions, as well as between artists and healthcare professionals is essential to the way in which practices are mediated.

Arts practices in healthcare settings comprise cross platform artforms including; the visual arts (painting, sculpture, photography), performing arts (music, dance, drama, mime, story telling), literature, film and video, architecture, landscape architecture and design. They can have diverse modalities (Arts Council of Ireland 2003). Typically arts and health projects are found in different types of locations: hospitals; healthcare settings

¹⁴ Arts & Health: An International Journal for Research, Policy and Practice (Taylor and Francis) first published 2009. Journal of Applied Arts & Health (Intellect Books) first published 2010

¹⁵ See also Appendix 12.14

(residential units, day care centres and primary care centres); community and education / training centres (Moloney 2007). Approaches to implementing an arts and health project can take any number of forms, from a durationally extended collaborative process to a finite object oriented project. The awareness of practices has led to varied designations such as, 'arts in health', 'arts for health' and the preferred term of the Arts Council of Ireland 'arts and health', which 'reflects the equal partnership of skills necessary to ensure good practice' (Arts Council of Ireland 2010, p.4). For a time (2010 – 2012) in England 'culture and wellbeing' was used as an equivalent term, but now 'arts, health and wellbeing' is deployed there to describe activities.¹⁶ The Arts Council of Ireland definition is as follows:

Arts and Health is the generic term that embraces a range of arts practices occurring primarily in healthcare settings, which bring together the skills and priorities of both arts and health professionals. Good Arts and Health practice is characterised by a clear artistic vision, goals and outcomes. Alongside these, it aims to promote health and well-being by improving quality of life and cultural access in healthcare settings. It may incorporate different approaches, including conventional arts production and presentation, arts participation and environmental enhancement (Arts Council of Ireland 2010, p.4).

This definition was devised following a series of national consultations. It differs substantively to the approach adopted by Parkinson, a leading advocate and Director of Arts for Health, Manchester Metropolitan University. He really 'struggles' with this 'thing' called arts and health. He reminds us that 'our health and wellbeing are bigger than narrow notions of illness and disease' (Parkinson 2011, p.6). Eschewing current preoccupations with harnessing the benefits of arts for health through the establishment of practice kite marks, standards and tool-kits, he asserts:

It started out as arts, health and well-being, but it's underpinned by so much more. And that's the thing: it's the politics of being alive here and now. Our arts/health story can't ever be separated from the inequalities that underpin and undermine our world (Parkinson 2011, p.6).

¹⁶ Personal email correspondence with Victoria Hume Arts Manager, rb&Harts, Royal Brompton & Harefield NHS Foundation Trust. See also the National Alliance for Arts and Health <http://www.artshealthandwellbeing.org.uk/>

Parkinson reflexively conjures up notions of quack medicine administered by travelling doctors in the nineteenth century when he declares that those involved in arts and health might as well be peddling snake oil, because despite claims being made for health benefits, art is not going to change the fact that we are mortal. 'Magic bullets don't exist and we can't cheat death by painting' (Parkinson 2011). He is concerned that such cure-all narratives steal the power of the artist to provoke. He advocates arts and health to occupy a distinctly political position. Following a process of consultation, *The Arts & Health Manifesto Part Two*, developed as an evolving hybrid proclaims the following slogans; 'We dump the mouldering strategy: meaningless in the face of 'spiralling inequalities', 'the arts shape and challenge thinking', 'the arts are a vehicle for health wellbeing and social change' (Parkinson 2012b). Disappointingly the manifesto is thin on theory of any kind – political, social, philosophical and cultural, making it difficult to envisage this future oriented practice. This sparsity of critical writing has been identified as a hindrance (Coulter 2014). Such theoretical clarity is necessary to move forward as it offers a conceptual language with which to describe our encounters in world (see section 4.2).

Manifestly, there is a huge distance between the Arts Council of Ireland and Parkinson with respect to the positions they take concerning arts and health. Parkinson takes a globalised view of practices. He is an advocate for thinking through what an arts practice might mean in the face of health and social inequalities on a global scale, introducing a broader perspective allied to public health imperatives rather than individualistic biomedical approaches. He is clearly dissatisfied with current hegemonic discourses, but so far has failed to go beyond rhetoric. The Arts Council of Ireland adopts a more muted approach. Their definition places the promotion of health and wellbeing alongside artistic goals. This is a notable difference from an earlier Arts Council of Ireland definition which had solely referenced artistic goals (Arts Council of Ireland 2003). Importantly both iterations of the Arts Council of Ireland definition of arts

and health maintain the distinction between arts and health practices and arts therapy.

The definitions outlined above by Parkinson and the Arts Council of Ireland set out a very broad palette of practices and pre-occupations. They are specified here to illustrate the breadth of approaches and to underline understandings of arts practices in healthcare settings as a contested cluster of practices and ideas.

Raw et al. (2011) detail a wide range of definitions and models in their survey of literature noting the difficulty in agreeing any definitive terminology. They conclude that although the wide range of working definitions and models accommodates a wide range of practices, this diversity prohibits the emergence of a unified and bounded framework recognisable to academics outside the sector. Raw et al. (2011) suggest that by looking to the micro processes deployed by artists in their practices they can be placed theoretically in relation to outcomes. Their study points to 'considerable convergences in the practice itself across all sites' (Raw & Mantecón 2013, p.21). Yet this practice oriented account does not account for the engagement of healthcare professionals as arts and health practitioners.

This is why in my research I sought to focus on healthcare professionals. Why would trained healthcare professionals get involved in commissioning and implementing an arts project? Healthcare clinicians and managers, as individual champions, have supported project commissioning and implementation on a piecemeal basis, accessing funding from varied sources (Moloney 2007). Much emphasis is placed on the negotiated partnerships between artists and healthcare professionals prior to project commencement. These encounters involve the elaboration of a shared understanding between different worldviews negotiating in practice what is not contemplated in theory. The negotiation between healthcare professional and artist is a key characteristic of practices and in many senses can be said to be part of the artwork itself:

Meaning and value exists in the negotiation between what is accepted as art and what is 'not art', the relational field where the non-artist is acknowledged as a participant or co-producer and where the artist, the curator, the critic/writer enter that field on the same terms but with different intentions and baggage (McGonagle 2010, p.54).

Here, McGonagle has succinctly expressed the agonistic relation between the non-artist and the artist that can be extrapolated to healthcare settings as the relation between the healthcare professional and the artist.¹⁷ Furthermore, McGonagle has also referred to the ongoing negotiation of what is accepted as art. The art world exists in a state of constant flux as claims for what constitutes art is keenly contested. Yet healthcare professionals find themselves enmeshed in the actuality of these arts practices. They find themselves in negotiation with artists in relation to projects commissioned for their healthcare setting and service users. What may appear at surface level to be congruent activities may actually stem from differing project intentions. It is not a matter of privileging one approach over the other, rather it is a question of parity of esteem between disciplines (McGonagle 2007). The field of inquiry then is positioned at the intersection of individual (artist) and institutional (healthcare professional) concerns. As for example with *Emergency Department Commission* (Walsh 2007).

The Emergency Dept at St James's Hospital awarded a Percent for Art commission to Louise Walsh in 2007. Part of the proposal was to work with staff to evolve texts for the Hospital Emergency Department. The staff had been concerned with how waiting can be stressful or frustrating for patients. Walsh focused on materials that prevent the hospital from becoming damaged and scarred, linking it to the protection of staff and the prevention of accidents. Etching trolley guards with images and poetry generated following consultation with staff, and putting portraits of staff on door push plates implicated the staff both in the fabric of the building and the institution in a complex entanglement of relations.¹ This

¹⁷ The term agonism has been developed by Esche (2005) based on the work of Laclau & Mouffe (1985). Esche characterises agonism as the interaction between friendly enemies sharing a common symbolic space whilst negotiating to organise it differently.

project took an extraordinarily long period of time to complete.¹⁸ This was due to a number of factors associated with working in such a large institution, e.g. the space dedicated to the project was changed when a vending machine was put in its place and installation of artworks was delayed while the position of arts coordinator was left vacant. The agonistic legacy of the artwork continues even after project completion. In a building with such heavy use ongoing negotiation is required to maintain the artwork.



Figure 1 Louise Walsh Emergency Department Commission (2007-2012)

¹⁸ The completion date is give as 2012, but the artist herself has indicated in private correspondence that she is still involved in legacy issues.

2.2 SITE SPECIFICITY

For the sake of clarity in this research project I refer to arts and health, as 'arts practices in healthcare settings' to specifically anchor the type of practices under discussion. Other conjunctions such as, 'arts in health', 'arts for health' and 'arts and health' indicate particular orientations for practices.

It is my intention that the term 'arts practices in healthcare settings' adopted in this thesis specifically orients the practices towards healthcare settings as heterotopic spaces.¹⁹ Healthcare settings can exist, as heterotopias of crisis in the way that an acute illness presents itself as a crisis to the individual, and also as heterotopias of deviation because of deviant behaviours brought on by for example, illness or old age (Foucault 1986). These are closed spaces whose entry is regulated by healthcare professionals based on specified guidelines. Rather than just seeing healthcare spaces as totalising or determining, Street and Coleman (2012) suggest that healthcare settings exist as sites with the 'paradoxical capacity to be simultaneously bounded and permeable, both sites of social control *and* spaces where alternative and transgressive social orders emerge and are contested' (Street & Coleman 2012, p.5, italics in orig.). This elaboration goes beyond the opposition of panoptic biomedical processes and practices of resistance, to consider multiple processes of ordering in everyday relations.²⁰

¹⁹ Foucault (1986) describes heterotopias as being constituted through six principles that are common to all cultures, but taking varied forms. 1. Norms of behaviour are suspended through heterotopias of crisis (reserved for individuals perceived as being in crisis e.g., adolescence, pregnancy, aging) and heterotopias of deviation (reserved for individual whose behaviour deviates from the norm) 2. Heterotopias have a precise and determined function originating in the society in which they exist (e.g. cemeteries) 3. Heterotopias have the power to juxtapose simultaneously in a single space several incompatible sites (garden of varied plantings) 4. Heterotopias are linked to slices of time, which can be accumulated (library) or be transitory (fairground) 5. Heterotopias operate systems of opening and closing limiting access to those with permission to entry, 6. Heterotopias function in relation to other space as an illusion (brothel) or compensation (colonies).

²⁰ The panopticon was first proposed by Bentham to describe a prison architectural design that would allow observation of all inmates without they knowing whether they were being watched or not. This idea was developed by Foucault (1995) to describe the operation of power in disciplinary societies. Individuals who are subject to a field of visibility (and know it) become inscribed in the power relation by disciplining themselves and guaranteeing power even when it is not being asserted.

Although removed from conventional figurations of activist practices, healthcare spaces might be read as places where art can operate a modest 'tactical quietism' distinct from an art that operates through loud 'copycat gestures' that 'fetishise politics' (Adajania 2012). This sentiment resonates with the work of Esche (2005) who formulates the idea of modest proposals which are at once speculative and concrete as 'artworks that make more impact when using existing objects, existing proposals, existing conditions, existing situations and manipulating the elements into different, more aspirational or purposeful configurations' (Esche 2005, p.25).²¹ They are realised in the concrete mundanity of the everyday (symbolic, physical and discursive spaces) as speculative endeavours.

Kwon formulates a provisional conclusion concerning the operative definition of the site in the past thirty years of advanced art practices that has been transformed from a physical location to an ungrounded, fluid and virtual discursive vector:

The site is now structured (inter)textually rather than spatially, and it's model is not a map but an itinerary, a fragmentary sequence of events and actions *through* spaces, that is, a nomadic narrative whose path is articulated by the passage of the artist (Kwon 1997, p.95, italics in orig.)

Kwon asserts that the distinguishing characteristic of site oriented art is found in a discursively determined site, specified as a field of knowledge, intellectual exchange or cultural debate and subordinating the site figured as both the actual location and the social conditions of its institutional frame. Thus the site is not prior, rather, it is generated by the artwork and then verified by its convergence with an existing discursive formation (Kwon 1997, p.92). In this inquiry, my own practice is positioned within the field of knowledge, characterised as arts and health, as a knowledge practice within a wider intellectual debate.²² This entailed a

²¹ Here modesty refers to 'dealing with real stuff, and with the pragmatics of day-to-day life' as the quality that defines the limits in expression, rather than the scale of the issue involved, or the absence of grand ambition (Esche 2005, p.25).

²² Kwon (1997) further elaborates that the dominance of a particular formation of site specificity is not to deny the possibility of it co-existing with other formulations (phenomenological and social/institutional), just to note the competing definitions that often overlap and coexist simultaneously.

shift in orientation for the project in terms of reconfiguring the site of practice. This was enacted by subordinating the site figured as the actual location to the discursive sites in academic and professional discourses within the institutions of academia, health and art practice.

Kwon claims that site oriented practices are tasked with mapping the relational specificity that holds in tension the spatial poles that both shrinks the globe for those who own it and expands the globe for the displaced and dispossessed.²³

This means addressing the differences of adjacencies and distances *between* one thing, one person, one place, one thought, one fragment *next* to another, rather than invoking equivalencies via one thing *after* another. Only those cultural practices that have this relational sensibility can turn local encounters into long-term commitments and transform passing intimacies into indelible, unretractable social marks—so that the sequence of sites that we inhabit in our life's traversal does not become genericized into an undifferentiated serialization, one place after another (Kwon 1997, p.110, italics in orig.).²⁴

Drawing from Kwon, an arts practice in addressing prevailing relational sensibilities has the prospect of making local, modest encounters into permanent social marks. Healthcare settings, the associated discursive sites of arts and health research and artistic research form the relational axes within which this research is situated. This research is intended to question these relations giving rise to a specific localised orientation, aspiring to be of relevance to arts and health practitioners (i.e. artists and healthcare professionals) and researchers.

²³ Thinking along these lines, the physical and social distance demarcating the space of healthcare services users is an as yet unrecognized border within critical arts practice.

²⁴ Kwon's text resonates with that of Foucault 'The site is defined by relations of proximity between points or elements: formally we can describe these relations as series, trees or grids' (Foucault 1986, p.1)

2.3 BOUNDARIES TO RESEARCH INQUIRY

Following from the remarks made in the previous section, this inquiry is not concerned with artwork that is made solely for exhibition in the standard sites of art distribution. For example it excludes the work of Javier Téllez although his work typically involves contact with people who would otherwise be excluded from normal participation in society because of a health issue (Muller 2008). Téllez has worked with in-patients in psychiatric institutions for *La Passion de Jeanne d'Arc* (2004), *One Flew over the Void* (2005), *Caligari and the Sleepwalker* (2008), with blind people *Letter on the Blind For the Use of Those Who See* (2007) and with communities suffering from endemic Huntington's Chorea, *Choreutics* (2001). These projects were developed in Australia, Mexico, Berlin, New York and Venezuela, for exhibition in high value galleries, museums and international biennials. It has a decidedly different character to the projects under discussion here, most of which will have a durational character typically lasting at least six months and often many years and which might or not have outcomes giving rise to exhibition practices.²⁵ The artist notes accompanying the Whitney Biennial (2008), claim that Téllez 'attempts to "cure" viewers of false assumptions, rather than the patients of their disorders' (Dalton 2008). This intentionality excludes Téllez and other similar artists from this research as the focus of this thesis is on participatory processes rather than the creation of artworks intended for viewing.

The arts practices with which I am concerned do not relate to any of the arts therapies. Arts therapy is conceived and delivered with clinical intent. Arts therapists undergo specialised clinical training and are part of a clinical team. The Arts Council of Ireland distinguishes arts therapy from

²⁵ For example Téllez's work was included in an exhibition I visited as part of my research. Niet Normal: Difference on Display, Diversity in Art, Science and Society, Amsterdam 2010, Liverpool 2011, Berlin 2012 which included other stellar artists such as Thomas Hirschhorn, Damian Hirst, Bruce Naumann, Marc Quinn, Patricia Piccinini, Louise Bourgeois, Birgit Dieker (see www.nietnormal.nl for a full list of participating artists) The work displayed here was made for an audience and therefore is essentially different in character to the work in which I am interested in which the viewer is displaced by the participant in a post Cartesian artform (Beech 2010) see Section 3.1.

arts practice because of this differing orientation (Arts Council of Ireland 2010). Art therapists work alongside other therapy grades in the planning and delivery of patient care plans.²⁶ From the perspective of the therapist interventions are primarily therapeutic and art is used as a methodology to elicit specific outcomes. The Arts Council of Ireland further clarifies that 'for artists (working in healthcare settings) ... the primary intention is artistic and any therapeutic effect is seen as a bonus' (Arts Council of Ireland 2003, p.113). McHarg et al. (2011) identify sixteen points of difference in practice between an artist and an arts therapist, based on their experience of an artist and art therapist working together on a project over an extended period (see Appendix 12.1). De Burca (2014), a musician who also practices as a music therapist adds weight to the distinction between these divergent practices. She avers that attending to the thought processes and intentions in both practices clarifies distinctions. As a music therapist she understands her role is to respond to the client (usually it is a one to one relation) in what can be unstructured, directionless and sometimes unpleasant free improvisation. As a musician performing in a healthcare setting her objectives are primarily artistic and social, choosing what to play, what to improvise, who to improvise with, balancing the needs of individuals vs. needs of the group. De Burca characterises this work as walking a 'careful tightrope between musical ambition and inclusive collaboration' (2014 unpaginated). This distinction between arts practice and arts therapy is important to this inquiry. Arts therapy exists alongside other clinical roles on a professional care team, with full access to patient records. An artist does not have any access to clinical records and is not involved in the delivery of healthcare services. On that basis alone, it would seem unreasonable to expect a specific clinical outcome from their work. The Arts Council positions arts and health alongside other participatory arts practices, each of which has a specific remit with a specialist arts council advisor and associated institutional protocols and regulations.

²⁶ Arts therapy is not a recognized grade within the Irish Health service although many arts therapists are employed in the delivery of service. Irish Creative Arts Therapist Association: www.icat.ie.

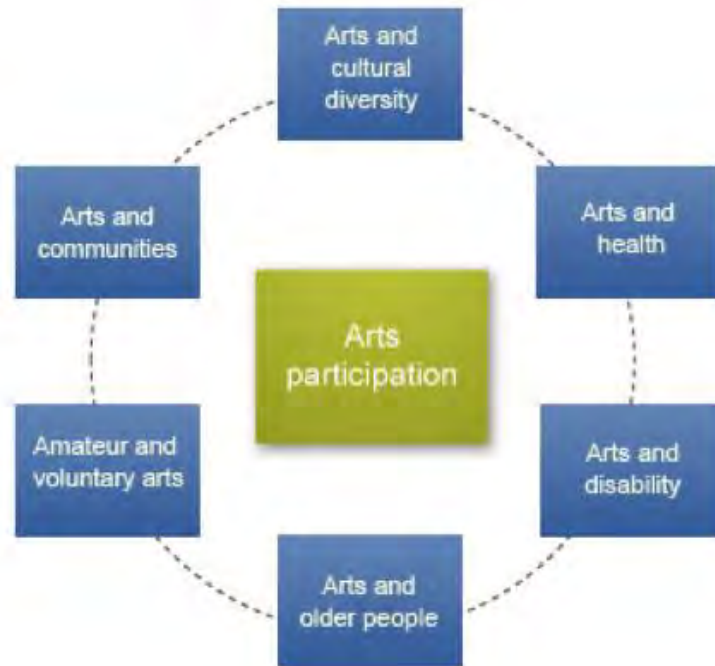


Figure 2 Arts Council of Ireland Arts Participation Infographic

I distinguish between participatory arts practices and recreational practices, which are provided as part of health service delivery through, for example, occupational health interventions. Recreational arts practices provide an important creative outlet, but are generally understood as being uncritical. The activity is concerned with making and/or doing, but is not related to a broader interpretative and historical art narratives. These services are very common in healthcare settings and used to improve the ambience of institutional settings and to attract clients. Other deployments of recreational arts services include behaviour change models, which aim to use recreational arts to evince changes in behaviour and improved wellbeing through for example, the use of puppetry, clay modelling and dance (Escobar-Chaves et al. 2010; Goldblatt et al. 2010; Quiroga Murcia et al. 2010). Increased regulation in residential care creates further demand for these types of recreational services. So for example the Health Information Quality Authority (HIQA), the Irish regulatory body, includes in its standards for residential care, specific reference to recreational activities under Standard 12 Health Promotion (HIQA 2009). This leads residential care services to strive to

provide a social and cultural life for their residents, in part, through the provision of recreational arts activities.

The peak organisation in the USA describes itself as The Global Alliance for Arts & Health (having rebranded itself from the Society for Arts in Healthcare in 2012).²⁷ It has a focus on five key areas of activity: Patient Care, Healing Environments, Caring for Caregivers, Community Wellbeing and Education.²⁸ A somewhat similar taxonomy has been suggested by Coats (2005, p.19) ; 1. Arts projects to enhance the built environment, 2. Supporting health professionals to engage with their own creativity for educational, life-long learning, practice development or research purposes, 3. Working with patients as part of arts activities programmes, 4. Supporting patients to share their feelings and views about their experience of illness to inform the education of health professionals, 5. Working with patients and communities from a health promotion and public and user involvement perspective to support communication, health and wellbeing. These categories are not useful for the inquiry as they are premised on an instrumentalisation of practices.²⁹ I bracket my area of interest to participatory arts practices led by professional artists and mediated by healthcare professionals.

The Lost Children (Brett 2007) took place with artist Charlotte Donovan, patients, staff and visitors at St Finbar's Hospital, Cork. It is typical of most arts projects taking place in healthcare settings due to its participatory and durational character. Participation was not predicated on an easy and relaxed subject matter. The artwork was a response to an embedded social memory. It uncompromisingly addressed the terrible legacy of Magdalene Laundries. Sculptural artworks composed of plaster of paris

²⁷ A peak organisation is a non-profit association groups and / or individuals, established for the purposes of developing standards and processes, or to act on behalf of all members when lobbying government or promoting the interests of the members.

²⁸ http://www.thesah.org/template/page.cfm?page_id=604

²⁹ For example, narrative medicine uses metaphor and figural language in an attempt to provide more humane medical services see (see Charon 2008). Autopathography deploys patient narratives of illness (exemplified by visual artists Jo Spence and Hannah Wilkes which are understood critically as 'a militant act of situated visibility, as a vehicle for catharsis and recovery from suffering, as a performance of identity, and as a relational outreach towards others' (Tembeck 2008, p.87). This has been accompanied by a phenomenological interest in exhibition making, e.g. *Living Loss: The Experience of Illness in Art*, Glucksman Museum, Nov 2012 – March 2013.

moulds of children's dresses were created in response to the memory of unmarried pregnant girls, abandoned by their shamed families, their babies taken at birth, to be sold or given away. This was at a time in Irish history when the authority of the Catholic Church was beginning to crumble under the weight of its hidden history of institutional abuse. The artwork proposed a medium of expression for those who had been shunned and forgotten, contributing to a new narrative that challenged institutional authority, enfranchising the disenfranchised. This project, although convivial in nature, did not suffer the 'imposed consensus of authoritarian order' (Bishop 2004, p.66) a typical critique leveled at participatory art practices. Rather, the project revealed an uncomfortable truth and in doing so distinguished itself from ameliorative intentions, aligning itself instead with artistic practice.

Finally arts and health is often conflated with arts and disability. However this is disputed from within the arts and disability sector. Naughton (2011) proposes that they are different practices that can and do overlap. Arts and disability is 'an umbrella term that is concerned with furthering the participation in and experience of the arts by people with disabilities'. He suggests that the confusion between the two practices arises due to the misapprehension that disability is primarily a health issue. He characterises arts and health as incorporating artistic and health aims. This is a highly problematic claim. For years disability rights activists have struggled not to be defined by their disability, rather they advocate a social model in which society is seen as disabling. Yet in his perspective piece for the Irish arts and health website Naughton (2011) suggests that health service users arts engagement be defined by their health needs. This distinction is not useful for developing practices and indeed there is much to be learned from disability literature that redefines itself in terms of ability. These boundaries are specified at the outset to contain the area in which research happens, but in practice these boundaries are also permeable, as artists do not discriminate by working within one context only.



Figure 3 Marie Brett *The Lost Children* (2007)



Figure 4 Colette Lewis *training to be a service user* (2004)

training to be a service user (Lewis 2004) is an example of an arts project in a disability setting. In July 2001 the management of a number of Sheltered Workshops for people with disabilities in the Rehab Group transferred from National Learning Network (formerly NTDI) to RehabCare, which is the health and social care division of Rehab. These sheltered workshops were originally set up in the 1970's as a facility for people with long term disabilities considered unable for open employment. At the initial stage of this 'changeover' there was a lot of concern from people in these workshops as to what this change in management would bring. The primary change was the closure of many of the sheltered workshops being replaced by programmes with a rehabilitative, developmental and therapeutic focus. For some this created a sense of 'work' displacement, and for others, an opportunity for self-development.

The concept for making *training to be a service user*, (Lewis 2004) was first talked about in RehabCare Hollyhill with management and service users soon after this changeover. Lewis became interested in the political and social situation and over the following year worked with the centre to source funding to develop the project. The main objective of the project was to creatively open up dialogue to explore and discuss issues of 'work and identity' and to facilitate giving voice and visibility to people's concerns and experience of the changeover. In doing so the work is not dominated by 'disability' narratives. The project was concerned with the issues important to the people affected by institutional changes and found a vehicle for expression through photography and video.

2.4 ACADEMIC CONTEXT

The proliferation of institutional policy, guidelines, professional development, funding supports, research programmes, academic departments, conferences, journals and (to a lesser extent) books demonstrates the increasing prevalence of academic research scholarship on arts practices in healthcare settings in Anglophone countries.³⁰ Exact statistics on activity levels are unknown, but to date, articles claiming to represent the state of arts and health in the UK, America, Canada and Australia have been published in the lead journal published by Taylor and Francis, *Arts & Health: An International Journal for Research, Policy and Practice*, (Cliff et al. 2009; Sonke et al. 2009; Cox et al. 2010; Wreford 2010).³¹ Activity is known to happen in France, Finland and Holland through participation in European Partnership projects, conferences and book publications respectively, but there is insufficient information published to make any general claims with regard to non-Anglophone countries.³² This inquiry is concerned with practices as they are implemented within the Irish constitutional context as a contribution to knowledge in a sparsely developed critical field. The research is informed by academic scholarship in Anglophone countries, but this is not a comparative study.

Arts practices in healthcare settings have been thematised in the literature in keeping with current accepted best practice in those contexts. Healthcare services are dominated by protocols associated with evidence-based medicine and as a consequence arts projects based in

³⁰ In 2011, NUI Maynooth established a Level 9 Postgraduate Certificate in Arts in Healthcare Settings with the aim of providing students with an understanding of: 1. The key theories that inform teaching and learning in adulthood; 2. To provide them with the knowledge and skills to work creatively with groups; 3. The capacity to critically reflect on their practice in the field of arts and health; 4. An understanding of what 'arts and health' is and the role of the arts in healthcare, both theoretical and practical.

³¹ The Society for Arts in Healthcare was rebranded as the Global Alliance for Arts & Health in 2012.

³² Musique et Santé in partnership with Music Network ran a Music in Healthcare Contexts Training programme in 2010, Helsinki Metropolia University of Applied Sciences organised a conference "Arts, Health Entrepreneurship" in 2012, SKOR published a book documenting 25 years of commissioning work for healthcare contexts (Melis & Gestel 2010). See also (Parkinson 2012a) for reference to arts and health activities in Latin America made during a keynote address to the 2012 Art of Health and Wellbeing Conference, Fremantle, Australia.

healthcare settings became increasingly required to demonstrate evidence of health outcomes.³³ Looking at journal article titles, the preoccupation with evidencing health benefit is obvious (see section 11.2).³⁴

This has led to significant debate within the literature reviewed concerning validation of practices. Putland (2008) identifies the risk of an 'eclipse of art' as a consequence of different knowledge systems competing to dominate discussion of practices. White (2009a) after many years of struggling with issues of validation of practices concludes that negotiating a philosophical space of creative enquiry is preferable to pursuing clinical evidence based benefit (Macnaughton et al. 2005; White 2006b; White 2008; White 2010). Yet persistently in the academic literature this 'holy grail' remains sought after (see section 3.2).³⁵

The impasse continues as knowledge claims are contested in a manner that echoes the 'method war' that emerged following the proliferation of social impact measures of community arts projects in the 1980s and 1990s (Merli 2002; Reeves 2002; White & Rentschler 2005; Mirza 2006; White & Hede 2008). These were predated again by the 1959 thesis of *The Two Cultures*, which describes the rift between the sciences and the humanities and even earlier instances of the 'method wars' dating back to the late nineteenth century. As Wilson notes, method is one of the key determinations of disciplinary difference. It is 'one of the historically key divisions within the taxonomy of knowledges – the *natural sciences* contra *human sciences* divide – has often been read as indicative of the saliency of 'method' in determining disciplinary distinctions' (Wilson 2006, p.248). The irresolvable conflict continues as arts and humanities disciplines continue to struggle to articulate their 'value'.³⁶ These competing claims

³³ This approach to providing evidence has already been seen in Ireland where *The Open Window* project at St James Hospital, was subject to a randomized control trial supervised by the clinical director of the National Bone Marrow transplant Unit (Roche et al. 2008).

³⁴ Note also the price tag for articles. The cost of accessing journal articles is a barrier to arts and health practitioners who wish think about their practices.

³⁵ (Hamilton et al. 2003) in their article 'Arts for Health; Still Searching For The Holy Grail'

³⁶ For example, HERAVALUE, a European consortium of arts and humanities disciplines concerned with measuring the public value of arts and humanities research, presented it's findings at a conference in Dublin 25- 26 Oct 2012.

to knowledge shall be revisited as a theme throughout this thesis as a 'melancholic echo' (O'Sullivan 2007, p.77).³⁷ Yet recent developments in the UK point to a growing interest in reconfiguring academic discourse.

White (2009a) claims that different perspectives are coalescing to guide mission and practice, proposing that arts in community health has gone beyond a structural partnership between the arts and health sectors, rather he suggests it is now situated in the central arena of health policy (White 2009a, p.234). Furthermore, White highlights individual champions located within a health service delivery context. He sees the arts as playing a central role in the reinvigoration of health service management functions through creative collaboration.³⁸ White also presses home claims for improved public health outcomes due to creative cultures.³⁹ Nevertheless, he finds that the absence of strategic vision has led to an unfocused research agenda. According to White, research has been limited by a focus on the individual rather on the social and by poorly developed research methods. He suggests that a new research agenda is being established around a social model of health (White 2009a, p.225).

In 2013 an Economic and Social Research Council funded interdisciplinary Arts and Health academic research network was established in the UK. In a new departure from perpetual debates on method, in April 2014 they convened again to meet. 'In a deliberately provocative intervention to the emerging health-and-arts field, this seminar engaged social theoretical resources in order to help elaborate how researchers and

³⁷ The melancholic echo is borrowed from the following text 'a politically engaged art practice that contents itself solely with refusal and dissent ... is blind to the very ontological force that exists prior to that which it seeks to negate. Such critiques, although important as an entry point, can become caught in what we might call a melancholic echo chamber of negative critique. They remain reactive rather than creative. We might say that this latter attitude is to do with a certain style of thought; for those who think resistance as secondary (in a sense produced by a repressive state), then political art practice will always be reactive and involved in negative critique and in fact determined by that which it critiques. In this place political art practice will be involved in a continuous struggle against the 'ideological veils' of the state. If on the other hand one sees resistance as primary, and the state apparatus as secondary (as capturing this 'life'), then one becomes involved in affirming this ontologically prior moment. This is the move from critique to creativity, or in fact the location of critique from within creativity' O'Sullivan (2007, p.77).

³⁸ For example, see the Health Care Analysis special edition 2009 arising from the Creativity in Health and Care workshop programme. This work originated in response to recent UK Government agendas promoting more creative working practices within the sector and arising in the 'context of a general interest in creativity within contemporary culture' (Brodzinski & Munt 2009, p.278). See also (Allen & Brodzinski 2009) and the special edition of Reflective Practice (Kinsella & Vanstone 2010).

³⁹ The Journal Perspectives in Public Health published a special edition in Spring 2013 (Cliff 2013).

practitioners might experiment epistemologically in ways that encourage a movement 'beyond scientism' and recycled debates about evidence'.⁴⁰ This is a new departure for academic researchers who have been labouring under the weight of producing evidence of clinical health benefits. Instead themes under consideration included;

1. 'Rights to experiment': understanding arts impacts through ideas of justice rather than collection of evidence;
2. 'Working at boundaries of evidence': the role of phenomenologies of artistic practice and sensings of the arts;
3. 'Epistemologies and artistic cultures': questioning what happens as ways of thinking merge with artistic practice.

It is too early yet to say whether this will amount to an affective turn in arts and health research, yet it does indicate a cohort of researchers who are looking for a different set of theoretical references with which to consider practices.

Another dissenting position appears in the UK Arts and Humanities Research Council (AHRC) Cultural Value project in a strand of research led by Dr Samuel Ladkin called *Against Cultural Value*. Although the title might seem counter-intuitive, the project intends to describe and defend the value of the arts from a predatory audit culture. Ladkin makes the case that;

value judgments can behave insidiously, and incorporate aesthetic, ethical or ideological values fundamentally opposed to the "value" they purportedly name and describe. It argues that even the most ostensibly virtuous of values can become oppressive when disseminated bureaucratically, and as a set of official renderings or statements of artistic accounts (Ladkin 2014 unpaginated)

The project will lead to publication of an edited collection of essays dealing with the following themes. Against Value as;

1. a pragmatic recognition of the harm the auditing of value can cause

⁴⁰ See www.artsandhealthresearch.ac.uk for archived documentation of themed meetings.

2. a critique of the ideology of value,
3. as the critical function of art;
4. as being irrecuperably against value.

This project anticipates a re-indexing of critical engagement with the arts away from the slew of research and reports on cultural value. The most recent manifestation of which is Arts Council England's *The Value of Arts and Culture to People and Society: An Evidence Review* (Mowlah et al. 2014). The report includes a section on health and wellbeing. It links health outcomes to cultural participation and uses the income compensation approach to assess gains in subjective wellbeing, so for example £2,000 is the value placed on being an audience member, while £1,500 is the value placed on participating in the arts. It also deploys systematic reviews to establish that engagement in structured arts and culture leads to improved cognitive ability in children and young people. Such reports will be discussed further in section 3.2. For now I wish to register the academic interest in this area of practice and the divergent approaches taken to its study.



Figure 5 Sheelagh Broderick *Indexical Transfigurations* (2011)

Such interest became palpable in *Indexical Transfigurations* (Broderick 2011c) a temporary installation at the Centre for Humanities and Health, Kings College, London, Medical Humanities conference *Irish Eyes: Vision in Irish Culture*. Following collaboration between the Physics Dept at DIT, a series of holograms were displayed at the Royal College of Ophthalmology as part of a repertoire of everyday drawing room objects and in the context of the adjacent the library of artifacts and instruments associated with medical history. Academics and artists assembled to discuss this work in the context of a revisionist exercise critically re-examining the historiography of medicine, literature and the visual arts. These were analytical participants whose task was to unsettle foundational claims. In the subsequent discussion section they lent their support to the direction the research was taking as the academic context revealed itself to be a field in flux.

2.5 INSTITUTIONAL CONTEXT

There is a history of art in hospitals of a monumental, commemorative religious, moral and therapeutic nature dating back to the Renaissance (Hogan 2001; Cork 2012). During the 1980s hospitals were assisted to purchase artworks, primarily paintings, through the Arts Council of Ireland funded Joint Purchase Scheme.⁴¹ Some years later the community and voluntary sector were active in bringing participatory arts to hospital settings signalling a problematic shift from hardware to software, from durable monumental artworks to the medium of soft tissue temporary relationships. The poor visibility of these socially engaged practices has meant that the institutional awareness of art is still understood as being object oriented in nature.⁴² In 1995 the first Arts and Health Conference

⁴¹ The Per Cent for Art Scheme is a significant vehicle for the commissioning of contemporary art, linked with public spending on capital construction projects in Ireland. It has included a number of large scale and budget projects through the Department of Health. The scheme has developed from the commissioning of sculptural and object based work to the development of artist in residence programmes, contemporary art projects / expanded arts practices and longer-term engagements with service users.

⁴² *Health Matters*, is the quarterly national staff magazine of the HSE. It featured cover articles on Per Cent for Art commissioned visual artists Colin Martin, Jackie Nickerson and Michelle O'Donnell in three

was held in Ireland. The conference was jointly organised by Dublin Healthy Cities and the City Arts Centre with the objective of examining 'how the arts can make a significant contribution to promoting good health' (Dublin Healthy Cities, 1995).

In 1998, the Arts Council of Ireland responded to this growing area of activity by instituting a programme of work that included the establishment of a Joint Steering Committee with the former Eastern Health Board. The committee oversaw five pilot arts projects in healthcare settings with the aim of developing, documenting and evaluating them. Their report, *A Picture of Health: A Framework for the Practice of Arts in Health Settings*, was drawn up with the participation of the Eastern Region Health Authority, the three Area Health Boards, the voluntary sector and the Arts Council of Ireland (Eastern Regional Health Authority 2004). The report details projects involved with people with intellectual disability, older people, children, people with physical disability and recovering addicts.

A second conference was held in 2000, '*Creating a Healthier Future*'. The event was organised by Dublin Healthy Cities, Arts Officers from the four Dublin local authorities, the Health Promoting Hospital Network, City Arts Centre, the Arts Council of Ireland and Soilse.⁴³ Building on the momentum generated by this conference, Dublin Healthy Cities employed a researcher to produce a report on the links between the arts and health sectors and the projects active at the time. Over 120 groups were identified (Brenner, 2001). Another report commissioned by the Arts Council of Ireland exhibited a similar magnitude of activity, accounting for 150 arts and health projects in existence in Ireland (O'Cuiv 2001). Many of these projects were operating on an ad hoc basis, being uncoordinated, dependent on the individual artists, arts coordinators and organizations involved. Funding for projects was sourced from a wide range of

consecutive editions Spring 2012/Summer 2012/Spring 2013 - to the neglect of more widely prevalent participatory practices.

⁴³ Soilse is an adult education training and rehabilitation programme.

agencies, including arts, health, community development, anti-poverty agencies and educational institutions, all of whom would have had different programming objectives and funding criteria (Moloney 2007).

In an effort to understand the dynamic of the arts within the healthcare environment, the Arts Council of Ireland reviewed exemplary arts projects and published a practice based *Arts and Health Handbook*. This was a practical guide to support artists and arts coordinators and to ensure that artistic practice was of a high standard. The handbook offered descriptions of case studies and a practical guide to planning, financing, implementing and evaluating an arts and health project from beginning to end (Arts Council of Ireland 2003).

In 2004, the Arts Council of Ireland organised an international *Arts and Health Conference* at Dublin Castle as part of a long-term initiative to encourage a policy based approach to arts and health. In recognition of the complexity of the subject matter and the diversity of perspectives, the conference was thematically broad. Keynote speakers came from the specialist areas of science, arts, health and philosophy. There were many common themes emerging from the conference (Arts Council of Ireland 2004);

1. Arts and health projects were perceived to be undervalued by the health sector because of the prevailing biomedical approach to health and illness.
2. Arts and health projects were perceived to be peripheral by the arts sector by virtue of the fact that they exist outside traditional venues for art display in galleries, theatres and concert halls.
3. There was a need for national coordination based on a partnership approach.
4. There was a need for training, support and mentoring as part of professional training.
5. Support for good practice, documentation and evaluation.

6. Establishment of networks and linking with existing networks on a national and international basis.
7. Policy development to establish mechanisms for strategic development.
8. Review of funding mechanisms.

Notice the double exclusion of practices at 1 and 2 above, based on biomedical dominance and art institutional prejudice (since how and what we validate as art is determined by institutional authority (Bishop 2005, p.105)).

The Arts Council of Ireland subsequently published a background discussion paper (Arts Council of Ireland 2004) and a summary policy paper (Arts Council of Ireland 2005a) followed by *Partnership for the Arts*, a strategy document encompassing policies, goals and actions for the period 2006 to 2010 (Arts Council of Ireland 2005b). These documents outlined initiatives to: establish support services; facilitate networking; establish a forum on architecture, health and the arts; respond to the needs expressed at the 2004 conference; and support a small number of exemplary arts and health initiatives on a sustained basis. Advocacy goals encompassed: implementation of best practice standards; making proposals to health services and medical education providers regarding the value of the arts; and advocating for a higher level of recognition of arts and health as a legitimate area of artistic practice (Arts Council of Ireland 2005b, p.69).

Subsequent to the appointment of an arts and health advisor to the Arts Council, the 2009 *Vital Signs* suite of events included an exhibition, conference and commissioned opinion pieces with a particular focus on Irish arts and health practices (see Appendix 12.3 for a specification of artworks selected by Curator Michelle Brown for the *Vital Signs*

Exhibition).⁴⁴ Following a series of national consultations the Arts Council of Ireland arts and health policy and strategy was published in 2010.

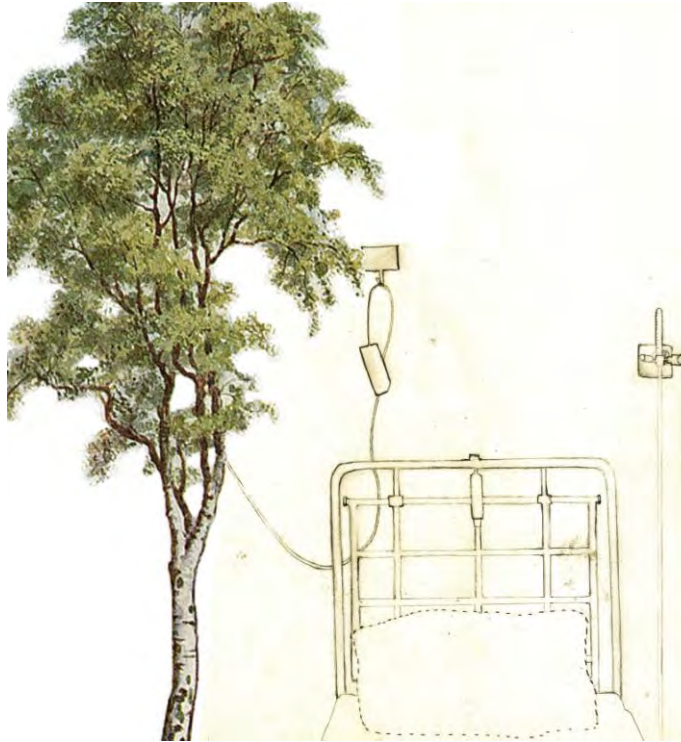


Figure 6 Jenny Moran *Personal Effects: Infection Control* (2010)

One of the projects included in the *Vital Signs* Exhibition was *Personal Effects* (Moran 2010). Artist Jenny Moran worked at Merlin Park Hospital, Galway with the support of a Create Artist in the Community award. She was based on a ward that accommodates men and women who have recently experienced a stroke. The project aimed to de-institutionalise the healthcare context through the illumination of its inhabitants' stories. This was done by slowly gathering fragments of lives from individuals passing through the hospital and allowing these details and narratives to reappear on hospital items, such as pillowcases thereby altering the hospital landscape. These pieces of re-appropriated bed linen also serve as a record of a very particular time for the men and women who contributed towards them. Shaffrey describes these interventions as small interventions in daily life, micro solutions to the problems of existence (Shaffrey 2009).

⁴⁴ Vital Signs was a programme of arts and health events that took place in Dublin in October 2009. It included a conference, a national exhibition in five venues in Dublin and a series of opinion pieces about arts and health practice. Vital Signs was an Arts Council initiative, developed and delivered in association with Create, the national development agency for collaborative art.

In parallel, the HSE was taking steps to resource arts coordinators (primarily in hospitals) and fund projects and artist in residence schemes supported through a variety of budgets (e.g. community work, health promotion, per cent for art scheme and development funds). These projects have largely been delivered on the basis of local innovation. The HSE does not have a national policy for arts and health; rather it links locally with partner organisations such as local authority arts officers, Vocational Education Committees (VEC), Age & Opportunity, and the Arts Council of Ireland.⁴⁵ As of 2011, four regional contacts for arts and health projects have been identified within the HSE East, South, North and West. Notwithstanding the deficit of a specific arts and health policy, there are many HSE strategy documents in which there is an acknowledgement of the contribution of broad based health determinants in maintaining and improving quality of life and wellbeing (Department of Health and Children 2001; Eastern Regional Health Authority 2004; Department of Health and Children 2000). These policy documents indicate that patient care involves more than medical intervention and flags the intention to move away from a medical model of care to a social model of care.

This shift is evident in the type and quantity of health services provided going from cure to care. The development of treatments, which have reduced mortality due to infectious and communicable diseases has meant that health services are no longer pre-dominantly providing interventions to acute episodes and infectious diseases, rather they concern the provision of services for people with chronic and degenerative illnesses. Prolonged longevity as a result of improved medical interventions and increased affluence has also shifted the balance of service delivery. In 2005, healthcare constituted 8.2% of GDP in Ireland. An indication of the changing orientation of health services from cure to care can be perceived from health budgets. In 2008 overall HSE spending was €14.7 billion, of which €5.2 billion went to the National Hospitals Office, but a greater proportion of spending was dedicated to

⁴⁵ Age & Opportunity organises *Bealtaine* the month long festival celebrating creativity in older people

Primary, Community and Continuing Care Services with a budget of €8.9 billion (Burke 2009, p.267).⁴⁶ Much of this budget is normally considered as a social spend e.g. €1.8 billion on care for older people, €0.69 billion children and family services, €1.6 billion disability services, €1.1 billion mental health services.⁴⁷ These are the contexts in which artists work and as such arts practices represent a tiny area of overall activity. Furthermore, the participatory nature of these arts practices in tandem with the confidentiality associated with healthcare contexts has led to poor visibility of practices and as a consequence sparse commentary.⁴⁸

Per cent for art has been a major source of funding for arts projects in healthcare settings and has given a profile to arts projects in healthcare settings at the institutional level through the HSE publication *Health Matters*.⁴⁹ It featured front cover articles on per cent for art commissioned visual artists Colin Martin, Jackie Nickerson, Marie Fallon, Michelle O'Donnell and writer Ellen Gibbons in five consecutive editions Spring 2012/Summer 2012/Autumn 2012/Winter 2012/Spring 2013. Only the publication of a long awaited strategy *Healthy Ireland – A Framework for Improved Health and Well-Being* interrupted this run of front covers. In the Autumn 2013 edition, percent for art was again front cover news featuring

⁴⁶ The HSE has been undergoing a continuous programme of management reconfiguration and as a consequence budget lines. Although the statistics published here are dated, they do indicate the scale of activity within the public healthcare system and the balance between visible hospitals based care and less visible but more prevalent community and social care services. It would be impossible to get data relating to public expenditure on arts projects in healthcare settings as budgets are drawn from diverse sources including Local Authorities, Education & Training Boards (formerly known Vocational Education Committees), Arts Organisations, Voluntary Groups and the HSE. But it is safe to say that spending on art would constitute significantly less than 0.5%, given that in 2013 the total Arts Council of Ireland budget is €59.9 million constituting 0.44% of the total HSE budget of €13.4 billion. A former chief executive of the British Medical Publishing Group actually suggested diverting 0.5% of health budgets to arts activities asserting that as life processes (birth, death, ageing, unhappiness, tiredness, loneliness, perceived corporeal imperfections) are increasingly medicalised then, 'If health is about adaptation, understanding, and acceptance, then the arts may be more potent than anything that medicine has to offer' (Smith 2002)

⁴⁷ Health services are huge industry, progressively becoming privatised under the guise of offering consumer choice. Ireland in particular suffers from structural inequality in the provision of care that has been characterized as a system of apartheid (Burke 2009). As chronic and degenerative diseases have replaced infectious disease, life expectancy has increased. Increasing emphasis is being placed on prolonging active life expectancy, the actuarial calculation of the number of years a fit person of a specified age can expect to enjoy before suffering disability. From a health services perspective this is about maintaining individual independence, for the individual it is more about autonomy, especially because as one ages, health gains are likely to be proportionately greater from improvements in quality, rather than length, of survival (Evans 1993). See also (Fox 2005) for a discussion of autonomy, amongst other factors, across cultures of aging.

⁴⁸ Claire Bishop has remarked that the paradox of participatory art is that the more participatory an artwork is the more it forecloses spectatorship and the less open it is to future audiences, (*Exhibitions of Contemporary Art in the 1990s*, Art and the Social, TATE Britain 30th April 2010).

⁴⁹ *Health Matters* was the quarterly national staff magazine of the HSE until budget cuts saw its withdrawal at the end of 2013.

the work of Ceramicist Diane McCormick followed in Winter 2013 by the work of Martina Galvin. This focus on per cent for art neglects more widely prevalent participatory practices, although the two are not mutually exclusive as for example in the work in the work of visual artists Cleary and Connolly.

Ballymun Sequence (Cleary & Connolly 2007) ⁵⁰, was commissioned from per cent for art funds allocated through the capital spend on a HSE primary healthcare centre in Ballymun, Dublin. This 11-minute video is the result of a participatory art project that took place from June 2006 to June 2007. *Ballymun Sequence* was conceived as a 'temporal mural'. The artists wanted to make a work that would go beyond the specifics of the place and look at more universal questions - movement essentially - as a metaphor for life and growth. The images were abstracted from documentation amassed, when working with locals who visited the healthcare centre, using custom designed software to transform the fragments of life into fragments of moving as painting. Cleary and Connolly took their inspiration from the tradition of social mural painting in the early 20th century. Just as Diego Riviera and Roal Dufys' murals showed people in the context of cultural or political symbols Cleary and Connolly chose to place images of people side by side with the new fabric of the city as it was being created in the form of a primary healthcare centre as part of an urban regeneration project - in the lived spaces created through institutional interventions what kind of movement is possible?.

⁵⁰ www.connolly-cleary.com

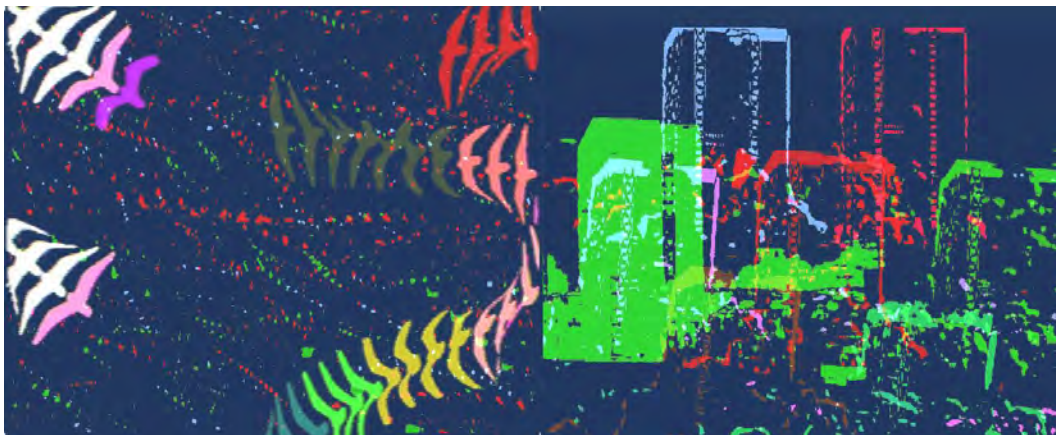


Figure 7 Cleary & Connolly Ballymun Sequence (2007)

Local Authorities have been active in supporting the implementation of arts and health projects through the backing of Local Authority Arts Officers. They have been a resource for research and strategy (Moloney 2007) and partnering in innovative projects (Russell 2007).⁵¹ They have shown financial commitment to the field, allocating resources through artist in residence schemes based in healthcare settings and through the appointment of support staff. In 2007, Kildare County Council appointed an Arts in Health Specialist to develop and deliver a programme of arts and health projects and to provide support for artists and agencies involved in arts and health practice.⁵² Clare County Council has established a mentor service to provide support to arts and health practitioners.

⁵¹ Typically projects involve a number of partners, e.g. *Burning Bright* is a partnership project between Galway County Council Arts Office, Galway Arts Centre, and Age Action West. *Between Colours* was initiated by Mayo County Council, in partnership with Age & Opportunity and supported by the Arts Council and the HSE Western Region.

⁵² Post currently vacant due to Public Service Recruitment embargo

Institutional Partnerships have led to the establishment of diverse cross section of organisations and initiatives:

- WHAT Centre for Arts and Health at Waterford Healing Arts Trust funded by HSE / Arts Council of Ireland
- Helium, an arts and health company for children, supported by the Arts Council of Ireland / HSE / Sligo County Council / Social Entrepreneurs Ireland
- Cork 2005 European Capital of Culture (Culture + Health Strand) in association with (CA+HP) funded by HSE / Arts Council of Ireland / Local Authorities
- Music in Healthcare, in association with Music Network funded by HSE / Arts Council
- Blue Drum, a national resource organisation providing arts support services to the community development sector funded by the Family Support Agency through the Department of Social Protection
- Arts and Health Coordinators Ireland (AHCI), an all-Ireland support network of professionals who are responsible for managing Arts and Health initiatives funded through institutional host organisations.
- Professional development course for arts and health practitioners Create / Institute of Art, Design and Technology / Adelaide and Meath Hospital, incorporating the National Children's Hospital (AMNCH) and funded by the Arts Council of Ireland.
- *Dialogue Arts + Health* was a regionally based professional development project for artists and practitioners working in arts and health settings. The project was developed by the Arts + Health Coordinators Ireland (AHCI) in partnership with the Association of Local Authority Arts Officers (ALA:AO). The Arts Council of Ireland funded it through a one-off Projects Award.⁵³

⁵³ *Dialogue Arts + Health* could not have taken place without the considerable contributions including support in kind that it received from a number of project partners, as well as the key funders listed in the text. These included: South Dublin County Council; the National Centre for Arts and Health, Adelaide and Meath Hospital, incorporating the National Children's Hospital (AMNCH); Create; Waterford Healing Arts Trust; Helium - Children's Arts and Health; West Cork Arts Centre; Galway

- artsandhealth.ie is a national arts and health website developed by the Waterford Healing Arts Trust (WHAT) and Create, the national development agency for collaborative arts in social and community contexts. The development phase of the website was funded by the Arts Council of Ireland.
- National Centre for Arts & Health (Adelaide & Meath Hospital Dublin, Incorporating the National Children's Hospital)

These networks, initiatives and projects are cited here to give a sense of the degree to which the broad practice of arts and health has become an established part of the Irish institutional landscape.⁵⁴

2.6 RECAPITULATION

This chapter has situated the research inquiry in terms of a field of practice, operating within institutional contexts. It addresses itself to healthcare professionals in their role as arts and health practitioners specifying the kind of arts practices under consideration in recognition of the broad and disputed field of arts practice. It locates the research project as having a particular contingency associated with its emergence during a period when institutional positions were being adopted. Boundaries to research are established in relation to adjacent practices of arts therapy, recreational arts and other cross platform participatory arts contexts (albeit with a caveat referring to the permeability of these boundaries). It proposes to anchor the inquiry in its designation of healthcare settings as heterotopic spaces and its figuration of associated discursive sites in academic scholarship, introducing knowledge conflicts concerning validation of practices. A specific characterisation of the Irish institutional context is presented to indicate the embedded nature of practices in the Irish institutional landscape.

University Hospitals Arts Trust; HSE Cork Arts + Health Programme; the Arts Initiative in Mental Health and St. Patrick's University Hospital, Dublin. Regional partners, included: Cavan County Council; Cavan County Museum; Galway County Council; Limerick City Council; Offaly County Council, The Midlands Regional Hospital at Tullamore and RUA RED, Tallaght.

⁵⁴ This is not a representative survey. It is a purposive sample based on the fieldwork research.

The next chapter presents diverse literatures to emphasize the transdisciplinary nature of this inquiry and presents particular texts of relevance in shaping it.

3 LITERATURES

This chapter positions this thesis as a transdisciplinary inquiry straddling a number of source literatures that are historically and socially embedded. My intention is to recontextualise these texts in the terms of how they relate to this research on arts practices in healthcare settings. The chapter is divided in 4 sections concerning:

1. The social turn in arts practices and attendant critiques
2. The dominance of evidence-based research
3. Alternate narratives for healthcare practice ⁵⁵
4. Disputes arising from the academic disciplining of artistic research

Throughout conflict will emerge concerning knowledge practices as they are enmeshed in the logic of logocentrism in which claims to authority to speak the truth originate in an external point of reference, as an unmediated knowledge of the world, rather than as an effect of power constituted in language (see section 5.1).

3.1 THE SOCIAL TURN

The arts literature is largely concerned with participatory practices and what is termed the social turn in arts practice (Beech 2008; 2010; Bishop 2004; 2006; 2012; Bourriaud 2002; Kester 2004; 2006; 2013). Arts practices in healthcare settings can take many forms as already discussed (in section 2.1), however the predominant approach adopted is one of participatory arts practice (Arts Council of Ireland 2003, p.113). In an opinion piece commissioned for the 2004 Arts and Health suite of events, *Vital Signs*, Shaffrey (2009) notes the emphasis placed on the social dimension of participation and collaboration in contemporary arts practice that has proliferated since the 1990s, but which is also part of a longer historical

⁵⁵ This thesis restricts itself to dominant institutionally based discourses concerning health primarily. It does not engage with complementary approaches to health and medicine.

trajectory, finding its roots in historical and neo-avant-garde movements that set out to reconnect art and life. These practices have been conceptualised in a number of different ways in the work of Bourriaud on relational aesthetics, Kester on dialogical aesthetics and Bishop, who has contributed critical texts on both these approaches to participatory practice.⁵⁶ Bourriaud - reflecting on the changing arts practices of the 1990s - proposes that artworks are judged based on the inter-human relations they represent, produce or prompt (Bourriaud 2002, p.112). Reflecting on these ideas, Bishop challenges the significance of the relations formed in the process (Bishop 2004, p.65); Kester proposes a dialogical aesthetics, a performative process based approach in which artists become context providers not content providers (Kester 2004, p.3).

In relational art the audience is envisaged as a potential community. Art is no longer just an encounter between a viewer and an object: rather, relational art produces intersubjective encounters.⁵⁷ Through these encounters meaning is elaborated collectively, rather than in the space of individual consumption. The success or failure of relational art depends on its ability to foster relations among its participants. In writing about relational aesthetics, Bourriaud confines himself to the work of 'star performers in gallery settings' (Bishop 2004, p.55), however his reading of the social turn could be applied to arts practices in healthcare settings in the way emphasis is placed on conviviality. The work of Laura Fitzgerald during her residency at Waterford Healing Arts Trust had such conviviality at its core. *Once Upon A Time* (2009) is based on the idea of a collective gathering of memories from staff and patients of Waterford Regional

⁵⁶ The authors discussed are those most commonly referenced, but other views are relevant such as Kwon who has suggested that the notion of the artist, 'as an overspecialized aesthetic object maker has been anachronistic for a long time already. What they *provide* now, rather than *produce*, are aesthetic, often "critical-artistic", services' (Kwon 2002, p.50 italics in orig.). Fraser (1993) abandons the idea that an artist produces objects, in favour of an artist as social provider suggesting we understand, 'art making as a kind of social practice, as a social activity as opposed to strictly a kind of specialized activity that is about producing a particular kind of object' and that we understand 'art as a form of counter practice within the field of cultural production' (1993 unpaginated).

⁵⁷ In describing his conceptualisation of relational aesthetics, Bourriaud is careful to contextualise the practice in a historical context. He eschews conceptions of artistic artistry as an 'immutable essence', rather he views it as 'a game whose forms, patterns and functions develop according to periods and social contexts' (Bourriaud 2002, p.11). Relational art reflects the concerns unique to this period of time and may be described as 'a set of practices, which take as their theoretical and practical point of departure, the whole of human relations and their social context, rather than an independent and private space' (Bourriaud 2002, p.113)

Hospital. Fitzgerald located herself in various parts of the hospital and asked staff, patients and visitors to spare ten minutes of their time to relate a vivid memory from their lives. Fitzgerald drew this memory while they spoke. Part of her work as an artist involved consulting, negotiating and communicating with many departments leading her to observe; 'One of the interesting aspects of a hospital environment is that although it is one community, it is in fact on closer examination, sub-divided into smaller communities. Each has its own distinct culture' (Fitzgerald 2009 unappiginated). She installed a cardboard Memory House in the hospital foyer and invited people to visit, establishing, as she saw it, yet another sub-community.



Figure 8 Laura Fitzgerald *Once Upon A Time* (2009)

Responding to Bourriaud, Bishop challenges, 'if relational art produces human relations, the next logical question to ask is what types of relations are produced, for whom and why?' (Bishop 2004, p.65). She asserts that there is no reason to expect that relations established through these arts practices will be intrinsically democratic, and that socially engaged art

has fallen prey to limited critical examination. The discourse, she argues, has focused mainly on the artist's process and intentions, or the projects socially ameliorative effects, to the neglect of the work's aesthetic impact. The ameliorating tendency to be found in relational aesthetics leads to criticisms of it as a social salve. Without radical roots or vision, it is congenial to both government and business as an exercise in maintaining the social glue. Bishop challenges the conviviality of socially engaged practices as the imposed consensus of an authoritarian order and instead seeks an agonistic discourse in which 'relations of conflict are sustained not erased' (Bishop 2004, p.86).⁵⁸

In contrast to canonical texts referring to identity politics, Bishop claims that 'the project' becomes the descriptor for the kind of artistic practices that engage with the social after the 1990s. It is an umbrella term for describing the expanded field of post-studio arts practice in relation to society through various modes, through elective practice, self-organised activities, documentaries, transdisciplinary research practices, participatory and socially engaged art. This orientation is characterised by 'the artist ... as collaborator and producer of situations; the work of art as an ongoing project ... while the audience ... is now repositioned as a co-producer or participant' (Bishop 2012, p.2). She notes that the paradox of participatory art in general is that the more participatory the artwork, the more it forecloses spectatorship and the less open it is to future audiences. This is a particular challenge for arts practices that take place in healthcare settings, as in addition to the process-oriented nature of practice, projects usually take place in contexts far from public gaze. Bishop favours the use of the term *participatory practice* to denote the way in which 'people constitute the central artistic medium and material' (Bishop 2012, p.2). Bishop proposes that a tension be sustained between the artistic and the social putting each other in question, otherwise reconciliation will inevitably lead to appropriation.⁵⁹ An example of this tension is to be found within the practices themselves as artists become freelance, mobile and affective project workers within a deregulated

⁵⁸ See also (McIntyre 2007)

⁵⁹ See also (Martin 2007).

labour market (see section 5.5.2).

Condé and Beveridge have produced a series of artworks based on participatory work with healthcare staff, *Not a Care: A Short History of Health Care* (1999), *Theatre of Operations* (2000) and *Ill Wind* (2001). *Not A Care*, originated in workshops held with healthcare staff during a period of crisis in the Canadian healthcare system and from which it became apparent that there had been a fundamental shift in attitudes about caring. Twelve images are presented as a history of healthcare from early history to the present, looking at who received what type of care and who provided the care and framed within the dream of socialised medicine. *Theatre of Operations* is made up of eleven portraits of healthcare workers from diverse roles. Each portrait includes a comment from the worker about their working conditions and a is staged against a background illustrating a key message about healthcare in the U.S. e.g.; '44 million people in the U.S. have no health insurance'. The images were originally developed for display on the interior and exterior of transit buses. In the case of *Ill Wind*, six images are developed based on a series of visual workshops held with healthcare workers in Ontario and enacted in the final photographs. The images depict the concerns workers have about the care given their patients, expressing their anger and frustration at not being in a position to provide the care their patients need.

McGonagle (2009) reflects on the social turn in arts practice in an analysis of the work of Canadian artists, Condé and Beveridge. He foregrounds their work as an exemplar of the reconfiguration of arts practices, being both participatory and collaborative, and, reconnecting aesthetic values and ethical responsibilities to lived experience, 'These are artists who engage in social processes and see no contradiction in their practice being validated as art' (2009, p. 35). He avers that the social turn requires a reconsideration of arts practices in relation to a repositioned understanding of art and its functions in the human project over the longer term. It differs radically from conventional understandings of arts practices in which the validation of artworks is mediated through the



Figure 9 Conde & Beveridge *Not a Care: A Short History of Health Care* (1999)



Figure 10 Conde & Beveridge *Theatre of Operations* (2000)



Figure 11 Conde & Beveridge *Ill Wind* (2001)

market, the academy or peer recognition. Much of this work is process led with a lesser emphasis on specific material outputs. As a result, they are not easily validated in an environment where merit is primarily accorded to artworks that have commercial value. Condé and Beveridge have succeeded in securing validation for their work by positioning it within the distribution zone where validation is conferred and using dissemination beyond that of the exhibition (Kester 2011).⁶⁰

Commenting on Bishop's claims, Kester (2006) charges that she polarizes practices, rather than viewing them as part of a continuum. He considers that her analysis (in which she dismisses activist art) seeks to privilege the acute critic in decoding artworks. According to Kester's reading of Bishop, the critic is preferred to the viewer, because Bishop intimates that the viewer cannot be trusted. Furthermore he exposes the limits of art criticism while for object or event based art, the work of art, has a clearly bounded beginning and end, separating the moment of production and reception, in dialogical art practices production and reception are concurrent, and reception itself re-imbricated as a mode of production. Kester advocates for new research methodologies 'in which the critic inhabits the site of practice for an extended period of time, paying special attention to the discursive, haptic and social conditions of space, and the temporal rhythms of the processes that unfold there' (Kester 2013).⁶¹ He poses a different view of aesthetic experience suggesting that it can challenge conventional perceptions and systems of knowledge by locating outside the institutional confines of the gallery or museum and separate from a tradition of object making to carve out a new identity in the facilitation of dialogue among diverse communities. Kester proposes the idea of collaborative labour that is not intended as spectacle, but rather is experiential in nature and characterised by proximity and sociability, a

⁶⁰ See also www.condebeveridge.ca

⁶¹ Kester frequently uses the word haptic to describe immersive, somatic art experiences. It is deployed to refer to bodily, physical knowledge embracing all kinds of other orders of experiences that simply cannot be understood as being purely visual.

practice that he suggests contemporary theory is unable to address (Kester 2011).⁶²

For example, *The Green Room Project* (Keena 2006) was a ten-month collaboration, carried out in the basement of The Rotunda Hospital, Dublin. The artist worked with a group of mothers, who had all experienced bereavement at childbirth within the past months, year(s) and decade(s). The work they created arose out of and was informed by a process in which together they looked at, returned to, looked away from, and tried to look again, iteratively, at the experience of profound separation and loss in all its aspects and circumstances.⁶³ This work was constituted by drawing, writing, stitching, talking, of listening and silence (Keena 2006).



Figure 12 Pauline Keena *The Named Body* (2008)

The women kept journals during the project, one journal entry reproduced in the catalogue told of a mother's visit to the registrar's office to get a

⁶² Kester claims collective and socially engaged practices pose a challenge for contemporary critics informed by the post structural cannon as the risk of compromise undermines aesthetic autonomy (Kester 2011, pp.58–59).

⁶³ The artist Pauline Keena is also a trained midwife and neo-natal intensive care nurse see paulinekeena.net for further information.

birth certificate for her stillborn child. Having failed to find the registration, the clerical officer turned to the woman and said 'are you sure you had a baby?' In such moments the line between reason and madness are exposed, the madness of a reasoning bureaucracy that can only countenance its own truth. If the record of birth did not exist, then a baby could not have been born. As the woman herself reasoned afterwards, 'maybe I am a mad women, I was pregnant, but have no baby, that's mad isn't it?' (Keena 2006, p.21). Such experiences can be relayed through the artwork *The Named Body* (2008) – but cannot ever fully encompass the haptic experience of the exchange between project participant and the clerical officer made possible through the context of *The Green Room Project*.

Searing criticism is heaped on Bishop by Liam Gillick (2006), whom she had discussed as a paradigmatic example of a relational artist. Gillick claimed that not only was her analysis lacking in rigour, but that it was also substantially inaccurate. Gillick's expressed interest is in institutional engagement. He says;

Things get truly interesting when art goes beyond a reflection of the rejected choices of the dominant culture and attempts to address the actual processes that shape our contemporary environment' (ibid. 2006, p.100),

His approach is described dismissively by Bishop as 'the middle ground, the compromise' for its failure to assert an antagonistic relation. Gillick declares that while Bishop asks for a more explicit exposure of artist relationships to the dominant social framework, this displays a naivety on her part. As an academic working within the security of the university intelligentsia he suggests that she merely represents rather than realises a critical position, whereas those artists with a colonial heritage have learned to be 'shape-shifters in relation to the dominant culture in order to retain, rather than merely represent the notion of a critical position' (Gillick 2006, p.106). Evidently for Gillick, Bishop is not herself devoid of the

sanctimoniousness that she discerns in discourses concerning participatory practice.⁶⁴

More criticism is piled on Bourriaud, Kester and Bishop in a polemic in which it is claimed that the participatory project is doomed by virtue of its inherent contradiction, the price of participation is the neutralisation of difference and the diminution of the power of subversion (Beech 2008).⁶⁵ In a later analysis, Beech (2010) taking a different approach looks at what Bourriaud, Bishop and Kester have in common. He groups them together in the shared context of the art of encounter, in a post-Cartesian art that has decentred the artist, the art object and the viewer requiring a rethinking of social relations at large, rather than just those found in relation to artworks. He points to the inadequacy of contemporary art, with its incomplete map of narrow possibilities, to attend to interactivity, participation, collaboration and so forth. He exclaims not only do we need a better map, 'we need to change the landscape that is being mapped' (2010, p.28). When art opens up to life, to participants rather than viewers, then a theory of the encounter with art must include a theory of the social. As we will see the exchanges between Bishop and Kester have led them to re-evaluate the limits of criticism (see section 8.3). However, as Beech asserts without an equivalent re-evaluation of their ontological orientation, their map will remain limited, their landscape unchanged.

O'Sullivan (2007) drawing on a Deleuzo-Guattarian lineage, establishes the art of encounter as a challenge. However, rather than engage with the disputes already outlined above in this section, O'Sullivan claims that foregrounding dissent in contemporary arts practice neglects the probability of it being caught up in the same terrain as that which it seeks to oppose, being nothing more than an acceptance of the status quo

⁶⁴ Bishop has previously described ethical themes in discourse as a re-inscription of Christian morality idealising themes of self sacrifice (Roche 2006).

⁶⁵ Furthermore Martin (2007) charges that the relational art practices extend the commodification of art by incorporating social events and exchanges into the field of art's commodities and questions whether relational art's form can resist the value form.

(O'Sullivan 2010a). Pondering the problem of disentanglement from negative critique he remarks,

I do not want what I write to be *predetermined* by the terms, or rather, the 'rules' I attack (the 'rules of engagement'). I do not want to be *precomprehended* by a system which is put in place through the very act of writing against it (O'Sullivan 2000, p.104, italics in orig.).

According to O'Sullivan this calls for two strategies; one of dissent (a strategic withdrawal as a form of engagement, or a strategic engagement itself), and one of creativity (the production of new forms). He articulates a different approach suggesting 'a kind of super-conviviality that is to do with productive joyful encounters' (O'Sullivan 2010a, p.52).⁶⁶ Choosing affirmation over negation establishes an ethical principal for the aesthetics of affect. O'Sullivan establishes a conceptual frame for participatory practices that speaks to the way in which artists can strategically engage by choosing healthcare settings as a site of practice. Furthermore he establishes the possibility not only of making new relations and but also the possibility of thinking about how these new relations might be made as an aesthetics of affect. He brings new language to speak of extant arts practices. This language differs from the conceptual frame that is typically associated with evaluations in terms of evidence-based impacts. In the next section I will explore approaches to impact studies associated with evaluations of participatory arts practices that neglect the kinds of concerns named above in favour of more instrumental intentions.

3.2 EVIDENCE BASED STUDIES

In this section I briefly refer to the large literature on evidence-based studies. I then problematise the idea of evidence-based research which

⁶⁶ O'Sullivan cautions that this not to conflate joy with a liberal ideology of consensus. Rather following Spinoza, it is to choose affirmation over negation. He finds in the affirmative a possibility for productive violence, rather like the violence of a storm or volcano in which frozen energy is released to create new worlds (O'Sullivan 2000, p.104).

has emerged from literature concerned with the social study of health and medicine.⁶⁷

Alongside the critical texts discussed in the previous section there is a raft of literature on the perceived impacts of participatory arts projects. These range from texts attributing health benefits to practices (Matarasso 1997; Macnaughton et al. 2005; Lewis & Doyle 2008; Rosenberg 2008; Staricoff 2004; White 2008) to commentary claiming instrumentalisation of practices (Baum 2001; Mirza 2006; Putland 2008; Rossiter 2010) as well as a more philosophical approach that foregrounds the historicity of simplistic characterisations of positive beneficial and negative corrupting influences of the arts rather than a more 'nuanced understanding of how the arts can affect people' and have done so throughout recorded history (Belfiore & Bennett 2008; Belfiore 2009). In tracing a history of ideas concerning art they reveal that there is nothing new about narratives characterised as 'the transforming power of the arts', 'art for art's sake' and 'the arts are good for you'. They claim instead that it is merely another rehearsal of ideas dating back to Aristotle and Plato (Belfiore & Bennett 2008).

The primary mode of evaluation of arts practices in healthcare settings has been to borrow from healthcare research practices in the form of evidence based practice (Dileo & Bradt 2009; Roche et al. 2008). In the domain of health, evidence based medicine (EBM) has become the dominant mode of validating knowledge. EBM is characterised by its reliance on secondary sources. A hierarchy of evidence is deployed to rank the verifiability of research design. Yet these practices do not reflect the concerns of the artists delivering projects. Shaffrey comments on the curation of the *Vital Signs* exhibition as:

an opportunity to focus on both the artistic drives behind the artists' work as well as its potential value or usefulness. This usefulness, which may or may not have a practical function, is not founded in the application of art as therapy, but rather in the more elusive spaces of dialogue, empathy, sharing and

⁶⁷ A more detailed treatment of evidence-based impacts can be found in section 12.1 and 12.4. Supplementary texts can be found on the website www.sheelaghmagig.net/artsandhealth.

listening, in the transformative power of the imagination, in finding missing language and in the silences that matter too (Shaffrey 2009, p.22).

Despite these assertions, and the work of a few researchers who highlight the incongruity with developing an evidence-base for non-clinical arts and health practice (Baum 2001; Broderick 2011a; Raw et al. 2011; Rossiter 2010), there is an overwhelming attempt to attribute health benefits to the arts, using diverse methods and toolkits despite internal and external critics (see section 12.4). Critics of evidence-based practice identify EBM as:

an indeterminate and malleable range of techniques and practices characterised not by particular kinds of methodological rigour, but by the pursuit of a new approach to medical knowledge and authority (Lambert 2006, p.2633).

Evidence is a concept that can fall into many categories; judicial evidence to establish a burden of proof, experimental evidence to verify or falsify hypotheses and statistical evidence to establish patterns (Csordas 2004, p.474). It exists in relation to questions originating from a particular context and which are as a consequence already guided by inference. In the domain of healthcare, the specific context is largely one of cure or care. Therefore it is unsurprising that the questions originating within this specific domain concern cure or care and in the case of arts practices are often formulated to consider 'the healing power of the arts'. As a consequence of the dominance of evidence-based approaches to medicine (EBM) and in tandem with a misunderstanding of the differences between arts therapies, arts recreation services and contemporary arts practices, the question of evidence has become a pressing one in relation to arts practices in healthcare settings.

The purpose of Evidence Based Medicine (EBM) is to identify safe, replicable and cost-effective interventions that can provide positive clinical outcomes to a target population. Policy makers and practitioners often see EBM as a 'gift horse' in the way that it combines science and managerial practices (Lambert et al. 2006). EBM purports to offer a transparent evaluative process. It offers the promise of objective measures to distinguish between effective interventions on the basis of resource

allocation. It is easily deployed by decision makers who act on the basis of its 'independent' advice. It has become the dominant mode of validating knowledge in healthcare, providing a ranking schema for deciding which studies warrant greater recognition by deploying a hierarchy of evidence. Systematic reviews and randomised control trials rank highest while expert opinion is ranked lowest.

But EBM has also been seen as a 'Trojan horse' as it obscures the subjective elements that inescapably enter all forms of human inquiry (Goldenberg 2006). The seemingly self-evident common sense of EBM occurs because it is assumed that contaminating factors such as social context have been statistically removed. The pervasive view that evidence-based practices stand or fall in the light of 'evidence' is based on outdated understanding of evidence as 'facts', through the scientific elimination of culture, contexts, and the subjects of knowledge production. Even advocates for EBM have expressed concern that a critical appraisal of studies can reveal a lack of rigour and tendency to bias (Florczak 2011; Ioannidis 2005). This blind belief in method 'permits the use of evidence as a political instrument where 'power interests can be obscured by seemingly neutral technical resolve' (Goldenberg 2006, p.2622).

Notwithstanding these critiques, the question whether arts interventions should be subjected to clinical trials depends largely on what kind of arts intervention is at stake. The clinical evaluation of arts therapies is logically consistent as they are conceived of as clinical interventions, but clinical evaluation of contemporary arts practices is to misunderstand them. Expectations of positive clinical outcomes, places an intolerable burden on artists who are not clinically trained and imposes an unreasonable doubt on contemporary arts practices (Broderick 2011a). These arts practices are concerned with issues such as power and knowledge, spectatorship and participation, institutional and public spaces, technology and embodiment, through diverse art forms including digital media, sculpture, performance and painting. They are not intended as

clinical interventions and present clinical researchers with substantive and ethical impediments in research design.

Substantive issues relate to the necessity for trials to be replicable and to be constructed so that findings can be generalised to a given population. Arts practices are not replicable. An artist working with a specific cohort of people will not come up with the same outcomes or outputs when working with other groups. Similarly two artists working with the same group will not generate the same outcomes or outputs. Nor will an installation in one setting amount to the same thing when transported to another. Neither do arts practices give rise to generalisable outcomes. Sample sizes are too small to make generalisable claims that will stand up to subsequent scrutiny. In order to generate a statistically reliable outcome, a large sample is required as research findings are less likely to be true when the studies conducted in a field are smaller. Finally ethical issues arise in relation to the imposition of a clinical frame on an arts practice that is not concerned with clinical outcomes.

The artist is concerned with an aesthetic that stands apart from clinical practices. When artists infiltrate healthcare spaces, their practices enter what Gadamer has coined 'the grey zone' - 'those areas which are not fully amenable to techniques of methodological verification' (Gadamer 1996, p.106). Blum has also noted this indeterminacy when he writes of the zone of ambiguity that haunts modern medicine with unspoken assumptions, understandings and equivocations that cannot be completely mastered and made explicit (Blum 2010). The field of art itself operates in this 'grey zone' of indeterminacy refusing to offer a definitive answer to the question 'What is art?', although Aranda et al (2014) concede that art at its best does not provide answers and solutions; it creates problems, troubling accepted narratives.

According to Cohen in an analysis of criticisms of EBM, five critical themes emerge: (1) it has a poor philosophic basis for medicine; (2) the definition of evidence is too narrow; (3) it does not meet its own empirical tests for

efficacy;(4) its utility in individual cases is limited; and (5) it threatens the autonomy of the doctor–patient relationship (Cohen 2004, p.37). A social movement perspective is offered by Pope (2003) who analyses the rise of EBM disclosing power struggles between different factions within the medical profession and beyond. She suggests that resistance to the EBM movement was related to how evidence was specified as rational/technical rather than contingent/experiential. Denny (1999) provides a different reading of the rise of EBM. He suggests that EBM operates as a discourse responding to specific contemporary challenges to medical authority. It can be understood as an attempt to re-establish medical dominance in relation to patients, other health professions and practitioners of complementary therapies. Yet even within medicine there is scepticism about its application to arts practices, 'The notion of evidence based art is as absurd as an impressionist school of science' (Baum 2001, p.306).

Evidence based approaches 'limit ways of knowing, normalizing a narrow range of positivist research conventions and relegating alternatives, including much qualitative inquiry, to the margins' (Mykhalovskiy et al. 2008, p.196).

We like to pretend that our experiments define the truth for us. But that's often not the case. Just because an idea is true doesn't mean it can be proved. And just because an idea can be proved doesn't mean it's true. When the experiments are done, we still have to choose what to believe (Lehrer 2010).

Indeed, Bishop (2012) is troubled by the methodological aspect of the 'social turn' finding positivist social science approaches an inducement to retain 'the constitutively undefinitive reflections on quality that characterise the humanities ... to restore attention to the modes of conceptual and affective complexity generated by socially oriented arts projects' (Bishop 2012, pp.7–8). As we shall see in the following section diverse positions are adopted within health literature that problematise such logocentric strategies in support of 'undefinitive reflections'.

Cradle to Grave (Pharmacopoeia 2003) is an art installation that tells the story of the health and wellbeing of a typical man and woman in Britain.⁶⁸ It draws from primary data sources based on the composite patient records of eight individuals at specific life stages. Each piece contains over 14,000 pills, tablets, lozenges and capsules, the estimated average prescribed to every person in Britain in their lifetime. The drugs are knitted into two lengths of fabric displayed under 13 metres of glass. The installation uses three linked narratives: a pill 'diary', objects and documents, and personal photographs which are displayed in strips across its 2.2 metre width. The photographs, drawn from the albums of friends, family and colleagues of the artists, reflect personal responses to health but also remind us that personal choices are framed at various levels; by the doctor, the healthcare institution, the pharmaceutical industry and social mores which medicalise human behaviours. As such our personal choices are directed by political forces to a greater extent than we acknowledge when making those choices.⁶⁹

⁶⁸ *Cradle to Grave* was developed by artist David Critchley, GP, Dr Liz Lee and textile artist Suzie Freeman.

⁶⁹ *Cradle to Grave* was adapted for the Dutch population, during its 2010 exhibition in *Difference on Display*, Amsterdam.

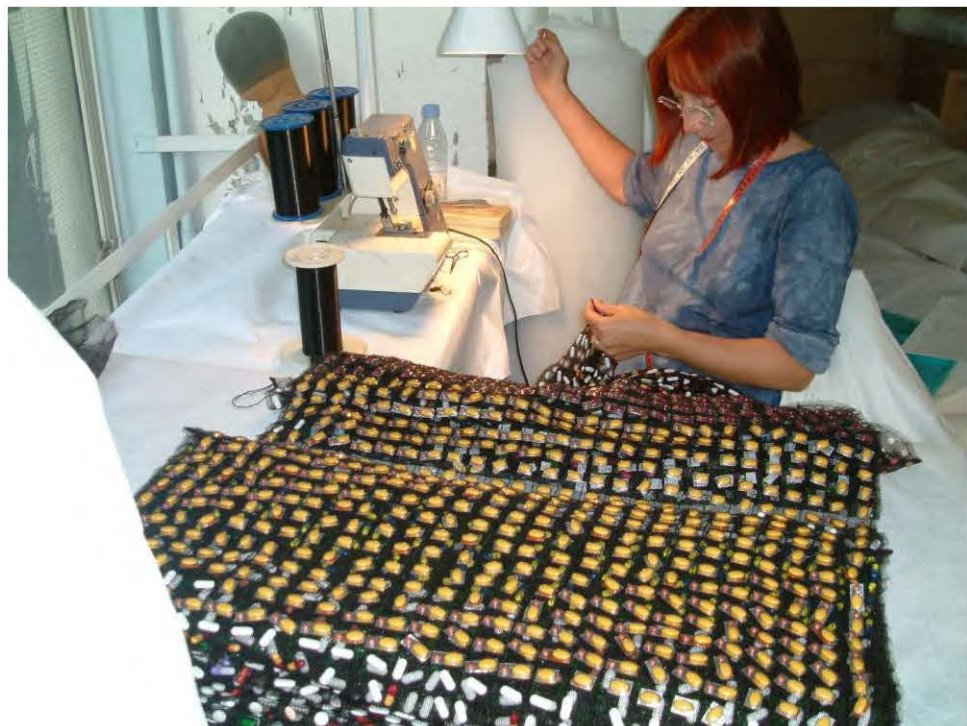


Figure 13 Pharmacopoeia Cradle to Grave (2003)

3.3 HEALTH LITERATURES

In this section I draw from academic literature originating from medical sociology, the sociology of health and illness and the philosophy of health and illness, professional journals on public health and health promotion and reflexive practice. Each discloses a complex and disputed terrain. In particular works discussed at *Critical Perspectives in Public Health* introduced key texts to alternate literatures within health and medicine (see section 11.14).⁷⁰ The work of Svenaeus (2001; 2003; 2009) in his hermeneutic analysis of the medical encounter uncannily resonated with the preoccupations of the arts practice of artist researcher Dr Kaisu Koski (2011) in her explorations of the doctor patient relationship in the artworks *Second Opinion* (2008) and *Listening Gaze* (2008).⁷¹ However, this approach could not offer me leverage in my ambition to look at practices as a collectivity

Critical public health discourses were revelatory in the way they freely explored the embedded nature of health in 'social relations of power and historically inscribed contexts' (Labonte 2005, p.1). They were reflexive in the way they analysed the terms of their own discourse foregrounding the shift from public health to population health as an occlusion of power and situating critical public health as 'a moral praxis built upon explicit social values and analyses' (Labonte et al. 2005, p.5).⁷² For example, Warr et al. (2012) relate how in health promotion practice, health professionals must occupy a paradoxical space whereby they are required to navigate between procedural (top down) and cooperative (bottom up) approaches as the exigencies of demands from health service agencies and health service users apply. Lhussier and Carr (2008) further amplify this position with an analysis that highlights the competing discourses of

⁷⁰ A module of the Masters in Public Health degree at University College Cork.

⁷¹ *Second Opinion* (2008b) DV PAL 16:9, 4'21" and *Listening Gaze* (2008a) DV PAL 16:9 is part of a series about doctor patient interaction. Kaisu Koski graduated from the Faculty of Art and Design in the University of Lapland, and Amsterdam School of the Arts. In 2007 Kaisu earned her doctoral degree with a dissertation on interactive performances and installations in the University of Lapland. Her art practice is intertwined with academic research, focusing currently on the dialogue between art and medicine, and the methodology of arts-based research. Dr Koski currently conducts her postdoctoral research in collaboration with The Arts and Genomics Centre in Leiden University.

⁷² Population is 'devoid of the same political connotation of rights and responsibilities that inhered in the concept of "public"' (Labonte et al. 2005, p.5).

expertise and empowerment, autonomy and independence, necessitating navigation between different sets of realities at different times and different geographical, cultural and conceptual places. They deploy a post-structuralist narrative that rather than fixing identities recognizes the continuous flow between these positions. (Lhussier & Carr 2008).⁷³ Critical reflection is not limited to impacts on service users but also encompasses the context in which healthcare institutions operate. Hanlon et al, (2012) suggest that the tools of modernity (science and technology) are unsuited to finding solutions to intractable contemporary health problems which are themselves a product of modernity (Hanlon et al. 2012).⁷⁴

O'Hanlon et al (2012) suggest that the ability to examine evidence to establish truth, without recourse to other domains such as morality and aesthetics, is what has made the modern possible through an imperialistic form of science. They make a claim for other currencies of truth to be attended to in a future public health. They point to steps being taken toward an integrative framework in which science, ethics and aesthetics and their emergent forms are postulated in integrated form (Hanlon et al. 2012) ⁷⁵

⁷³ See also (C. B. R. Smith 2012) for a discussion of the way in which harm reduction in discourses of addiction emerged from a grassroots oppositional social movement to become a depoliticised institutional policy.

⁷⁴ This conclusion was previously anticipated in the analyses of Dreyfus and Rabinow (1983) 'Bio-power spread under the banner of making people healthy and protecting them. Where there was resistance, or failure to achieve its stated aims, this was construed as further proof of the need to reinforce and extend the power of experts. A technical matrix was established. By definition there ought to be a way of solving any technical problem. Once this matrix was established, the spread of bio-power was assured, for there was nothing else to appeal to: any other standards could be shown to be abnormal or to present merely technical problems. We are promised normalization and happiness through science and law. When they fail, this only justifies the need for more of the same' (Dreyfus & Rabinow 1983, p.196).

⁷⁵ The figure taken from the journal article is problematic although the text claims integration the graphic presents components in an isolated form.

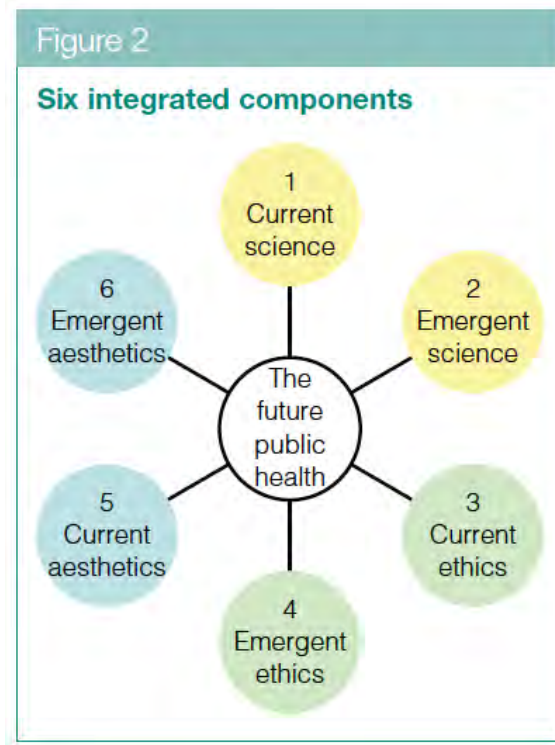


Figure 14 Hanlon Towards An Integrative Framework (2012)

Parallel discourses in health and science journals demonstrate how multiple explanations are possible based on a given dataset. In the philosophy of science the claim that any given body of evidence may support numerous and contradicting theories is commonly referred to as the 'Duhem–Quine thesis'. Scientists must adopt extra-empirical criteria for what counts as a good theory when deciding to accept one theory in preference over its empirically adequate rivals. These 'extra-empirical criteria' are subject to the whims, preferences, biases and social agendas of the researching scientists. Goldenberg (2006) cites a 1995 publication in 'The Lancet' documenting the disagreement among research team members regarding interpretation of their trial results. Upon 'agreeing to disagree', the team presented two views. Neither position was seen to be inaccurate; at least insofar as both sides appeared to be supported by the clinical data. Furthermore taking a light-hearted view, De Vries and Lemmens record their frustration with the displacement of professional judgment by EBM. They refer to an article published in the 'British Medical Journal' (BMJ) entitled: *'Parachute Use To Prevent Death And Major Trauma Related To Gravitational Challenge: Systematic Review Of*

Randomized Controlled Trials'. With tongues firmly planted in cheeks, the authors review the medical evidence on the value of parachute use and conclude: (1) no randomised control trials of parachute use have been done, and (2) the basis for parachute use is 'purely observational' and could potentially be explained by a 'healthy cohort' effect. They conclude; 'individuals who insist that all interventions need to be validated by a randomised clinical trial need to come down to earth with a bump' (Smith & Pell, 2003, p. 1460 cited in De Vries & Lemmens 2006). The yearning for certainty confines everyday understandings of science to remain hopelessly Newtonian even though we know that Newtonian science 'has been debunked by far more complex visions that embrace uncertainty' (Waymack 2009, p.228). These examples demonstrate the openness and curiosity within science for post-positivist analysis.

Interest in contested truth claims led me to the field of medical humanities. The emergence of this field of inquiry is characterised as a countermovement to the dominance of EBM by advocates of patient centred practice, 'to encourage curiosity about the human condition and healthy scepticism about the nature of medical "truth" and to model acceptable moral behaviour' (Kidd & Connor 2008, p.51). Or as Greaves and Evans have formulated it as response to 'the shortcomings of a medical culture dominated by scientific, technical and managerial approaches' (Greaves & Evans 2000, p.1). They formulate the deployment of medical humanities as additive or integrative. Additive refers to the practice of medical humanities where the objective is to produce more empathetic doctors, whereas integrative suggests encounters with the knowledge base of medicine itself (Greaves & Evans 2000). Thus debate can be said to revolve around and between two poles: a) cultural interventions that are instrumentalised for their anaesthetic, healing and educational powers and b) cultural interventions that are seen to operate as critique challenging the knowledge base and cultural practices of medicine itself (Macneill 2011). Manifestly then, there is a huge curiosity within health discourses to see the world other than from prevailing

dominant logocentric perspectives. In the next section I look at how these narratives are played out in the context of artistic research.

3.4 ARTISTIC RESEARCH

In this section I present some of the concerns stemming from the academic disciplining of artistic research. I do this to contextualise research parameters and to mark out yet another territory in which competing disciplinary interests limit discursive practices.

This research is taking place under the supervision of a fourth level academic art institution that has been sanctioned to issue doctorates.⁷⁶ These research practices do not occur at a remove, outside other discourses. In fact they intersect and intermingle with them. Artistic research, arts-based research, practice led research in the arts and arts-based inquiry are descriptors for research practices often encountered in academic literature troubling this new found institutional identity post Bologna.⁷⁷ Admitting art as a knowledge practice in academic institutions has proven to be controversial (Beckstette et al. 2011). In fact, much of the associated debate echoes the antagonistic relationship between science and humanities already referenced in the way that it connects two domains: art and academia.⁷⁸ Discussions are oriented around curricular issues and the institutionalization of artistic research complicit with new modes of production within cognitive capitalism. However, 'Both perspectives agree on one point: artistic research is at present being constituted as a more or less normative, academic discipline' (Steyerl

⁷⁶ The Graduate School of Creative Arts and Media (GradCAM) is a collaborative initiative of national and all-island significance, which builds on the expertise of the Dublin Institute of Technology, the National College of Art & Design, the University of Ulster, and the Institute of Art, Design and Technology, Dún Laoghaire. These institutions work in close collaboration with each other and with a range of national and international networks to realise the Graduate School. The School is a shared space of structured doctoral studies and research support - what has come to be known as "fourth-level" education: the School is a centre for creative research development; the School is a framework for critical interdisciplinary dialogue; and the School operates as a permeable institution of enquiry that facilitates, promotes and leads the interaction between cultural practice, educational practice and the everyday world of work and innovation beyond the academy. www.gradcam.ie/about

⁷⁷ The Bologna Declaration is an EU wide agreement to ensure comparability of standards and quality of higher education qualifications. The consequent shift from art academy to University art department has presented challenges for validation of standards.

⁷⁸ Or as Daly would have it *academentia* – 'a normal state of persons in academia marked by varying progressive degrees; irreversible deterioration of faculties of intellectuals' (Daly & Caputi 1987, p.182)

2010a, p.31).⁷⁹

Busch (2011) arguing against a scientification of the arts, identifies three emblematic motifs which will be discussed in detail:

1. artistic research is transformed from an unregulated field to an academic discipline there are issues relating to higher education policy.
2. a tendency for the defence of artistic procedures that move beyond cognitive attainment and critique.
3. an epistemological interest in the material, instrumental and institutional conditions of the genesis of knowledge.

Firstly, there are issues relating to higher education policy as artistic research is transformed from an unregulated field to an academic discipline. At stake here is the standardization of practices through which artistic research is being aligned with other university disciplinary research practices. In order to achieve the academic benchmark of a PhD, ‘“new knowledge” being “produced” ... must meet certain criteria and be recognised and held to be relevant and interesting by a ‘community of assessment’ (Holert 2011, p.38). It entails ‘a simplistic conception of theoretical practice ... (which) relies on an anachronistic concept of objective science that ignores ‘post-positivism’ of recent research into scientific practices’ (Busch 2011, p.72). This is a salient point. Science is not monolithic; it presents a diverse discursive field in which some advances have been made informed by the seismic epistemological shifts of the post structural period and in which tensions arising from methodolatry are

⁷⁹ This techno managerial mode of interpretation is strongly linked to the overarching narrative of the knowledge economy, a meta-narrative that inscribes value only to those activities that have economic value. Cognitive capitalism is a radical critique of knowledge-based economy discourses associated with post-Fordist society in which immaterial labour, creative labour, cognitive labour and affective labour are deployed as central concepts. Theorists of cognitive capitalism reflect on the developments and transformations of societies in which knowledge based activities mould economic conditions, and which seeks to turn all kinds of knowledge into commodities by creating value through intellectual, communicative, relational and affective activities, whether they are artistic, philosophical, cultural, linguistic or scientific. See (Raunig & Ray 2009)

discussed (Chamberlain 2000). Wilson (2009), in addressing the higher education policy context, historicises and renders clear a plurality of research ideals to reveal a contingent nature in the research doctorate which has emerged as 'specialised-discipline' at the expense of the 'general erudition ideal'. Wilson suggests that research should reconnect with alternate traditions, and rather than enacting disciplinary mimicry in conserving and reproducing the institution, the PhD as a contingent construct offers an opportunity to be creatively and critically redeployed at both the individual level (with the ongoing interrogation of the supervisor's role) and the institutional level. Furthermore, Holert argues that this self-reflexive institutional criticality is made necessary by the way in which artistic research is integrated into transnational processes of the economisation and corporatisation of higher education through the academic reorganisation of art education and artistic practice in higher education (Holert 2011).

Secondly, Busch notes, a tendency for the defence of artistic procedures that move beyond cognitive attainment and critique, 'artistic research is not autonomous ... since it is decisively determined by criteria not immanent to art' (Busch 2011, p.72). Elkins (2009) remarks that the naturalisation of 'research' and 'new knowledge' into the vocabulary of studio art practice is incommensurate with creative practice and is to stretch their meaning. Further he considers their deployment useless to artistic practice and implausible to scientists. Even more polemically EARN suggest that the main evaluative criteria for artworks is still 'wordless apprehension' and that 'discourse of meaning around the visual arts is always prone to nothing more than an elaborate sales pitch' (Day 2011, p.140). To act otherwise is to risk not only instrumentalising art, but also extinguishing it in favour of design. "'Artistic research" must be judged by the same terms as art in general' (Day 2011, p.140). A more transparent approach can be found in the review criteria for accepting submissions to JAR (Journal of Artistic Research). Reviewers are asked if the submission

exposes practice as research by meeting seven criteria.⁸⁰ Whether the art is research is less important than whether a particular artistic practice is *intended* as research, because by exposing a practice as research, the artist inscribes that work into research discourse transforming it from an artistic product to an artistic argument with the potential for knowledge and understanding (Borgdorff 2012, pp.231–232).

Thirdly, Busch asserts an epistemological interest in the material, instrumental and institutional conditions of the genesis of knowledge.⁸¹ Borgdorff (2012) asserts that artistic research does not make explicit the knowledge produced, but rather articulates the pre-reflective, non conceptual content of art offering an invitation to unfinished thinking through contingent perspectives. Art as a producer of knowledge becomes a fully operative member of the knowledge society, but is this at the expense of strategies of resistance? Can artistic research be more than a governmental technique? Holert remarks that:

It remains to be seen whether artistic research will become an institution equipped with the faculty of self-criticism ... that can respond to the hegemonic economies and politics of knowledge within and outside the academy (Holert 2011, p.48).

Busch finds solace in philosophy, invoking a litany of instances where philosophers mitigate the straitjacket of academic requirements, as philosophical speculation 'imagines art to be its ally ... its critique of the sciences can conversely serve to defend forms of artistic cognition that defy the constraints of scientific knowledge' (Busch 2011, p.76). The fine line between the known and the unknown is the site of knowledge generation. Positioning artistic research at the edge of doubt and uncertainty opens it up to risk and failure, but diverts 'attention away from description (and thus the possible solution) of a problem to the process of problematisation itself' (Dertnig et al. 2011, p.134) and a 'critical

⁸⁰ The seven elements are as follows: 1. Intent, 2. Originality, 3. Enhancement of knowledge, 4. Research question, 5. Contextualisation, 6. Methodology, 7. Documentation and dissemination (Borgdorff 2012)

⁸¹ This interest extends beyond the confines of the narrow university bounded field of artistic research necessary for a PhD, to a more generalised and prevalent conception of contemporary art as a site for the production of knowledge (Moulier-Boutang 2012). They cite the instability and untranslatability of knowledge in which the unknown becomes a provocation for practice in an expanded field as well as a concern with implications for art as knowledge in a knowledge economy - strategies for making the 'invisible visible' can co-opt.

reorganization of the fields of knowledge and practice' (Holert 2011, p.38).

Steyerl (2010a) claims that artistic research leads to clashes between specificity and singularity. When artistic research claims to participate in a general paradigm, within a discourse that can be shared and which is manufactured according to certain criteria, the associated validation usually originates in scientific, legalistic or journalistic truth procedures. But artistic research projects also lay claim to singularity, producing their own field of reference and logic, claiming to be unique, autonomous, holding out against dominant modes of knowledge production. Steyerl sees through the maze of methodology wars, to name a basic problem for all artist researchers. While a project may have coherence in relation to itself, how can that be communicated beyond the frame of reference for that project?

While specific methods generate a shared terrain of knowledge – which is consequently pervaded by power structures – singular methods follow their own logic. While this may avoid the replication of existing structures of power/knowledge, it also creates the problem of the proliferation of parallel universes, which each speak their own, untranslatable language (Steyerl 2010b,unpag.).

Steyerl's project lies in challenging the current trajectory of academicisation of artistic research, in the form of a discipline. She deploys conflict as an alternate heuristic for artistic research, understood in terms of an aesthetics of resistance, which has been in play for far longer than the current pre-occupations with Bolognaisation. In Figure 5.1 Steyerl offers a schematic distinguishing between specific and singular practices. Specific practices relate to paradigmatic research made within a disciplinary context with particular truth procedures. Singular practices relate to artistic research, which claims to be unique and sets up its own field of reference and logic. While the former generates a shared terrain of knowledge that is appropriated by power, the latter results in a proliferation of parallel universes – inaccessible to power. Steyerl considers that artistic research operates in both registers simultaneously and schematically maps these tensions that both frame and undermine the

institutionalisation of artistic research when it is transformed into academic research.

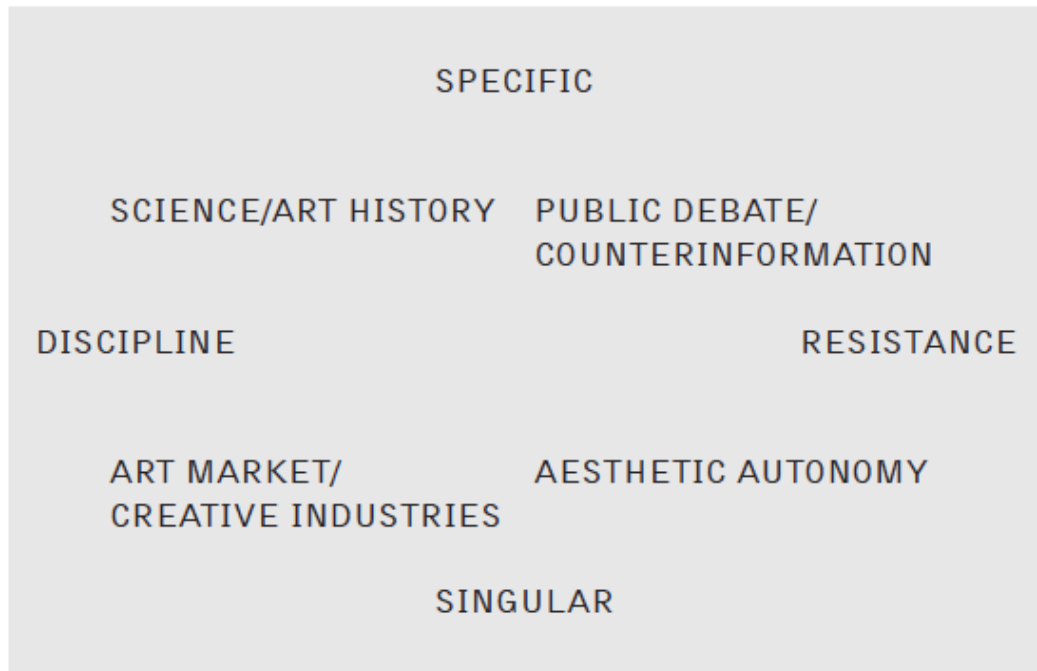


Figure 15 Hito Steyerl Semiotic Square (2010a)

In this way artistic research resists the demands of knowledge protocols for outcomes, outputs and impact, and instead forms new and unexpected alliances in numerous directions producing relations and agendas that do not emanate from shared identities, shared ideologies or shared belief systems (Rogoff 2010a). This resistance side-steps dialectical positions and the likelihood of becoming ensnared in representational systems.

3.5 RECAPITULATION

This chapter presented selected themes from a number of historically and socially embedded source literatures positioning the research as a transdisciplinary inquiry. The texts referred to concerned the social turn in arts practices and attendant critiques, critiques of evidence-based research, alternative narratives for healthcare practice and disputes

arising from the academic disciplining of artistic research.⁸² These four literatures are important to this inquiry, as when interlinked they establish the possibility for contextualising practices anew. Critiques of evidence based research open up the possibility of seeing such methodologies as knowledge practices rooted in a logocentric perspective. Critical health literatures articulate an awareness of the problems associated with such a perspective in healthcare practices; such awareness is also evident in disputes concerning the admission of artistic research as a knowledge practice in academic institutions. The social turn in arts practice and its preoccupation with the operation of knowledge and power in relation to the dominant social framework problematises varied strategies and distinguishes a set of concerns rather than relying on a logocentric determination of 'facts'. Bauman suggests that following the disenchantment of logocentrism, we learn to value actions without purpose or calculable rewards, respecting the inconclusive and the ambiguous, not only as the not-yet-explained, but as the inexplicable (Bauman 1993, p.33). Linking these texts together and applying them to arts practices in healthcare settings makes it possible to reorient the scope for these practices.

In the next chapter I turn to the way in which arts practices in healthcare settings and associated research are constrained and enabled through the operation of discourse.

⁸² I paid particular attention to journal articles available (see section 11.08 for an analysis of Journals referenced and section 4.1).

4 DISCOURSES

In this chapter I add substance to the claim made (in section 1.1) asserting that scholarship in arts and health places a limit on its discourse that is through visual images, speech acts and texts as well as the practices that mediate them. In order to do this I analyse a regime of practices that have prescriptive effects concerning what is to be done and what is to be known, what is taken for granted and what is imposed (Foucault 2002a, p.225). Given that there had not been any previous research that approached arts and health in this way, it was inevitable that I would spend time negotiating my way into these discourses, 'touring between texts' (Allen 2011, p.1), by reading associated literature, attending conferences, art exhibitions, professional development days, artist talks, meeting with artists and health professionals. The choice of texts is of consequence, because looking and listening is an act of choice 'we only see what we look at' (Berger 2008, p.8). In this chapter I therefore offer a particular selection of texts, presentations and artworks as instances of written, spoken and enacted practices organised to create and reproduce a coherent claim to a particular perspective. Readings of discourses are contingent and necessarily incomplete; furthermore, reading is not passive, all reading involves a degree of participation by the reader, contributing some of ourselves based on our memory, experience and desire, therefore I am very much implicated in this elaboration.⁸³

The Foucauldian concept of discourse refers not only to language, but also to language *and* practices that operate to produce objects of

⁸³ My entry into this research was presaged by a period of time as an arts coordinator at Cork University Hospital and while that gave me a localized understanding of how practices were being understood, I had no idea how they were being understood 'out there' in official and academic discourse. Understanding that discourses operate in rhizomatic ways – that is they are not linear, or separate, and that discursive systems are connected to and across each other, I traced connections of these different systems by immersing myself in these contexts at a regional, national and international level in terms of policy, practice and critique. Attending to what was being said in discourse, my initial task was to listen, which later in the research project was reconfigured to, rethink practices away from the codified logic of disciplines.

knowledge. It does so through webbed connections linking knowledge, power, institutions, regulations, statements and practices that regulate the limits of what is accepted as a regime of truth (Barrett 2006). As Foucault reflects on his research in prisons, 'the target of analysis wasn't 'institutions', 'theories', or 'ideology' but *practices* - with the aim of grasping the conditions that make them acceptable at this moment' (Foucault 2002a, p.225 italics in orig.). He identifies different thresholds that operate neither to a regular nor homogeneous chronology in the formation of discourse, but in establishing limits, criteria become available to evaluate which talk is acceptable and which is not, which talk will find legitimacy and currency and which will not. Scholarship on arts and health, as with other scholarship, is constituted by people talking to each other in prescribed ways, in familiar places to familiar audiences citing a literature of familiar authors by invoking a disciplinary specific vocabulary. These form the limits of its discursive domain.

Foucault proposes that; 'in every society, the production of discourse is at once controlled, selected and redistributed by a certain number of procedures' (Foucault 1990, p.52). These procedures of exclusion are historically and culturally specific rules for organising and producing different forms of knowledge. Three conditions govern the procedures of exclusion and are elaborated below:

1. 'the prohibition', which describes control over who can speak, what they can speak about and when they can speak.
2. 'the opposition between reason and madness' which can be interpreted as the perceived difference between reasoned or authoritative discourse and 'mad', unsanctioned, unreliable discourse.
3. 'the opposition between true and false' whereby the producers of discourse construct 'truths'. These truths are embedded in institutions and reinforced and renewed through whole strata of social practices.

(Foucault 1990, pp.52–54)

4.1 PROHIBITION: A DOUBLE EXCLUSION

In this section I present instances in practice that foreground the operation of discourse in the way it proscribes control over who can speak, what they can speak about and when they can speak (Foucault 1990, pp.52–54). In the first instance I refer to the power of medical dominance, that is the way in which the medical profession attributes authority to certain speakers. Secondly I refer to critical arts discourses that limit participation in and direction of discourses. Thirdly I refer to an artwork that seeks to intervene in these practices. All of these point to a double exclusion for those concerned with arts practices in healthcare settings.

When planning and implementing an arts project in a healthcare setting, lengthy negotiations take place between artist and healthcare staff to meet standards for best practice in terms of duty of care, confidentiality and consent. Furthermore the artist faces the challenge of garnering an arts credibility for projects which exist outside traditional sites of validation. The artist is both resistant to and engaged with arts institutions and health institutions, being part of and apart from the institution. Although these practices of negotiation and resistance are prevalent they remain unremarked upon with a few notable exceptions (Fox 2012a; Parkinson 2011; Raw et al. 2011; White 2009a). This work is an essential part of any arts projects that takes place in a healthcare setting and is often overlooked, in favour of the more visible practices with service users. This supports the finding of the Arts Council of Ireland (2004) report that a double exclusion is in operation. These exclusions are proscribed based on medical dominance and art institutional prejudice (since how and what we validate as art is determined by institutional authority (Bishop 2005, p.105)).

The power of medical dominance to control who can speak and what they can speak of became apparent after a public talk about the

Transplant arts project.⁸⁴ A medical consultant authoritatively dominated the discussion in a filibuster like interjection from the floor. The substantive issue concerned the imputed voyeuristic exploitation of patients through the use of their images; but the subtext was a demonstration of the way in which those sanctioned to speak in discourse exclude.⁸⁵ On the following day at a professional development workshop, the Arts Manager at Harefield Hospital, London, clarified how complex arts projects are negotiated in healthcare settings with consideration for governance and ethics in collaboration with other stakeholders (Hume et al. 2010).⁸⁶ The process of embedding an arts project in a hospital setting is lengthy and complex, dependent on a series of relationships and agreements in a range of fora e.g. Clinical Risk Committee, Ethics Committee, Trust Management Committee, Arts Committee. The complex nature of the institutions of healthcare necessitates a wide degree of consultation and collaboration prior to project start-up and this is a defining feature across all such projects. This work is an essential part of any arts projects that take place in healthcare settings and is often overlooked, in favour of the more visible practices with service users. As the Development Officer with Music Network notes 'building a genuine relationship of trust' in the hospital / healthcare setting with nursing managers and managerial staff is a key part of the work (Geraghty & Blake 2012).

Returning to the 'exploitative' image in question, it originated in the *Transplant* residency involving sound-artist John Wynne and photographer Tim Wainwright at Harefield Hospital, England.⁸⁷ The image concerned the portrait of a man attached to a Ventricular Assist Device (VAD), which

⁸⁴ Medical dominance is term applied in the delivery of health care services. Amongst other factors medical power is wielded through the professional autonomy of doctors and dominance over allied health occupational groups. In a study Kenny and Adamson (1992) found that a significant proportion of health professionals did not feel regarded as a professional equal by doctors, nor did they feel that doctors had an adequate knowledge and understanding of the allied health professions. See also (Willis 2006).

⁸⁵ The culture of healthcare settings varies, but it is worth bearing in mind that some of the biggest arts and health projects have been consultant led, e.g. *Open Window* St James Hospital see (1992), *Lived Lives* St Vincent's University Hospital (McGuinness 2011)

⁸⁶ *Transplant* was a year-long residency involving sound-artist John Wynne and photographer Tim Wainwright at Harefield Hospital, England, which looked at the impact of heart and lung transplants on patients, and led to a major installation which was exhibited in Harefield Hospital and Beldam Gallery in London in 2009. For further information about the *Transplant* project see <http://www.thetransplantlog.com/>

⁸⁷ Exhibited in Harefield Hospital and Beldam Gallery in London in 2009. For further information about the *Transplant* project see <http://www.thetransplantlog.com/>

had kept him alive for the past year. As photographer Wainwright explained, Ian had initially not wanted to be photographed, but changed his mind after he had seen a TV documentary that misrepresented the transplant experience. 'The day after the programme, his attitude changed completely and he became totally involved in our project, opening himself up to us – almost literally' (Carlyle 2008, p.16). The patient whose photo had caused such controversy had in fact volunteered the image of the external heart.⁸⁸



Figure 16 Tim Wainwright *Ian* (2008)

⁸⁸ See (Gibson 2006) for an exploration of the interconnectedness of persons with disabilities, technologies and the environment and problematising Western notions of the independent, autonomous subject.

In this instance the weight of medical dominance had erased the very significant efforts made by healthcare staff and artists to avoid exploitation of patients and indeed sought to excise the choice of the patient to be photographed.⁸⁹ That is not to say that discussion of exploitation is to be avoided altogether. The idea of exhibition making often sits uncomfortably within these arts practices for reasons of consent and confidentiality. Furthermore, as Arts Manager, Hume explains although the *Transplant* exhibition received critical acclaim, in general there is a difficulty in garnering an arts credibility for these projects as galleries and critics 'don't want to know' (Baxter 2008; Carlyle 2008). This exclusion is discussed in the next section (4.2).

Another example of such exclusionary practices revealed itself from within critical art discourses. While contemporary critical arts practices might profess an interest in the blurring of art and life, they largely operate within a small, enchanted circle, ring-fenced by the necessity to have academic credentials and/or reputational economy.⁹⁰ At a 2010 MaKHU graduate symposium whose theme was *Doing Dissemination*, guest speaker, Bourriaud characterised the distance between individuals and historic phenomenon as leading to a specific frame of mind, a passivity.⁹¹ His presentation focussed on the opposition between activity, passivity and history, distinguishing between the mass as an active force and the crowd as a passive force. He called for 'more locally oriented activity as a way to inject humanity in a world that becomes ever more impersonal because of large phenomena such as economic crisis, globalization and supranational entities' (Metropolis 2010). Using the metaphor of a tennis game he suggested that artists are like tennis players serving a ball in the sense that they present an artwork, but cannot control the way to which it is responded. This positioning of an arts practice in relation to activity, passivity and history has particular resonance in relation to arts practices in healthcare settings, as they are places where passivity becomes almost

⁸⁹ See (Willis 2006) a review essay of the factors influencing medical dominance,

⁹⁰ Wilson (2006) formulates the idea of reputational economy and intradisciplinary conflict. See also (Kaprow 2003) *Essays on the Blurring of Art and Life*.

⁹¹ *Doing Dissemination*, maKHU Symposium, Utrecht, Holland, April 1st 2010.

inevitable, where disciplinary power makes 'docile bodies' (Foucault 1995).^{92,93}

The types of concerns expressed at this symposium are typically the preserve of a small 'enchanted circle' who through language and distinctive theoretical and historical resources legitimise practices marking out those inside the circle from those outside. Such boundary marking is particularly acute for novel arts practices, 'it is apparent that any non-traditional art form justifies its significance with reference to a welter of initiatory knowledge, an expanse of text and an archive of historical precedent' (Charnley 2011, p.51). Yet in the actuality of locally oriented practices such as those found in healthcare settings, many artists are unfamiliar with these debates and resources and nor do they have access to archives of knowledge. Recognition for arts practices in healthcare settings is problematic as it does not fit into the cross-section of validation provided by the academy and the market, leaving peer recognition as the sole conduit for approval. The platform provided by the 2011 *Dialogue Arts + Health project* which delivered nine regionally based professional development workshops followed by a national conference provided an opportunity for such peer reflection and recognition, as do the case studies documented on artsandhealth.ie. Yet these fora struggle to find currency within zones of critical validation. This should be of no surprise as it adds weight to the Arts Council of Ireland (2004) report that a double exclusion is in operation. These exclusions are proscribed based on medical dominance of biomedical and art institutional prejudice (since how and what we validate as art is determined by institutional authority (Bishop 2005, p.105)).

These exclusionary practices led me to create an artwork that could create a small local archive of critical texts based on abstracts from journal articles that focussed on key topic areas; evidence, reflective

⁹² Foucault describes how disciplinary institutions (prison, hospital and school) create docile bodies to be transformed and improved.

⁹³ Later at the same symposium, Jurgen Bey in his presentation, *Thinking Matters*, specified a need to develop public space as an alternative to private space based on local knowledge. It is all the more notable that arts practices in healthcare settings take place within the remit of public health provision contexts. To my knowledge there is no equivalent within the private provision of care.

practice, medical humanities, knowledge practices, ethics, Irish arts practices in healthcare settings and, a particular instance of claim and counterclaim relating to the instrumentalisation of arts practices. These formed the basis for *CT Scan Dec 6 2011*: a commissioned installation at Rua Red Arts Centre for the *Dialogue Arts + Health* Project (Dec 2011). The curator Annette Moloney and I agreed an approach in which a temporary installation would engage with the space and the audience for the National *Dialogue Arts + Health* Exchange Day. After a visit to the Rua Red Arts centre we agreed to arrange texts around the space in a way that would integrate with participants and the building. Attention was directed towards academic discourses on arts and health practices and medical humanities. The cross-section of narratives brought into focus rich conversations for participant engagement and interaction. Panels of text were wrapped around the supporting columns of the building in the public areas of the arts centre. The fabric of the building then provided an infrastructure, to support these discourses, embedding them into the everyday life of the site and as part of the functioning apparatus of the arts and health community.

The temporary installation consisted of seven text-based pieces. Each took a theme as follows:

1. *Research*

(Baum 2001; Macnaughton et al. 2005; Putland 2008; Dileo & Bradt 2009; Raw et al. 2011),

2. *Knowledge*

(Goldblatt et al. 2010; Bell 2011; Padfield 2011; Radley & Bell 2011),

3. *Ethics*

(La Jevic & Springgay 2008; Charnley 2011; Ponc & Jategaonkar 2012),

4. *Medical Humanities*

(Scott 2000; Ousager & Johannessen 2010; Williams 2010; Macneill 2011),

5. *Reflective Practice*

(Rossiter et al. 2008; Allen & Brodzinski 2009; Sánchez-Camus 2009; Cheng 2010; Wald et al. 2010; Fougner & Kordahl 2012)

6. *Irish Commentary*

(Roche et al. 2008; Moss & O'Neil 2009; Broderick 2011a; McHarg et al. 2011)

7. *Culture Vultures*

(Mirza 2006; White 2006a).

The seven A0 paper panels were printed with journal titles and abstracts. They were affixed to polished concrete supporting pillars in the main concourse of Rua Red Arts Centre intended for the close scrutiny of conference attendees as they assembled prior to conference commencement.⁹⁴ These abstracts were intended to introduce arts practitioners themes in academic scholarship not generally found in practice. The intent was to build knowledge leading to further reading, reflection and discussion. Reminiscent of kiosk culture, the pillars allowed conference attendees to circulate around the texts, to see both sides of a diverse field - literally and figuratively. By affixing the panels to the interior architecture of the building the work became a functioning part of the fabric of the building.

Twenty-eight journal articles were selected across a transdisciplinary spectrum: Methodology (1), Arts (3), Medical Humanities (4), Health (5), Arts and Health (15). The large number of topic-specific articles on arts and health was made possible due to the publication of Special Edition Journals across a broad range of disciplines: Health Education (2005), Journal of Health Psychology (2008), Health Care Analysis (2009) and Reflective Practice: International and Multidisciplinary Perspectives (2010) representing diverse disciplinary interests.⁹⁵ It seemed incredible that so much debate could be happening at such a remove from practices, underlining the distance between disciplinary discourses, practices and commonly held beliefs. Barriers to participation in these disciplinary debates included the cost of accessing them, if you were not affiliated

⁹⁴ Special permission was sought from Rua Red Arts Centre as there was a fear that the process of affixing might damage the polished concrete columns. In the end the panels were supported by the surface tension of paper glued to itself rather than directly to the columns.

⁹⁵ One conference presentation (later published as a peer-reviewed article) is included. One book and a refutation of its thesis is included as it was an exemplar of the intensity of debate regarding impacts.

with a University library, and also academic ring fencing through disciplinary practices requiring academic credentials.



Figure 17 Sheelagh Broderick CT Scan 6 Dec 2011 panel detail (2011)



Figure 18 Sheelagh Broderick CT Scan Dec 6 2011 installation view (2011)

4.2 BETWEEN REASON AND MADNESS

In this section I cite instances which can be interpreted as the perceived difference between reasoned or authoritative discourse and, unsanctioned, unreliable discourse often designated as 'mad' (Foucault 1990, pp.52–54). I refer to the *2 Voices* project in which differences between an artist and an art therapist are elaborated, I draw on the recent researcher led turn to philosophy and refer to my own text interventions that attempt to lever open a space for enquiry beyond logocentrism.

For artists working in healthcare settings, there is a clear distinction to be made between arts practices and arts therapy. Artist Marie Brett and art therapist John McHarg established these differences very clearly following collaboration on a project *On the Edge of My Sky* over a period of approximately eighteen months (Brett & McHarg 2010).⁹⁶ The document *2 Voices* emerged from this project as an ongoing dialogue focussed on differences between arts practice and arts therapy (McHarg et al. 2011). Although their work may appear similar, they each adopt entirely different approaches to their professional practice. They itemised sixteen points of difference in practice. Including factors such as work practices, duty of care, supervision and support, and aesthetic vs. therapeutic concerns.⁹⁷ These differences highlight themes for discussion, yet they are eclipsed by the standard index for authoritative discourse concerning arts practices in healthcare settings, as clinical trials are the 'reasoned' route to 'truth' expressed foreclosing other 'unreasonable' or 'unverifiable' statements.

Yet this is not a crushing weight, rather it can be seen as an entanglement as manifested in the artwork *A Quickening* (2011). This site-specific installation was another outcome of the *2 Voices* collaboration. The work

⁹⁶ This work was first presented at a Continuing Professional Development Day at Waterford Healing Arts Trust March 2010

⁹⁷ This presentation was later published in the *Irish Journal of Creative Arts Therapists* (McHarg et al. 2011). See also (Rogers 2008, p.13) for a specification of similarities and differences between art therapy in general and the Drawing Encounter method developed for her practice based PhD. See also articles in the special edition of *Contexts Journal* (Cahn 2004b; Cahn 2004a) and (De Burca 2014) for an elaboration of intentionality in the work of a musician and music therapist.

comprised a large floor drawing using soil/compost and cement with interconnected sound, plus a separate video and audio work. The collaborative artwork was exhibited at Wandsford Quay Gallery, Cork. Brett & McHarg worked collaboratively through research and reflective dialogue, to produce this body of artwork and published findings.



Figure 19 Brett & McHarg *A Quickening* (2011)

These entanglements, figured as irresolvable conflicts by Putland (2008) in 'the eclipse of art' is explored by White (2009a).⁹⁸ White has been a leading practitioner and commentator on arts and health (Macnaughton et al. 2005; White 2006b; White 2006c; White 2008; White 2009b; White 2010). He has worked through a cycle of attempting to prove the value of arts and health, applying varied methodologies, but finally concludes such attempts are fruitless, that it is in the philosophical space of inquiry that most can be gained (White 2009a, p.231). Furthermore, he suggests arts and health and its ally medical humanities can contribute to the dialogue by negotiating a philosophical space of creative enquiry rather than clinical evidence based benefit (2009a, p.231).⁹⁹ White seeks to reposition conflicting ideas concerning practices through philosophy. He is not alone in such a repositioning, as philosophical speculation 'imagines art to be its ally ... its critique of the sciences can conversely serve to defend forms of artistic cognition that defy the constraints of scientific knowledge' (Busch 2011, p.76). This departure signals dissatisfaction with current explanatory models, but is disadvantaged by a logocentric regime of truth in which there is a belief in objective knowledge, establishing a limit beyond which without concept or language, questions cannot be asked or answers imagined.

Current developments within the UK Arts And Health Research Network indicate a shift from such logocentrism at the level of researcher interest but at the level of Government such logocentric interests persist. Arts Council England's Report. *The Value of Arts and Culture to People and*

⁹⁸ Mike White is a research and development fellow in arts and health at the Centre for Medical Humanities at Durham University. He has over 20 years experience of managing and researching arts projects addressing community health issues in the UK, Ireland, Australia and South Africa. He has worked in Ireland on the Arts + Health strand of the European Capital of Culture 2005 with its programme manager, Ann O'Connor, who is currently Arts and Health advisor to the Arts Council. Mike White was commissioned by the Cork Arts + Health programme HSE South in association with Waterford Healing Arts Trust and funded by the Arts Council to produce a set of guidelines on participatory arts practice in healthcare settings. These were launched at the Arts Council / Create Vital Signs conference October 2009. He has published many journal articles and presented at many conferences internationally. In previous publications and presentations much of the focus was on building an evidentiary base for practices, but this book marks a new departure from this concern. He has, as Dr Mick Wilson would say, reputational economy.

⁹⁹ White cites as an example the research project underway at Durham University, which seeks to understand factors influencing human flourishing by addressing the schism between scientific and experiential accounts of human nature. The Centre for Medical Humanities at Durham University is a recipient of a Wellcome Trust Medical Humanities Strategic Award 2008 – 2013 to support a research programme exploring 'Medicine and Human Flourishing'.

Society (Mowlah et al. 2014) flags a return to the impact wars discussed in the previous section. The report states that:

the time is now right to build on previous reviews of evidence over the years and refresh our thinking on the impact arts and culture can have on the social and economic landscape (ibid. 2014, p.10).

Yet the UK Arts & Health Research Network expressed their serious concerns regarding the limitations of this report stating in a six-point letter that it did not provide an adequate overview of the field and neither would it provide an adequate basis for a programme of research to support policy development.¹⁰⁰ In this exchange between researchers and institutions we can see that only particular recognizable themes can be cultivated in discourse and the 'melancholic echo' of competing claims to knowledge continues.

My own research led me intervene in a series of texts that sought to challenge the way instrumental claims for arts practices in health settings were being made (see section 3.2) in professional arts publications and in an academic journal. The peer reviewed Journal Article *Unreasonable Doubt* was an attempt to engage the academic community with a set of problems associated with this instrumental approach (see section 12.1). The article distinguishes between arts therapy and arts practice and discusses the social turn in arts practice, approaches to health, healthcare and evidence-based medicine. At this stage of the project I was scrambling for coordinates in which to locate practices and was exploring the social model of health which focuses on the social determinants of health (Warner 2011). This approach is informed by public health literature in which health has become less a corporeal concern, and more a social issue.¹⁰¹ It seemed to me at the time that a bridge could be made between the preoccupations with inequitable distribution of power

¹⁰⁰ Letter sent to Sir Peter Bazalgette, Chair Arts Council England, 31 March 2014, from UK Arts and Health Research Network Members (private correspondence).

¹⁰¹ Social determinants of health include factors such as poverty, working conditions, unemployment, social support, good food and transport policy. The WHO Commission on the Social Determinants of Health includes a commitment to tackle inequitable distribution of power, money and resources (CSDH 2008)

considered problematic in health literature and the social turn in arts practice concluding that:

It is important that the ineffable character of arts and health projects is not lost in clinical service provision. Further research on arts and health as a field of practice is necessary to provide a conceptual frame as an alternative to the hegemony of the clinic. All research should be informed ... by an inter-sectoral dialogue based on parity of esteem (Broderick 2011a, p.12).

This excerpt of text blindly anticipates the shift in orientation for the research, although at this stage my interests were still very particularly concerned with healthcare professionals. In invoking the ineffable, I was anticipating the operation of affect in unknowing ways.¹⁰² The unreasonable doubt expressed in the article title was matched by my own unwarranted expectation that anything should change as a consequence, yet the article seemed to resonate with a readership that could understand its premise, but find no way out of its predicament.¹⁰³

The two other commissioned elaborations of this position were written for a professional arts readership in the Visual Artists News Sheet (see section 12.2) and for arts and health practitioners, as a perspective piece on the arts and health website (see section 12.4) (Broderick 2011b; Broderick 2011e). Each developed particular themes. In the former the separate work of three artists was referenced and a claim for alternate knowledge practices made. The writing operated within an oppositional frame. Hegemonic knowledge claims were positioned as hampering criticality (alongside poor visibility of practices). In the latter, a close encounter with the evidence debate was made possible through the readings discussed

¹⁰² Struggles with the ineffable are not the preserve of art encounters, they find resonance with healthcare encounters as Brown and Tucker put it: 'The dilemma is to find the means to describe the living, embodied encounter of the service user, suffering the aches and pains of routine medication, with his or her psychiatrist, who is able to marshal blood tests, dosage levels and diagnoses, but who also grapples with the moral and ethical conflicts of providing care, in a way that does not lose sight of the complex dispositif (the health-care system, the legal framework, the pharmaceutical industry, the dense web of families and carers) that serves as the necessary condition of their meeting' (Brown & Tucker 2010, p.231). Brown and Tucker position this dilemma in the theoretical incommensurability between top-down analysis of power relations and knowledge practices contra the bottom-up accounts of the everyday lives of service users and suggest that a theory of affect may keep both in view simultaneously.

¹⁰³ As of 18 March 2013 there had been 1080 pdf downloads or full text html views of this article, reflecting its consistent position as one of the most frequently read articles in the Taylor and Francis publication, *Arts & Health: An International Journal for Research Policy and Practice*. This article has been cited in at least four academic journal articles/ research reports (Fox 2012a; Raw et al. 2011; Sagan 2012; Sapouna & Pamer 2012)

at the Critical Perspectives in Public Health module at University College Cork. It sought to reveal critiques of evidence-based medicine emanating both from within health disciplines and adjacent disciplines as well as an internal logical incoherence arising from substantive and ethical impediments in research design. Very clearly there was an appetite to find a way to talk about practices without having to shoehorn them into protocols and categories of 'reasoned' discourse, yet there was not a way in which to speak of this 'madness'. My research then became focussed on finding a lingua franca so that practices could be the subject of transdisciplinary discussion.

4.3 BETWEEN TRUE AND FALSE

The producers of discourse construct 'truths'. These truths are embedded in institutions and reinforced and renewed through whole strata of social practices (Foucault 1990, pp.52–54). Below I cite three instances that expose the way in which knowledge practices privilege and reproduce specific ways of understanding phenomena.

1. In *A Clinically Useful Artwork? Part 1*, Roche playfully questions the validity of using clinical indices for art practices.
2. The Art of Good Health and Wellbeing Conference demonstrated not only global interests in these practices, but also the way in which knowledge is validated within a very specific set of practices.
3. *Placebos for Art* is a procedural artwork that was deployed as a hoax to provoke comment and discussion on the prevailing method of validating practices.

1. *A Clinically Useful Artwork? Part 1* Roche (2006)

Arts practices in healthcare settings are required to embrace the protocols of evidence-based clinical practice with the compliance of artists and arts institutions. This positivistic approach to activities that take place within clinical settings places an obligation on arts and health

practices to conform to a clinical standard of evaluation. Thus we find, when reflecting on arts and health practices, the discourse is dominated by claims for positive clinical outcomes for patients. For example, the arts project, *Open Window* (Roche et al. 2008) at the National Bone Marrow Transplant Unit in St. James Hospital, project was subject to a randomised control trial whose central research question was to assess whether the artworks had an impact on the recovery of patients, even though the original specification for the commission did not include this element (Roche et al 2008).¹⁰⁴ Randomised control trials are the basis for validating medical knowledge and rank highly in the hierarchy of evidence-based medicine. During project implementation, Roche noted that when creating an artwork that was accountable concurrently within the medical and artistic community, not only did he have to contend with the functional physical architecture of the hospital building, but also a second architecture composed of staff protocols and management structures.



Figure 20 Denis Roche *A Clinically Useful Artwork? Part 1* (2006)

¹⁰⁴ Exhibited as part of *Vital Signs* (2009) vitalsigns.artscouncil.ie/exhibition/

This led him to devise the artwork *A Clinically Useful Artwork Part 1*. Roche was able to make a conceit of the idea of architecture when he created an inflatable sculpture, which doubled as a meeting room. The art review committee composed of different health disciplines met in this inflatable room to approve submitted artworks for patient viewing using a manual of protocols devised by Roche. His purpose for the sculpture was to provide a space that could suspend the influence of the prevailing physical and psychological architectures in the application of normative criteria to the process of selection of artworks. In doing so he exposes the highly regulated arena with which artists working in healthcare settings have to contend.

2. The International Conference, the Art of Good Health & Wellbeing, 2009
This was my first experience of the weight and power invested in associated discourses. Speakers from America, UK, Ireland, Holland, Australia, New Zealand and Canada assembled in Australia to present research, connect with peers and set future research agendas. A core concern of the conference was the issue of evaluation. It was here that I first encountered the work of Dileo and Bradt (2009). They spoke of the prerequisites for establishing the discipline of arts and health calling for a greater cohesiveness in research metrics. They reasoned that in order to substantiate claims for practice, it was necessary to use standards accepted by the medical profession, calling for a meta-analysis and systematic review of research through improved metrics. This paper set a limit defining the logical conclusion for evidence-based practice as it was applied to arts practices in healthcare settings. It had an unsettling effect among many, but there was no voice for this unease as there was no acceptable vocabulary with which to tackle their proposition on the prerequisites for creating a discipline.¹⁰⁵

¹⁰⁵ No distinction was made between arts and health and arts and disability, which coexisted comfortably together in many presentations. Indeed Arts Access Australia was one of the main sponsors of the conference and their speaker at the conference later authored the State of the Arts and Health in Australia article for the Journal of Arts and Health (Wreford 2010). In Ireland Arts and Health is distinguished from Arts and Disability as an area of practice by the Arts Council of Ireland; see also (Naughton 2011)

This conference revealed how big the stakes were.¹⁰⁶ There was an emergent worldwide self-consciousness of these arts practices in healthcare settings, and a concomitant investment in terms of intellectual resources, giving rise to a rivalry to establish dominance in scholarship and practice. Yet the research focus was exclusively on health perspectives reliant on clinical evidence based practice driven by funding and policy imperatives to the neglect of arts perspectives concerned with instrumental practices as anticipated as 'the eclipse of art' in the work of Putland (2008).

3. *Placebos for Art* (2011) Circus Engelbregt.

The problem of 'the eclipse of art' in research almost exclusively oriented towards health sciences finds playful resolve in *Placebos for Art* (2011).¹⁰⁷ This artwork was commissioned by the Dutch arts organisation SKOR for an arts conference: *Who Cares? Actors, Agents and Attendants. Speculations on the Cultural Organisation of Civility*. The aim of the conference was to reflect on the potential and meaning of art in the present and in future healthcare practice.¹⁰⁸ In brief, a postcard sized leaflet advertising a call for submissions to a research project called *Placebos for Art* was left on seats as attendees returned for another session. The research project was seeking submissions of art placebos for an experimental control group in a project to determine whether there was a measurable health impact related to having art in your home. The call proposed that the placebos had to look like art, but not be art. The call was also circulated online through email circulation lists and it spread virally through digital networks.

A website which described the research project and the research institute added to its credibility.¹⁰⁹ To the casual observer the project looked and

¹⁰⁶ As of 07 November 2012, a consultation process was underway concerning the Draft National Framework for Arts and Health, published by the Ministerial Working Group for Arts and Health appointed by the Standing Council of Australian Health Ministers.

¹⁰⁷ <http://www.skor.nl/eng/archive/item/actors-agents-and-attendants-i-artist-positions#sthash.fSuXyreX.dpuf> or www.circusengelbregt.nl

¹⁰⁸ *Placebos for Art* was one of six artworks commissioned for this conference. The other participating artists were Elmgreen & Dragset, Bik van der Pol, Pilvi Takala, Marc Bijl and Laser 3.14

¹⁰⁹ http://www.behringinstitute.com/research/placebos_for_art/

<p>The Behring Institute is seeking placebos for art. With these placebos, long-term research on the influence of art on public health will be carried out as of 2011. Artists, art lovers, professionals as well as amateurs, are being called on to submit proposals for potential art placebos before 1 January 2011.</p> <p>Submit placebos www.behringinstitute.com placebo@behringinstitute.com</p>  <p>Behring Institute for Medical Research</p>	<p>Het Behring Instituut is op zoek naar placebo's voor kunst. Met deze placebo's wordt in 2011 een meerjarig onderzoekstraject gestart naar de invloed van kunst op de volksgezondheid. Kunstenaars, kunstliefhebbers, kunstkenners en amateurs worden opgeroepen mogelijke placebo's voor kunst voor 1 januari 2011 in te sturen.</p> <p>Insturen placebo's www.behringinstitute.com placebo@behringinstitute.com</p> <p style="text-align: right;"><i>Leading the way through research™</i></p>
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Figure 21 Circus Engelbregt Placebos for Art (2011)

call for

Placebos
for Art



felt authentic aligning itself with much of the language found in research projects that attempt to prove a link between art and health. It was intended that art placebos would be given to a control group to validate the research against an experimental group who were given real art.

What transpired was, that there was no *Placebos for Art* research project, but there was dissembling art. The project had been the work of Circus Engelbregt and was commissioned by SKOR, for the conference. Unsurprisingly many people submitted artworks and the 'Behring Institute' produced a report of submitted artworks, circulating it to their list of email contacts.¹¹⁰ *Placebos for Art* exposed both the hegemony of health discourses and the lack of critical engagement among health researchers and artists who actually submitted artworks. The enactment of this project can be seen as yet another iteration of the method wars, as a riposte to the Sokal Affair, a hoax in which a bogus text was published in an academic journal in an effort to discredit arts, humanities and social science research and particularly post structural continental philosophy.¹¹¹ The irresolvable conflict between science and humanities would continue as a disciplinary muscle flexed in irresolvably competing discourses. The inevitability of this melancholic echo of exchanges between disciplines became a confining and claustrophobic space for research. This realisation prompted new directions for research discussed in Chapter 5.

4.4 RECAPITULATION

In this chapter I look to ways in which arts practices in healthcare settings are constrained and enabled through the operation of discourse. As discursive practices define what counts as meaningful statements, I refer to specific statements as instances of the way in which discourse operates in practice through conferences, seminars and artworks. Particular emphasis is placed on themes from practice not typically heard in

¹¹⁰ 201 placebos were submitted from 24 countries.

¹¹¹ See Section 11.11 Medicine in Art, for an elaboration of *Placebos for Art* and The Sokal Affair

academic scholarship, and disclosing limits to the conditions of possibility for scholarship.

I identified the way in which discursive practices limit what can be spoken of through medical dominance and art institutional prejudice, the way in which some voices are excluded from discourse as unreliable in favour of reasoned approaches and finally the way in which true and false are fielded as operators to limit discourse;

1. as control over who can speak prohibits all but clinical and academic professionals
2. who offer reasoned, authoritative statements to
3. construct truth practices embedded in institutions and reinforced and renewed through whole strata of social practices.

Recognising that discursive statements are not merely the utterances of a unified subject; that statements and subjects emerge from a field of possibilities that is a dynamic and contingent multiplicity, the research problem was reoriented to reflect the limits of discourse in academic scholarship. But rather than proceeding according to the logic of negative critique, a tactic which neglects the possibility of being caught up in the same terrain as that which is ostensibly opposed, I sought affirmative directions for what (else) an arts practice could do.

In the next chapter I discuss the way in which the inquiry was reconfigured in theory following the exposure of limits to discourse in this chapter.

5 THEORETICAL FRAMEWORK: THINKING TOOLS

Philosophy, art, and science are not the mental objects of an objectified brain but the three aspects under which the brain becomes subject (Deleuze & Guattari 1994, p.210)

Invoking the question, 'what (else) can an arts practice do?' is an heuristic that emerged consequent to many and diverse attempts to find a way into, and a way out of my inquiry. It was essential to establish a theoretical framework that could be informed by and support the development of this inquiry, but the explanatory frameworks applied to these practices have been borrowed primarily from the medical field and as already discussed can be seen to be more appropriate to arts therapy. The absence of a robust theoretical framework has been identified as weakness which stems from a lack of critical writing (Coulter 2014). This inquiry seeks to foreground a theoretical framework within which to locate practices that are both transdisciplinary and transversal, 'as a catalytically eventful bridge between a multiplicity of movements and relations' (McCormack 2003, p.496). However, arriving at such a framework was not a straightforward, linear process as will be seen in the chapter below. Theories offer conceptual vocabularies (necessarily under determined) providing a way in which to understand our encounters in the world and are used in this research inquiry to bring into language previously unspecified problems and to anticipate consequent trajectories. Hence, the research is characterised by movement in terms of theory and practice.

This chapter is presented in five parts; Firstly, I outline the movement between theoretical positions adopted in an attempt to open up practices to discussion, briefly mapping shifts from; Gadamerian phenomenology, Foucauldian discourse and ultimately to a Deleuzo-Guattarian philosophy of pragmatics. Secondly it draws on the work of Deleuze and his precursors to lay out a groundless ground of immanence and the implications for thought. Thirdly, I distinguish between art, science and philosophy as each are centrally implicated in this inquiry (Deleuze &

Guattari 1994). Fourthly, I attend to the ways in which health is reconceptualised as a process rather than as a state, as a 'healthing', in terms of what it can do (Duff 2010; 2014; Fox 1993; 1999; 2011; 2012a; 2012b). A trajectory of health technologies from aetiology to ethology is traced and a link between creativity and health established. Finally, I elaborate an understanding of art in terms of what it can do and in which the work art is figured as an aesthetics of affect (O'Sullivan 2001; 2007; 2011a). This is followed by an elaboration of art critical concepts in terms of art's own self-understanding in the critique of creativity followed by that of institutional critique.

5.1 THEORETICAL NOMOS

This research is characterised by movement in terms of theory and practice.¹¹² The movement through theoretical positions discloses the nomadic character of this inquiry, detaching from theoretical conventions to locate theory within practice and as an unfolding practice. Deleuze notes; 'Theory is an inquiry: which is to say, a practice: a practice of the seemingly fictive world that empiricism describes; a study of the conditions of legitimacy of practices in this empirical world, that is in fact our own (Deleuze 2001, p.36). Deleuze considers that the world exceeds any categories with which we seek to capture, or represent it. By attending to theory in practice, it is enlivened as a processual going beyond and across and in between what may appear as tangential. Theory then, consistent with its articulation of emergence, becomes performative in the way that it enacts transversal connections and relations.

Initially the inquiry originated as a hermeneutic phenomenological inquiry based on the writing of Gadamer, as *Interpreting Arts and Health*. As the research progressed it became clear that this framework could not

¹¹² Although nomos is translated as law, according to Roffe (2005), Deleuze refers to it in the sense of its etymological root *nem*, which means to distribute or to arrange elements (in this case theory) in a way that does not rely on a fixed organisation or structure. He opposes nomos to the word *logos*, which ascribes elements to their right place. Nomos is deployed here to reflect the movement between theoretical orientations "in which encounters outside of the ordered conception of existence can become possible" (Roffe 2005, p.191).

support the project as it was proceeding in practice. It was inadequate to the task of exploring arts practices in healthcare settings collectively rather than as an individual case study.¹¹³ It became evident that although the specification 'and' in arts 'and' health, arts 'and' research, medicine 'and' humanities would indicate conjunction, their practice and language diverge. Clinical evaluation of contemporary arts practices is to misunderstand them. Expectations of positive clinical outcomes, places an intolerable burden on artists who are not clinically trained and imposes an unreasonable doubt on contemporary arts practices. My conclusion was that scholarship on arts practices in healthcare settings is limited through the exercise of knowledge and power in discourse. This was a key insight as it reoriented the research from substantive to discursive sites. The research then moved into a second phase where it was characterised as *(Mis)Interpreting Arts and Health*, and in which I sought to deploy the Foucauldian concept of discourse to assist in reformulating the research problem:

We must ... question those divisions or groupings with which we have become so familiar ... These divisions - whether our own, or those contemporary with the discourse under discussion - are always themselves reflexive categories, principles of classification, normative rules, institutionalized types; they, in turn, are facts of discourse that deserve to be analyzed beside others (Foucault 2002b, p.24).

The Foucauldian concept of discourse refers not only to language, but also to language *and* practices that operate to produce objects of

¹¹³ A hermeneutic phenomenological approach could only generate language related to essentialised practices unconcerned with wider disciplinary practices, but this would be a departure from a research ethic that sought to intervene. Gadamer is criticised by Habermas, claiming that the uncritical deployment of prejudice and tradition leaves Gadamer's hermeneutics enmeshed in ideology without either a means or an incentive for a self-reflective critique (Mendelson 1979). In his phenomenological account of our encounter with a work of art, Gadamer has described the artwork and spectator as players and participants in a continuous to and fro movement, out of which meaning emerges and is understood. His discussion of play laid the groundwork for grasping the process of hermeneutic experience in general. Further in his discussion of art, Gadamer unlocks the key to his meaning of understanding which is 'never a subjective relation to a given 'object'' (Gadamer 2004, p.xxxi) as the Cartesian model would have it, but rather it is a dynamic, social, multivocal process of engagement in which we move beyond the confines of our own perspective and toward more universal points of view (Vilhauer 2010, p.49). Of course this assumes that all participants want to play. The problem of a dominating power suppressing difference or a diversity of ideas, cannot be accommodated, despite Gadamer's claim that, 'tradition is not simply a permanent precondition; rather we produce it ourselves inasmuch as we understand, participate in the evolution of tradition, and hence further determine it ourselves' (Gadamer 2004, p.293). Habermas believes that Gadamer has forgotten the oppressive power of tradition, hermeneutics fails in its claim to universality as it is limited to the bounds of tradition (Vilhauer 2010, p.59). Hence a reorientation of the inquiry was inevitably precipitated.

knowledge through those webbed connections linking knowledge, power, institutions, regulations, statements and practices that regulate the limits of what is accepted as a regime of truth (Barrett 2006). Foucault (Foucault 1990) proposes that; 'in every society, the production of discourse is at once controlled, selected and redistributed by a certain number of procedures' (Foucault 1990, p.52). These procedures of exclusion are historically and culturally specific rules for organising and producing different forms of knowledge. Three conditions govern the procedures of exclusion (discussed in detail in Chapter 4). These exclusions describe; 1. control over who can speak, what they can speak about and when they can speak; 2. what constitutes reasoned or authoritative discourse and 'mad', unsanctioned, unreliable discourse; and 3. the process whereby the producers of discourse construct 'truths'. These truths are embedded in institutions and reinforced and renewed through whole strata of social practices (Foucault 1990, pp.52–54).

This understanding of truth connects it in a circular relation with 'systems of power which produce and sustain it, and to effects of power which it induces and which extends it' (Foucault 2002c, p.132). Foucault calls this a 'regime of truth'. Discourse not only structures the way we think about the world, but also produces us as subjects in the way we act in the world. It is possible to speak of a medical discourse in which, through rule and convention, types of knowledge are made possible in specified spaces, by subjects produced by that knowledge, as doctors, patients, and researchers. In this way;

Power and knowledge directly imply one another, there is no power relation without the correlative constitutive field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations (Foucault 1995, p.27).

Similarly, one could also refer to a discourse of art, which is not concerned with visual images but with knowledge, language, institutions and practices that set apart some work as 'art' and others as 'not art' (Nead 1988, cited in, Rose 2011, p.190). And of course there are discourses associated with academic research, which through their own

conventions, institutions and knowledge practices determine what is research and what is not (see section 3.4).

The Foucauldian concept of discourse is useful to the inquiry because it gives a vocabulary and conceptual framework that can be deployed in the articulation of a research problem, in the way that it infers a critical awareness of what is being said and by whom and in the way that discursive practices inhibit research in asking questions beyond the conditions of possibility of the prevailing regime of truth (see chapter 4). While the concept of discourse was sufficient for the task of naming the research problem, it did not provide a route to addressing that problem in a generative manner consistent with the intentions I have for my own art practice. Scheurich and Mackenzie (2005) argue that, in exposing the truth regimes of social life exemplified in the prison, the clinic and sexuality, as historical and contingent, Foucault himself becomes oppressive, leaving us with no way out, with no path of resistance. This view is echoed by Fraser who in her analysis of institutional critique remarks, 'every time we speak of the "institution" as other than "us", we disavow our role in the creation and perpetuation of its conditions' (2005, p.283) (see also section 5.5.3). This then led to the third theoretical orientation for the research inquiry.

In attending to the research problem in the way arts practices in healthcare settings are constrained and enabled through the operation of discourse (see chapter 4), the question for this research then lay in how to move beyond, rather than merely rehearse critical positions. Such positions can only offer opinion and judgement, limiting opportunities to repair and reassemble and binding us perpetually to the object of criticism (BAK, 2014). Resisting such a fate, I turned to the generative and future oriented work of Deleuze in conjunction with his collaborator Guattari as an affirmative strategy. As Foucault remarks in his preface to *Anti-Oedipus*, Deleuze and Guattari are 'less concerned with *why* this or

that than with *how to proceed*' (2004, p.xii italics in orig.).¹¹⁴ Deleuze considers that ontology is not about the discovery of already existing fixed entities, a move, which abandons dualistic distinctions of form/matter, mind/body, concept/content, transcendental forms of Truth/God/Reason/Being and determinate identities and subjects. Deleuze considers that the world exceeds any categories with which we seek to capture, or represent it in an ontology that is concerned with creation rather than discovery. Instead of trying to discover the true nature of the Universe's fundamental entities as matters of explanation, ontology begins when we abandon the search for conceptual stability and begin to see what there is in terms of difference and repetition rather than identity and representation (Deleuze 1994). The research then shifts from oppressive negative critique to a generative and future oriented practice invoking the work of Deleuze (1988b;1994; 2005) and Deleuze and Guattari (1986; 1994; 2004b). The adoption of a Deleuzo-Guattarian approach made possible an experimental propositional engagement with arts practices in healthcare settings, simultaneously, as an act of resistance and an act of creation. Consequently the project arrives at its third iteration as *(Mis)Interpreting Arts and Health: What (Else) Can An Arts Practice Do?*, where the 'Else' refers to the generative and iterative becoming of the project and the sub-clause conveys an understanding of an arts practice in terms of its affects. Parentheses are deployed as a framing device, as 'each parenthetical modification alters perception of the en-framing gesture' (Dick & Wolfreys 2013, pp.112–113), to prompt multiple readings of the title, rather than insinuate any foundational claim.¹¹⁵ The self-understanding of the project title can be read in many ways by readers of different dispositions and remains open to future readers.

¹¹⁴ Nevertheless, Foucault and Deleuze share an understanding of the relationship between their work as partial and fragmentary resembling the relationship between theory and practice in which 'theory does not express, translate, or serve to apply practice: it is practice' (Foucault 1980a, p.205). In a review of two of Deleuze's books, Foucault famously claims 'perhaps one day, this century will be known as Deleuzian' (Foucault 1980b, p.165) and later in the same review Foucault remarks on Deleuze's work 'new thought is possible: thought is again possible' (1980b, p.196).

¹¹⁵ Such notation is commonly used, for example, *(Mis)Understanding Photography: Works and Manifestos* is the title given to an exhibition at Museum Folkwang, Essen, Germany, 14 June – 17 August 2014, or for example a recent editorial title in e-flux journal *(Im)practical (Im)possibilities* 04/2013.

In the next section I attend to particular aspects of the Deleuzo-Guattarian oeuvre. I begin with a discussion of immanence, which opens up an arsenal of resources for rethinking the ambit of this research beyond the confines of predictability. Such an engagement allows us to see our situated and provisional knowledge as only one possible derivation of a multiplicity of relations. It releases us from negative critique that binds us to that which is criticised. Instead it offers the promise of fluid affirmative propositional gestures. Such work can be seen as part of an emergent and heterogenous affective turn in social sciences and humanities.¹¹⁶ How such work is applied in this research will be foregrounded later in this chapter in discussions of health and art. But first in order to depart from logocentric narratives it is necessary to consider the groundless ground of immanence.

5.2 THINKING WITH IMMANENCE

A single and same voice for the whole thousand-voiced multiple, a single and same Ocean for all the drops, a single clamour of Being for all beings: on condition that each being, each drop and each voice has reached the state of excess – in other words, the difference which displaces and disguises them and, in turning upon its mobile cusp, causes them to return (Deleuze 1994, p.304).

Thinking with immanence requires a radical reconceptualisation of thought because just as the world around us, just as life in all its forms emerges in immanence so too does the way we think about it, 'to think is not to represent life but to transform and act upon life' (Colebrook 2002, p.xxiv). In this section I provide a brief sketch of the way in which Deleuze drew on a particular intellectual lineage to develop an understanding of immanence in which the autonomous thinking subject is erased. The next section adds to this by attending to the distinctions made between art,

¹¹⁶ The affective turn is manifested diversely. Gregg and Seigworthy propose eight approaches with the caveat that this is a provisional, not a comprehensive account of all that is out there or yet to come (2010, pp.6–9). See also La Caze and Lloyd (2011) who summarise these vectors as 'phenomonological and post-phenomonological theories of embodiment; cybernetics and theories of the human/machine/inorganic; non-Cartesian traditions in philosophy; aspects of psychological and psychoanalytic theory; traditions critical of normalising power including feminism, queer, and subaltern and disability studies; a collection of attempts to react to the linguistic turn; critical theories and histories of the emotions; and aspects of science and neurology'.

science and philosophy at the disciplinary level which can be deployed to the particularities of art, health and research found in lived experience.

The entanglement of how we live in the world and how we think about it is parsed by Deleuze as the dogmatic image of thought. This is a mode of thought that is nothing more than a re-presentation of what is presented to us in the world. Representation provides stability in categories of recognition limiting how we can conceive of the world, 'It mediates everything, but mobilizes and moves nothing' (Deleuze 1994, pp.55–56). It denies the possibility that any identity can be more than its category. The dogmatic image of thought operates through common sense and good sense as modes of judgement that both partition and measure (ibid. 1994, p.33).¹¹⁷ Common sense and good sense allow a difference to be made between categories because the categories are not identical. These are differences of degree rather than difference in kind. Difference then is subordinated to identity and thinking becomes subordinated to opinion and orthodoxy (ibid. 1994, p.134).¹¹⁸ Such conformism is located within the structure of our thought. In order to break such bonds, we must learn to think differently rather than 'remain a prisoner of opinion' (ibid. 1994, p.144). Such work begins with 'someone – if only one – with the necessary modesty not managing to know what everybody knows' (ibid. 1994, p.130). For Deleuze such individuals are found in his predecessors Spinoza, Bergson, and Nietzsche who provide the armature to develop an immanent ontology that is experimental rather than dogmatic.

According to Spinoza all that exists in the world is a univocity of being, 'a single substance having an infinity of attributes' (Deleuze 1988b, p.17), the substance of being is one. This immanent substance is liberated from transcendental conditions such as God or Truth.¹¹⁹ From this Deleuze distills a compelling account of the immanent constitution of the world and all that it is, material, immaterial, human, inhuman, organic, inorganic,

¹¹⁷ 'Good sense and common sense each refer to the other, each reflect the other and constitute one half of the orthodoxy. In view of this reciprocity and double reflection, we can define common sense by the process of recognition and good sense by the process of prediction' (Deleuze 1994, p.226).

¹¹⁸ See (Deleuze & Guattari 1994, pp.145–149) where they refer to the popular conception of philosophy as after dinner conversation to accompany cheese.

¹¹⁹ Deleuze and Guattari refer to transcendence as 'a particularly European disease' (2004b, p.20)

artificial and natural. It provides a novel approach to thinking subjectivity, the body, relations and ethics. Immanence encompasses both the world and the thought of that world escaping the dogmatic image of thought found in opinion and habit. It can be understood as follows; 1. Immanence is never immanence *to* something – it is not transcendent in the mind of God, there is no constant identity outside our world. That is why I call this section 'Thinking with Immanence' as to do otherwise would be to create an outside that does not exist. 2. Difference is never simply difference *from* something rather it is the infinity of modifications that are part of one another: immanence therefore can be understood as the expression of difference.

Thinking in this way, an immanent plane is necessarily always open to re-conceptualisation, because there is no privileged point from which to form concepts, neither is there an outside with which to close down questions, rather it is the experience of living in the world that will lead to thinking and rethinking concepts. Spinoza offers the body as a model, insisting that the body exceeds the knowledge we have of it, consequently '*thought likewise surpasses the consciousness we have of it*' (ibid 1988b, p.18 italics in orig.). May (2005) offers the example of Origami to explain how difference is concomitant with univocity. In Origami a single sheet of paper is folded, unfolded and refolded to create distinguishable figures. The paper is not cut nor are any external elements introduced. 'Everything happens as an expression of the paper ... Substance folds, unfold and refolds itself into its attributes and its modes, to which it remains immanent' (2005, p.38). Accordingly, we can understand that these figures are not copies or models of an original, they are all modifications of substance folded, unfolded and refolded.

Being expresses in a single meaning all that differs. What we are talking about is not the unity of substance but the infinity of the modifications that are part of one another on this unique plane of life (Deleuze & Guattari 2004b, pp.280–281)

This unremitting expression of substance in its foldings animates it as a process of expression rather than as a stable entity. After all as Spinoza declares, *we do not even know what a body can do* and as a corollary,

the thesis of parallelism asserts that we cannot know what the mind can do.¹²⁰ These moments of expression cannot be accommodated by either linear or existential conceptions of time and lead Deleuze to Bergson and his work on duration.¹²¹

The capacity of the mind to think is opened up by Bergson who viewed it as a complex system of exchange in its perceptions and reactions. Between these two – a gap emerges in which memory, an a-subjective, universal and virtual force operates. Deleuze qualifies, 'It is the recollections of memory that link the instants to each other and interpolate the past in the present' (1988c: 25). The linear conception of time can only claim a 'now' as an ideal point that is infinitely divisible, but the concept of duration embraces the idea that 'we move from the past to the present, from recollection to perception' (Deleuze 1988a, p.63). The present passes into the past and flows in duration 'overtaking ... the "not yet" and passing away in "the already"' (May 2005).¹²² However, the present and the past exist in very different ways. We can say that the past is a virtuality, while the present is an actuality of our direct experience. The virtual is all that is 'real without being actual, ideal without being abstract' (Deleuze, 1994:208). Deleuze distinguishes between the virtual and the actual and the real and the possible as follows: 1. The possible does not (yet) exist, while the virtual is already real. 2. The possible resembles the real, but the virtual does not resemble the actual. The virtual is always there yet unexpressed. Actualising the virtual then is a process of its expression in folding, unfolding and refolding. The virtual is real, but not actual. Here we see the temporal character of substance emerging. In duration we see the virtual that is always there. Furthermore duration not only gives rise to the present, it is of the present – there can be no separation in immanence. Now the potency of this union of substance and duration reveals itself. The world is what it seems and more than it

¹²⁰ 'What is an action in the mind is necessarily an action in the body as well, and what is a passion in the body is necessarily a passion in the mind' (Deleuze 1988b, p.18)

¹²¹ May explains, 'The linear conception of time produces each event of expression as discrete and disconnected thereby undermining the claim to immanence, while the subjectively oriented existential conception of time cannot accommodate immanence because of its privileging of the human subject' (May 2005, p.44).

¹²² Note it is not *my* past but *the* past.

seems. After all, if we do not even know what a body is capable of, we do not know what may happen in the future. This future orientation brings us to the last of the three major influences in the way that Deleuze deploys the Nietzschean conception of the eternal return.

Nietzsche's poses the eternal return against the danger of nihilism inherent in the repudiation of the transcendental foundation of thought and knowledge. After all, If nothing is true then we jeopardise thinking altogether, but Nietzsche snatches thought from truth and falsity, turning instead to interpretation and evaluation (Deleuze 1986, p.xiv). The eternal return is found in the recurrence of difference. This can only be true if there is no stability of being.

For there is no being beyond becoming, nothing beyond multiplicity: ... Multiplicity is the inseparable manifestation, essential transformation and constant symptom of unity. Multiplicity is the affirmation of unity; becoming is the affirmation of being (Deleuze 1986, pp.23–24)

This stands apart from more typical interpretations of the eternal return, which understand it as the recurrence of the same. Deleuze asserts the eternal return is 'not the permanence of the same, the equilibrium state or the resting place of the identical,' (ibid 1986, p.46) Deleuze thinking through Nietzsche establishes life in difference. Each repetition of difference is different and so difference returns for eternity. The eternal return is the recurrence of difference, of multiplicity. The becoming of the world is understood as eternal repetition of difference, a constant reinvention of itself, of continuous variation and creation.

the eternal return is in no sense a thought of the identical but rather a thought of synthesis, a thought of the absolutely different which calls for a new principle outside science. This principle is that of the reproduction of diversity as such, of the repetition of difference (ibid. 1986, p.46)

Furthermore, the eternal return affirms the world as it is without meaning or final aim. What returns is not the same, rather the meaningless variation of a becoming world. Transience and contingency are involuted as absolute values. In accepting the being of becoming, the world is affirmed as *it is*

at every moment. We cannot appeal to any index of the future or the past with which to evaluate the present. In the eternal return an entirely new kind of valuation is played out. In the absence of any finality, at once, everything is valueless and at the same time of a novel contingent value. Each transitory moment is of value but cannot be measured against transcendental indices, 'each perception 'ungrounds' any stable point of view' (Colebrook 2002, p.175) giving rise to an ethic of affirmation rather than one of external judgment. This immanent affirming ethic is an unending struggle by thought to reorient its located perspective in order to think the whole of life and all its perceptions past, present and future in a joyful attitude.

To affirm is not to take responsibility for, to take on the burden of what is, but to release, to set free what lives. To affirm is to unburden: not to load life with the weight of higher values, but to create new values, which are those of life, which make life light and active. There is creation, properly speaking, only insofar as we make use of excess in order to invent new forms of life rather than separating life from what it can do (Deleuze 1986, p.185 italics in orig.).

The eternal return is an experimental relinquishing of the actual to explore the virtual. Laughter, play and dance are its affirmative powers: difference is happy and only joy returns. 'Multiplicity, becoming and chance are the properly philosophical joy in which unity rejoices in itself' (Deleuze 1986, p.190).

This immanent ontology is developed by Deleuze to address how one might live without falling into the trap of identity and representation. This materialist approach conveys the impersonal nature of life,

We will say of pure immanence that it is A LIFE, and nothing else. It is not immanent to life ... A life is the immanence of immanence (Deleuze 2001, p.27).

Immanence, then, is a life rather than *my* or *the* life. Deleuze (2001) goes on to offer an example of a life by citing the actual event of life before death, and life after birth, to convey its singular, impersonal and unindividuated nature. He hastens to add that 'a life' (and its virtualities) is everywhere in all moments of an individual's life coexisting with the

accidents of the life that correspond to it. In this way the human subject is always an emergent process of differing from itself in its 'becoming', a ceaselessly iterative process.¹²³ This applies equally to the inanimate and the animate, the artificial and the natural. Deleuze then can be characterised as a philosopher of *life* – a life that is;

conceived as ceaseless creativity and change, as the production of difference or novelty, as a proliferation of encounters between differing forces of affect, as a multiplicity of presents; in a word, as immanence (Cull 2012, p.3).

Thinking with Deleuze requires an image of thought that does not conform to existing transcendental structures. As part of the flux of an immanent world, thought is not a practice that exists separately to the world; it is a part of the flux of the world, 'To think is not to represent life but to transform and act upon life' (Colebrook 2002, p.xxiv). Deleuze and Guattari (2004b) develop the concept of the rhizome to allow us to think thought differently. The rhizome allows us to think beyond representation and the dogmatic image of thought, beyond the binary of subject-object and beyond hierarchical structures. Although the rhizome can take many forms, it is better understood as a dynamic flux rather than a structure. The rhizome has multiple entry and exit points, whereby any line can lead to any other. Unlike the 'tap root' or the tree root, the rhizome does not lead back to a single logic, a single truth or a common objective.

The tree imposes the verb "to be", but the fabric of the rhizome is the conjunction, "and ... and ... and ..." This conjunction carries enough force to shake and uproot the verb "to be" (ibid. 2004b, p.23)

The rhizome connects any point to any other point being composed of directions in motion rather than dimensions. It has no beginning or end, rather it grows from the middle having multiple entryways and exists like a map that is 'always detachable, connectable, reversible, modifiable' (ibid. 2004b, p.23). These connections should not be considered as social relations between individuals, but rather as a set of

¹²³ In order to think through immanence it is necessary to adopt a language that shifts from adjective-noun relation to an expression of the infinitive (Colebrook 2002, p.33). This expression does not distinguish between what something is and what something does and will be returned to in later discussion as a 'healthing'.

vectored interactions between elements and forces of heterogenous constitution. Yet, this is not to 'romance the rhizome' in a rhizomatic fantasy of liberation, creation and plurality (Wallin 2010).¹²⁴

The practice of arts and health can be considered a rhizome composed of connected elements and forces, in which alliances, collaborations, projects, equipments, artifacts and research are constantly being assembled and disassembled. This thesis is intended as a line of flight, that may or may not, lead to a reconfiguration of the rhizome through processes of deterritorialisation and reterritorialisation. The inquiry is neither imitation nor resemblance as it differs qualitatively with research that is intended to 'prove the practice', moving from representation and recognition to difference towards an approach that decentres human agency in the affects that unfold. The rhizome foregrounds a politics of practice that in terms of this thesis, asks, 'What does it function with?' (Deleuze & Guattari 2004b, p.4). Rather than confining the limits of practice to linear causality, it opens up this thesis to a wide field of potentiality making connections with and between health, art and politics.

Deleuze and Guattari introduce a rich and complex range of concepts such as; affect, assemblage, deterritorialisation, ethology, lines of flight, nomadology, territorialisation and more. These concepts will be explained as they appear subsequently in the text.¹²⁵ For now I register the way in which they refer to spatial relationships and to ways of conceiving of ourselves and other objects moving in space. For example, Deleuze and Guattari (2004b, p.23) distinguish the 'sedentary point of view' that characterizes much Western philosophy, history and science from a nomadic subjectivity that allows thought to move across conventional categories and move against 'settled' concepts and theories. This is both the strength and the weakness of the Deleuzo-Guattarian project; it's

¹²⁴ See Wallin (2010) who offers five provocations on the concept of the rhizome in order to resist its romanticisation. 1. The Rhizome is not, in Itself, Libratory, 2. The Rhizome as a Handmaiden of Neo-liberal Capitalism, 3. The Rhizome is Neither Model or Metaphor, 4. On not Taking it Personally, 5. The Third Space Under Threat

¹²⁵ See also the glossary in Chapter 11.

inherent heterogeneity demands perpetual heterogenesis such that philosophical concepts are, mobile both in themselves and in relation with other concepts, and hence irreconcilable to any systemic consistency (Bignall & Patton 2010). The absence of systemic closure is exemplified in *A Thousand Plateaus*, a book in which concepts undergo continuous variation across chapters, is without narrative structure and ends not with a conclusion but with definitions for the construction of yet more concepts which can be extended without limit. Such a project requires a thinking through in each case that is not easily accessible to conventions governed by opinion and cliché. In the next section I turn to the Deleuzo-Guattarian treatment of the chaotic disciplines of art, science and philosophy to address the manner in which they struggle with chaos and more crucially with opinion.

5.3 STRUGGLING WITH ART, SCIENCE AND PHILOSOPHY

Deleuze and Guattari propose a philosophy of 'pragmatics', in which the invention of concepts is not intended as a system of beliefs or architecture of propositions, rather, they are intended as a dynamic 'toolbox' (Masumi 2004b, p.xv). They distinguish thought as it is exercised in its three great forms – art, science, and philosophy, in the way that each 'is always confronting chaos' (Deleuze & Guattari 1994, p.197). Arts practices in healthcare settings precipitate encounters between art and science in the way each thinks and talks about the other. Add into the mix an academic PhD research inquiry and then all three forms of thought are centrally implicated within it. Distinguishing between art, science and philosophy will provide a vocabulary with which to negotiate these practices.¹²⁶

In the previous section I referred to the doxa of opinion that imposes conformity. Deleuze and Guattari characterize opinion as, 'a sort of "umbrella", which protects us from chaos' (1994, p.202), it is what allows us

¹²⁶ The practice of medicine and allied health disciplines in contemporary forms are denoted by the health sciences and so the elaboration of these encounters between philosophy, art and science are a central concern for this thesis.

to operate in the realm of representation. However Deleuze and Guattari register a particular interest in the chaoid activity of art, science and philosophy in the way each encounters chaos or as they so expressively put it 'tear open the firmament and plunge into chaos' (ibid 1994, p.202).

Chaos is defined not so much by its disorder as by the infinite speed with which every form taking shape in it vanishes. It is a void that is not a nothingness but a *virtual*, containing all possible particles and drawing out all possible forms, which spring up only to disappear immediately, without consistency or reference, without consequence. (ibid 1994, p.118 italics in orig.).

Order emerges from chaos through the sieve of immanence that filters some particles or forms on the basis of their consistency with other parts or forms. Philosophy gives consistency to chaos while also maintaining its variations through instituting a plane of immanence (likened to the breath) on which concepts (the skeletal frame) are created (ibid 1994, p.36). Art is a composition of chaos in which varieties of a being of sensation are composed through a constellation of affects and percepts on and constituting a plane of composition. Unlike philosophy and art, which opens up to chaos, 'science approaches chaos in a completely different, almost opposite way' (Deleuze & Guattari 1994, p.118). Science moves from the infinite to the finite, in the way it deals with real physical processes of an actualised world, retrieving variables as finite points on a a plane of reference. The emergence of the chaoid disciplines and their ongoing struggle with chaos, does not preclude a continuing relation, nor the conditions of their possibility. The distinctive styles of these intelligences is briefly sketched below and will be returned to in subsequent discussion.

According to Deleuze and Guattari, art is a composition of chaos. It is a composed chaos – neither foreseen nor preconceived. It is concerned not with technical composition, nor with communication of an artist's intention.¹²⁷ Rather art is concerned with an aesthetic composition of sensation, 'the work of art – is a *bloc of sensations*, that is to say a compound of percepts and affects' (ibid 1994, p.164). Percepts are not

¹²⁷ Deleuze and Guattari insist that the work of art 'is preserved in itself', independent of the artist's intentions, the viewer's reactions and the material's longevity (1994, pp.163–165).

perceptions. They do not refer to a perceiver, and neither are affects the feelings or affections of someone.

Percepts aren't perceptions, they're packets of sensations and relations that live independently of whoever experiences them. Affects aren't feelings, they're becomings that spillover beyond whoever lives through them (thereby becoming someone else) (Deleuze 1995, pp.136–137).

Affects and percepts are independent beings, which exist outside of the experience of a thinker, and have no reference to a state of affairs. Art is created on a plane of composition, which is immanent only to itself and populated with the pure forces of percepts and affects (Deleuze & Guattari 1994, p.196). Each artwork constructs a plane of composition as it is assembled.¹²⁸ We are asked to relinquish our preconceptions and opinions about our encounter with art. As Bolt ironically remarks 'whilst an image is conceived as a representation of the world, we are perfectly safe' (2010, pp.269–270), but instead of the safety of the known we are asked to encounter the unknown, we are asked to step out from beneath the ordering umbrella which protects us from chaos. The particularity of art then, 'is to pass through the finite, in order to discover, to restore the infinite' (Deleuze & Guattari 1994, p.197). By abandoning the aesthetic regime in which compositional dynamism operates purely within the frame of the work, Deleuze proposes that the task of art is a matter of capturing forces, rather than reproducing forms (Deleuze 2005, p.56). What emerges then from art's struggles with chaos are varieties of a being of sensation.

Deleuze and Guattari characterise science as a slowing down of chaos, 'in order to gain a *reference to actualise the virtual*' (ibid. 1994, p.118 italics in orig.). This slowing down sets the limits or borders through which science confronts chaos, returning variables that are finite coordinates on a plane of reference extending from local probabilities to global cosmology (ibid. 1994, p.202). Relinquishing the infinite, science lays out a plane of reference composed of undefined coordinates and through the action of partial observers, defines states of affairs, functions, or referential

¹²⁸ The plane of composition is fluid, dynamic and specific to the artwork, '... it is not abstractly preconceived but constructed as the work progresses, opening, mixing dismantling and reassembling ...' (Deleuze & Guattari 1994, p.188).

propositions. Science descends from the virtual to the actual through the operation of functions, while philosophy and art ascend in the opposite direction via the concept and bloc of sensation respectively. Thinking through functions and prospects, scientific systems operate in and shape the world to establish a plane of reference on which a virtual chaos can be actualised in co-ordinates, and described in propositions. These acts of reference are performances of scientific epistemology, being singular, limited and defining. They are 'finite movements of thought by which science constitutes or modifies states of affairs and bodies' (ibid. 1994, p.138).

Philosophy, art and science exist then as chaoids produced on the planes of immanence, composition and reference respectively. Deleuze and Guattari note that if any of these three disciplines attempt to extrinsically interfere in one another then, 'the rule is that the interfering discipline must proceed with its own methods' (Deleuze & Guattari 1994, p.217).¹²⁹ This is the case unless there is a dissolution of all three disciplines in chaos, in which case concepts, sensations and functions become undecidable, just as art, science and philosophy become indiscernible (ibid. 1994, p.218). Such dissolution is an absolute deterritorialisation. Deleuze and Guattari distinguish between absolute deterritorialisation and relative deterritorialisation. It 'is absolute when it brings about the creation of a new earth' (Deleuze & Guattari 2004b, p.561). It is relative when it releases movements within the actual realm of embodied and historical events and processes. In this thesis what is at stake are relative deterritorialisations.¹³⁰ Consequently taking the lead from Deleuze and Guattari, as art becomes imbricated in health settings it must proceed with its own methods.

¹²⁹ Deleuze and Guattari clarify that such distinctions are operable only while disciplinary thinking proceeds. They draw attention to the chaos that lies between disciplines and the complex plane that arises when there is a sliding or slippage in the plane of immanence. They draw attention to the potential for collapsing disciplines into chaos with the prospect of extracting 'the shadow of "the people to come" ' (1994, p.218).

¹³⁰ Deleuze and Guattari exhort us to 'Connect, conjugate, continue' (Deleuze & Guattari 2004b, p.178) and it is this orientation which drives this research.

In distinguishing between science, art and philosophy Deleuze and Guattari do not seek to hierarchically rank them, nor do they seek to flatten their differences. The purpose of the boundaries drawn between philosophy, science and art is not to exclude. Indeed often what is most interesting is the exploration of the interferences of each in the others. Yet as Amott puts it, 'the intention is rather to demarcate, to show that no one of these forms is reducible to the other, and that any attempt to blur the boundaries is to be resisted' (Amott 1999, p.49). Furthermore, the struggle against chaos exercised by art, science and philosophy is matched with an even greater struggle against opinion. This struggle is where art finds its ground; in the struggle against 'the "clichés" of opinion' (Deleuze & Guattari 1994, p.204). In the next section we will see what happens when philosophy insinuates itself within the health sciences to map out a radically different orientation for practices.

5.4 DIFFRACTING HEALTH

The ontology developed by Deleuze establishes points of departure for a 'nomad science' of health concerned not with the stable identities of 'royal science', but rather with mapping 'the affects, relations and events of a body's becomings' (Duff 2014 ch1 p8).¹³¹ Deleuze and Guattari distinguish between 'royal' and 'nomad'; the former consists in 'reproducing' through iteration and reiteration, while the latter is a 'following' of itinerant and ambulant character consistent with the ontology already detailed above.

Reproducing implies the permanence of a fixed point of view that is external to what is reproduced: watching the flow from the bank. But following is something different from the ideal of reproduction. Not better, just different (Deleuze & Guattari 2004b, p.410).

As such I am not setting out to undermine the royal science of health as it is currently constructed in bio-medical discourse, rather I am following an

¹³¹ 'What we have, rather, are two formally different conceptions of science, and ontologically, a single field of interaction in which royal science continually appropriates the contents of vague or nomad science while nomad science continually cuts the contents of royal science loose' (Deleuze & Guattari 2004b, p.405)

approach to thinking about health that will allow me to smear categories of health in favour of following matter-flow, those fuzzy aggregates that relate to materiality/corporeality. The steps I am taking are only made possible by authors, who have established the conditions of emergence for this work. Over many years they have developed a corpus that challenges fundamental positions on issues related to health and healthcare, in a radical rethinking of how health can be understood and health research can be implemented (Duff 2010; 2014; Fox 1993; 1999; 2002; 2005; 2011; 2012a; 2012b; Fox et al. 2005; Fox & Ward 2008a; Fox & Ward 2008b; Potts 2004). They have articulated an approach characterised by its methodological empiricism setting in motion a stream of thought which when observed from the riverbank is strange and exciting, but when experienced in its application is potent in its depth.

This work emerges as part of a wider trajectory in social inquiry, which decentres anthropocentric assumptions. The postanthropocentric turn encompasses a range of positions from anti-humanism through feminist matter-realism and posthumanism (Barad 2003; Braidotti 2011; 2013; Ferrando 2013) creating new alliances between the arts and the sciences with multiple ecologies of belonging that operate to deprivilege the human in favour of affective material flows. The practice of diffraction is to disrupt linear and fixed causalities, to pursue 'more promising interference patterns' (Van Der Tuin 2011, p.26). This trajectory broadens the scope of research to include the non-human and the technological providing a framework adequate to the task of addressing developments in medicine that increasingly resort to biotechnological interventions.¹³²

What are the implications of adopting a Deleuzian approach to health? In the first instance it requires a reconceptualisation of the body so that we do not think of it in terms of identities (patient, nurse, artist), rather we can reconceptualise bodies in terms of their capacities to affect or be affected in terms of their affective flows. This Spinozist approach

¹³² Post structuralism emerged in France post 1968 to overcome prevailing dialectical oppositions of structuralism and Marxism, its legacy in contemporary social inquiry is concerned with what has been called the 'posthuman condition' (Braidotti 2013).

underscores the Deleuzo-Guattarian understanding of what a body can do, and what it can *become* - what *else* it can do.

The corporeal body does not exist as a discrete entity, rather it is an assemblage of parts connecting to other assemblages. Paraphrasing Deleuze and Guattari's description of the book assemblage, we can begin to appreciate just how different this approach is to the way in which biomedical discourse conceives the body. The body no longer exists as a stable, unified or bounded entity, rather it is conceived in terms of the connections that it makes with other human and non-human bodies. In terms of social inquiry, concepts of subjectivity, agency and autonomy are replaced by concepts of assemblages, relations and affects. Rephrasing the words of Deleuze and Guattari by overwriting the word book with the word body clarifies the way in which the body assemblage works;

As an assemblage, [a body] has only itself, in connection with other assemblages and in relation to other bodies without organs. We will never ask what [a body] means, as signified or signifier; we will not look for anything to understand in it. We will ask what it functions with, in connection with what other things it does or does not transmit intensities ... A [body] itself is a little machine. (Deleuze & Guattari 2004b, p.4)

This is a key passage as it introduces concepts that will be deployed throughout the following text. The concept of assemblage is a mobile process of arranging - it is a process of connection and interaction. Any body or element is the outcome of a process of connections - the body referred to here could be a social body in the form of an institution, a text, a body of ideas, social practices or a molecular body in the form of cellular forms e.g. cellulose or chemical elements of chlorophyll. The human body as an assemblage is the outcome of genetic, environmental, relational and affective connections. It is machinic in the sense that there are no prior forms or connections (ibid. 2004b, p.81). The assemblage has no final destiny, its trajectory is found in the connections it makes. An assemblage is a desiring machine. Deleuze and Guattari explain, desire is not driven by a fundamental lack; rather, desire is a process of life, a drive to connect (Deleuze & Guattari 2004a, p.28). It is 'machinic' as the productive process of (a) life that produces organisms and selves that

have no prior form.¹³³ Writing this thesis is part of a research assemblage in which flows of desire connect ideas, practices, institutions and peers. Other parts of the researcher assemblage include texts, notes, technology, transport, time and academic protocols. My body functions as part of many other assemblages too as mother, artist, citizen, student, food eater, waste creator, pill popper, water user, sun worshiper, gardener etc - desire is not unidirectional, it is the productive force of (a) life. The identities we experience then are not stable categories rather 'they are events within the flow of desire' (Colebrook 2002, p.xvi). Assemblages replace essence as the foundation of an identity. What something *is* can be observed by the way it *acts*, by its capacity to affect and be affected. After all a 'racehorse is more different from a workhorse than a workhorse is from an ox' (Deleuze & Guattari 2004b, p.283). This is not taxonomy according to genera and species; it is an answer to the question of what a body can do. Furthermore, they state:

We know nothing about a body until we know what it can do, in other words, what its affects are, how they can or cannot enter into composition with other affects, with the affects of another body, either to destroy that body or to be destroyed by it, either to exchange actions and passions with it or to join with it in composing a more powerful body (Deleuze & Guattari 2004b, p.284).

This understanding brings with it the capacity to recreate ourselves by disregarding identity categories and actual values of common sense to engage in a process of becoming. Duff (2014) analyses assemblages of health. Mental health recovery is regarded as a process of becoming sensitive to the affects, relation, signs and forces by which bodies become healthy. Consumption of alcohol and other drugs (AOD) requires the discernment of the healthy encounter from the unhealthy, in the particular mix of bodies, forces, objects and signs and affect active in each encounter of AOD use, on the basis of real experience rather than adherence to norms. This approach frees us to think about embodied health not as a state but as an active process with a fluctuating nature. We can think in terms of 'becoming-healthy' or alternatively as a

¹³³ | see (Deleuze 2001) for an elaboration of the impersonal and pre-individual quality of (a) life.

'healthing' body (Fox 2012a, p.12).¹³⁴ ¹³⁵ The next section looks at the consequences for such an orientation and considers previous shifts in conceptual understanding.

5.4.1 AETIOLOGY, ETHOLOGY, AFFECT

The problem of what a body can do ... is best understood as an attempt to replace aetiology (cause and effect) with ethology (action and affect) (Buchanan 1997, p.74).

The doctrine of specific aetiology states that for every disease there is a single and observable cause that can be isolated. It is a biomedical approach, which attributes specific causes to particular diseases that contemporaneously emerged with scientific disciplines.^{136,137} Engel (1977) suggested that specific causes are a necessary rather than a sufficient condition for the manifestation of a disease. Not everyone exposed to a causative agent will succumb to the disease - an influenza epidemic will not infect the whole population. Furthermore, for many diseases, particularly those where the incidence is currently increasing, such as heart disease and cancer, the cause has proved difficult to ascertain and there appear to be many different causative agents rather than a single one. In his seminal paper Engel proposed that,

To provide a basis for understanding the determinants of disease and arriving at a rational treatments and patterns of health care, a medical model must also take into account the patient, the social context in which he lives and the complementary system devised by society to deal with the disruptive effects of illness, that is, the physician's role and the health care system. This requires a biopsychosocial model (Engel 1977, p.196).

¹³⁴ Varied definitions of health exist on a continuum from a scientific naturalist approach to a normative understanding with many hybrid definitions in between. The naturalist approach is exemplified in the bio statistical theory of health in which health is defined as a statistically normal function of species design, and 'health' and 'disease' are characterised as empirical, objective and value-free concepts (Boorse 1997). A normative approach to the concept of health is illustrated by Nordenfelt (2001), when he argues that a healthy person is one who can satisfy "vital goals", which are necessary and sufficient for minimal happiness. Interpretations offered under the rubric of the social construction of health offer socially and culturally embedded analyses of how we understand health at a given point in time and in a given place (Berger & Luckmann 1967).

¹³⁵ Trademark status was granted to Reckitt Benckiser for the term 'Healthing' on 13th May 2014, see <http://trademarks.justia.com/858/23/healthing-85823723.html>

¹³⁶ For example, exposure to the tubercle bacillus causes tuberculosis or vitamin D deficiency leads to rickets

¹³⁷ See Collyer (2008) for a typology of theoretical orientations to medical knowledge and theoretical orientations to history concerning the emergence of the biomedical model of health.

Since its publication the biopsychosocial model has become influential in understanding how multiple factors cause health and illness. Previously I would have adopted this frame of reference in thinking about health and illness (Broderick 2011a). Yet when understood through a Deleuzo-Guattarian lens, the biopsychosocial approach to health becomes something that is achieved through attention to biological, psychological, and social needs, implicitly conceiving of people and patients as socially and culturally determined, with little or no potential to resist the forces and structures that impact on them.¹³⁸ According to Fox et al. (2005) this explanatory model 'incorporates social science evidence into narratives retaining scientific reasoning from aetiology' (Fox et al. 2005, p.946) and in effect operate as a rival territorialisation to bio-medical discourses.

For Deleuze and Guattari, subjectivity is a consequence of the confluence between embodiment on one hand, and on the other, the physical and cultural worlds, which limit, yet also make possible. Because of this, human embodiment cannot be reduced to physiology. Embodiment needs to be understood as an always-unfinished project, of conforming and transgression in the construction of subjectivity. Deleuze and Guattari introduce the concept of the 'body without organs' (BwO) to access these processes. The BwO is both a set of practices and a limit, the outcome of physical, psychological and social territorialisation, but which may be deterritorialised to open up new possibilities for embodied subjectivity. The construction of subjectivity is in the dialogical play of social processes and affirmative, creative and embodied experimentation/engagement with the world. As a site of inscription the body is constantly constructed and reconstructed as discourses, practices, techniques of professional care as well as pain, suffering, illness and disease struggle to give meaning to it in an always-unfinished project, through which the BwO mediates notions of health and illness. From this perspective human beings are active and motivated rather than passive and determined 'docile bodies', incorporating their engagement with the

¹³⁸ Think here also of the shift from 'public health' to 'population health' and the associated practices of epidemiology, as an occlusion of power and the political connotation of rights and responsibilities inherent in the concept of 'public' (Labonte et al. 2005, p.5).

world through an ongoing work of 'experimentation' (Deleuze & Guattari 2004b, p.166). Deleuze and Guattari invite us to 'sing with your sinuses' and 'see through your skin'. It is a site of experimentation, 'you always carry it [the BwO] with you as your own milieu of experimentation ... the milieu of pure intensity, spatium not extension ... which is not undifferentiated' (Deleuze & Guattari 2004b, pp.181–182). The BwO is populated by intensities, imperceptible modulating affects. It is a strategy for accessing that part of yourself beyond signification. It is the unattainable limit of capacities, which the body continually drives back to increase the quantum of what it can do. 'It is a conduit from the actual to the real' (Buchanan 1997, p.88). Deleuze and Guattari refer to sadomasochistic practices, anorexia and drug use as different ways that have been used to open new realms of experience to perceive differently. Yet they caution such experimentation requires dosages to avoid ultimate dissolution. Later in chapter 8, I will turn to the way in which art can be understood as a practice of the BwO (O'Sullivan 2007, p.116).

The concept of BwO shifts focus from deterministic biological and social explanations of the body that infer that humans are totally written by their genes and culture. This move frees us to think about embodied health not as a state but as an active process with a fluctuating nature. We can think in terms of 'becoming-healthy' or alternatively as a 'healthing' body (Fox 2012a, p.12).¹³⁹

Deleuze draws on Spinozian ethics in which the body is not conceived of as a singular sovereign and a priori construct rather, the body emerges in a series of affective and relational 'becomings' that shape its distinctive 'capacities' or 'powers'.¹⁴⁰ The body to which I refer is not, as already stated the conventional body of natural science, instead it describes a

¹³⁹ Varied definitions of health exist on a continuum from a scientific naturalist approach to a normative understanding with many hybrid definitions in between. The naturalist approach is exemplified in the bio statistical theory of health in which health is defined as a statistically normal function of species design, and 'health' and 'disease' are characterised as empirical, objective and value-free concepts (Boorse 1997). A normative approach to the concept of health is illustrated by Nordenfelt (2001), when he argues that a healthy person is one who can satisfy "vital goals", which are necessary and sufficient for minimal happiness. Interpretations offered under the rubric of the social construction of health offer socially and culturally embedded analyses of how we understand health at a given point in time and in a given place (Berger & Luckmann 1967).

¹⁴⁰ 'After all, is not Spinoza's *Ethics* the great book of the BwO?' (Deleuze & Guattari 2004b, p.170)

body assemblage. The body assemblage can have organic, material and metaphysical characteristics.¹⁴¹ This body assemblage is connected in distinctive relational patterns or encounters as a mobile and modulating ensemble of simple parts (Duff 2010, p.625). These relations determine not what a body is but what a body can do, that is, its potential and capacities in material, psychological, social, economic, political and philosophical terms and with the proviso that the more relations a body has the more it can do. In tandem with this understanding of the relational body, Fox draws attention to the active, creative and experimenting attributes of the body (Fox 2012b). The body is not passive, it is always reaching out testing its own limits and making its own history. To ask what a body can do is to ask what particular relations a body is capable of and to ask what particular affects determine that body in its capacity to affect and be affected by other bodies.

We know nothing about a body until we know what it can do ... what its affects are, how they can or cannot enter into composition with other affects, with the affects of another body, either to destroy that body or to be destroyed by it, either to exchange actions and passions with it or to join with it in composing a more powerful body (Massumi 2004b, p.284).

Accordingly such an insight requires an approach in which the analysis of affects and relations displaces the study of structure and functions. This classification of individual bodies according to their unique affects and relations is called ethology (Duff 2010, p.625).¹⁴² An emerging voice in health literature establishes an ethological approach based on an understanding that bodies are always in relationship to other bodies and objects; that they affect and are affected by these relationships, in the way bodies are managed through healthcare institutions, in the way healthcare professionals care for bodies and increasingly, how bodies and technology are being progressively interlinked (Duff 2010; 2014; Fox 2005; Potts 2004).¹⁴³ This empirical move 'preserves difference by making identity the contingent and unstable achievement of intensive, differential

¹⁴¹ Deleuze (following Spinoza) 'will not define a thing by its form, nor by its organs and its functions, nor as a substance or a subject ... A body can be anything; it can be an animal, a body of sounds, a mind or an idea; it can be a linguistic corpus, a social body, a collectivity (Deleuze 1988b, p.127).

¹⁴² Also used to describe the study of animal behaviour

¹⁴³ The body is inscribed by discourses, practices and techniques of professional "care" as well as by pain, suffering, illness and disease.

processes' (Duff 2014, p.14). In this account neither health nor illness are taken to be stable, knowable properties of individual bodies, rather they are seen as intensive processes of individuation and becoming. Such an ethological approach seeks to identify the 'specific relations, affects and events that enable joyous, or healthy, encounters between bodies, and those that precipitate sad, or unhealthy relations'(Duff 2010, p.xiii). ¹⁴⁴ Clarifying what is meant by joy and sadness requires a reconsideration of affect.

In translations of Spinoza's Ethics, Deleuze draws attention to the two sided nature of affect, as *affectio* and *affectus* (Deleuze 1978). *Affectio* is experienced precognitively in the body and in the mind as temporal feeling states. An encounter can induce a certain feeling in a body. *Affectus* refers to a transition from one state to another - it is the passage in the body's power or capacity to act, in their power of acting (Deleuze 1988b, p.51). ¹⁴⁵ However encounters can be both good and bad - but not understood in the sense of good and evil (ibid. 1988b, p.22). A good encounter invests that body with joy and brings it, 'closer to its maximum power of acting and closer to perfection in its force of existence' (Duff 2010, p.628). The good encounter, with food for example, arises from a transfer of power from the affecting body to the affected body. Bad encounters, as a corollary, invest that body with sadness, deriving from a decrease in the power of the affected body. This would be the case if poison were ingested. Deleuze (1978) clarifies that Spinoza assigns two poles: joy-sadness, on a melodic line of continuous variation whereby, 'Sadness will be any passion whatsoever which involves a diminution of my power of acting, and joy will be any passion involving an increase in my power of acting' (1978 unpag.). Furthermore, each bad encounter entails the bodies own immobilisation, as its power is drained in its attempts to expel the offending body (Duff 2010, p.627). There is a secondary understanding too. An individual who struggles as far as she is capable to enter into encounters with bodies that amplify her power of acting is

¹⁴⁴ While Duff and Fox have a particular interest in it's application to health and illness, it should be remembered throughout that ethology can refer to each and any thing that arises from the plane of immanence and therefore does not distinguish between natural and artificial.

¹⁴⁵ Affect should not be confused with feeling or emotion see (Anderson 2014) and (Shouse 2005)

called 'good'. 'For goodness is a matter of power, and the composition of powers' (Deleuze 1988b, p.23). Any person that lives haphazardly entering into encounters in whatever circumstance diminishing their power of acting, will be called bad. Accordingly ethics replaces morality as transcendental values (good and evil) are supplanted by immanent modes of existence.

In order to further distinguish how the words joyful and sad are not intended to convey the meaning of the emotion joy or sadness, I refer to the commentary about the *Amulet* (Brett 2009). In this text Grehan (2013) acknowledges that almost half of the population will eventually die in hospitals, and more particularly that miscarriage and neonatal death at birth is part of maternity services.¹⁴⁶ The sadness of these events does not preclude the joyful affects made possible by an arts project. So for example, Grehan foregrounds the private and public conversations about bereavement made possible as part of and subsequent to the *Amulet* project. This can be read as an increase in productive capacity to affect and be affected, as a joyful affect, distinct from the sad emotions attached to such life events.¹⁴⁷

The task of Spinozian ethics is to increase good encounters and the associated joyful affects they induce, while also attempting to minimize the sadness of bad. It is a practice of ethics drawing attention to the importance of evaluating relations between all bodies. This ethic is about maximizing the capacities of all bodies to affect and to be affected, opening up the potential for the unknown 'rather than limiting the future to what has already been or to what is already known' (Hickey-Moody & Malins 2007, p.4).

¹⁴⁶ *The Amulet* is a national, multi-site participatory arts project, initiated and led by artist Marie Brett, as a community collaborative initiative. The project was informed by a two-year research phase Marie led in partnership with Cork University Maternity Hospital and subsequent collaboration with bereaved parents in partnership with Cork University Maternity Hospital, Waterford Regional Hospital/Waterford Healing Arts Trust and the Mid-Western Regional Maternity Hospital in Limerick.

¹⁴⁷ As noted already, just as it is not possible to know in advance what a body can do, O'Sullivan adds that paradoxically an arts practice often relies on not knowing exactly in advance what effect it may have, further more, it may be so small as to be almost imperceptible, 'a tiny affective deviation that nevertheless begins a landslide and the production of a new world' (O'Sullivan 2007, p.23).

Not only that, recalling that a body can be anything (an institution, a set of ideas or practices) draws attention;

Not simply to an experimentation with the individual body in its connections with a selected world but also to the formation of more complex collective bodies...Rather than merely testing the relations that augment the powers of individual bodies or threaten their dissolution, we must also determine the powers that may emerge in compound bodies (Bogue 2007, p.11).

Accordingly healthcare institutions, protocols, practices, equipments, environments may all form compound bodies that can either augment or diminish capacities with and through art. These capacities are acquired or exchanged in a process that obtains in encounters between bodies, and between bodies and context, through affects and relations (Duff 2010, p.620). This account of relationality and its composition emphasizes, 'the experience of the 'person in context' and the specific character of the connections and relations that materially and affectively conjoin person and place' (Duff 2010, p.620). The healthcare setting has already been explored through its relations and affects, for example in the areas of health and human development (Duff 2010), pharmaceuticals and sexuality (Potts 2004), and geriatric care (Fox 2005).

Fox (1999) elaborates what he calls the 'paradox of care' in which two idealised types of interaction between a care-giver and patient in the context of disciplinary protocols and practices, give rise to an augmentation or diminishment of capacities. Fox observes, 'The association of power with knowledge suggests that in the context of care, the professionalization of caring ... cannot but lead to a disciplining of care's clients' (Fox 1999, pp.80–81). Fox illustrates how the organization of the institutions of healthcare and the caring relationship itself are sites for contest of power and suggests how this power may be, and is, resisted.

The act of caring establishes a relationship between two bodies – the carer and the cared for, in which both bodies affect and are affected by the care given (Fox 2012b, p.160). In this way caring attaches bodies to each other as an assemblage. These assemblages determine 'what else a

body can do', the limits of possibility of embodiment and the experience of health identities. Fox distinguishes between 'care about' and 'care for' deploying respectively the analytic vigil of care in contrast to the gift of care. Both discourse (the vigil) and resistance to it (the gift) are embedded in the everyday practice of care, in the contact between carer and cared for. Fox is not suggesting that the vigil and the gift are mutually exclusive instead he suggests that;

The vigil of care is a technology of power, but the possibility of resisting that technology does not of itself entail a rejection of the caring which is given, but only a refusal to acquiesce in the subjectivity which the vigil of care would produce in its subjects (Fox 1999, p.80).

Fox proposes the vigil of care can be found in codified, organised routines and plans whereas the gift of care derives from an altruistic giving 'constituted in open-endedness, rather than theory and evidence based practice' (Fox 2012b, p.168). The gift relation celebrates difference, otherness and diversity and is reciprocal affecting both care-giver and cared-for. Such an ethos demands a radically different conception of human potential and of what constitutes the 'care', which engages with this potential. 'It is a process that offers promise, rather than fulfilling it, offers possibility in place of certainty, multiplicity in place of repetition, difference in place of identity' (Fox 1999, p.96). It concerns the reintroduction of the emotional and non-rational in care interactions. It is the re-enchantment that follows the disenchantment of rational modernity (Bauman 1993). These ideas are important precursors for the way in which Fox formulates a relation between creativity and health, outlined in the next section.

5.4.2 CREATIVITY AND HEALTH

Fox (2012a) attempts to rethink the principles underpinning arts and health practices through an analysis of creativity to provide a theoretical framework that can explain empirical findings of positive health gain accruing to creative arts activity. In a critique of biomedicine he shifts emphasis away from individualised analyses that dovetail individual

creativity with clinical perspectives.¹⁴⁸ Consequently, he claims, arts in healthcare is liberated 'to explore its contribution to the broader connectivities between patients, health professionals, healing institutions, art objects and health technologies' (Fox 2012a, p.13).

Fox claims that there is an intellectual lacuna in providing an explanatory framework linking creativity and health. Sociological, anthropological and psychological approaches to creativity have so far failed to provide an adequate account. He proposes an anti-humanist ontology that decentres agency from an anthropocentric privileging of human bodies to emphasize 'the extended networks of relations between creators, creations and their recipients or audiences' (Fox 2012a, p.3). Bodies, social institutions, ideas and other entities are contingent, ephemeral and relational. They exist only in so far as they are produced through physical, social, biological and abstract interactions with other bodies. Assemblages of relations are always in flux, without subject or object, and operate as 'desiring machines' shaping what a body can do and what they can desire, establishing conditions of possibility. Flows of affects (replacing conventional conception of human agency) within assemblages, represent a change of state of an entity and its capacities. These affects, fuelled by a productive desire, flow rhizomatically 'producing the capacities of bodies to do, desire and feel, in turn producing subsequent affective flows' (Fox 2012a, p.5). But this is not an indeterminate and open-ended system. Affects are not unidirectional; they may combine to cancel each other out. Affects can combine to territorialise a body in the way that biomedicine territorialises a sick person into a patient, or they may produce lines of flight to deterritorialise away from codified norms. Fox claims that human creative endeavour is not privileged in this anti humanist ontology, rather creativity is the territorialising/deterritorialising flow of affect between bodies, things and ideas.¹⁴⁹

¹⁴⁸ An approach also adopted by other commentators (White 2009a; Parkinson 2012b)

¹⁴⁹ Fox qualifies this by characterising creative production as a particularly rich and rhizomatic flow of affect when compared to the flows of everyday life (Fox 2012b, p.6).

Fox asserts that the processes that create works of art and scientific invention are not qualitatively different.¹⁵⁰ Furthermore he asserts that both science and art can be evaluated on an assessment of what creative products do, distinguishing between molecular and molar territorialisations that, in the case of the former, resist categorisation, and in the latter, aggregate and define. Fox chastens that such molar territorialisations are frequent, given the context (of capitalism, heteronormativity and social inequality), leading to the substitution of innovation and passion with imitation and profitability (Fox 2012a, p.8).

Fox proposes that creativity and health are tautological; 'creativity and health are part of the same phenomenon: the production of capacities to act and desire by flows of affect within assemblages of body relations' (Fox 2012a, p.10). The ill health assemblage that territorialises the body, setting limits on what it can do, is countered by the impact of creative production through the creative assemblage that produces new capacities in bodies to do and desire. The 'effect of a creative product is to increase the relations and capacity to affect and be affected; in the Deleuzian sense, health' (Fox 2012a, p.12). Hence Fox establishes the claim that health and creativity are tautological, providing an explanatory framework for evidence of health benefits accruing to participants in arts projects in healthcare settings. This claim will be addressed in Section 8.2. In the next section I turn to the way in which Deleuze and Guattari explore the specificities of what art does.

5.5 WHAT CAN ART DO?

As discussed already Deleuze and Guattari suggest, art is less about creating forms than about creating sensations. They say that the aim of art is to, 'extract a bloc of sensations, a pure being of sensations' (1994, p.167). They claim that the potency of art lies in its capacity to render perceptible forces that populate the world (in chaos) but that would

¹⁵⁰ The quote referenced reads as follows, 'In fact, sciences, arts and philosophies, are all equally creative, although only philosophy creates concepts in the strict sense' (Deleuze & Guattari 1994, p.5).

otherwise remain imperceptible. Art proceeds not in the continuous development of form or in the continuous variation of matter (as matter can no longer find intelligibility in form), rather in a direct relation of material forces. 'The visual material must capture nonvisible forces. *Render visible*, Klee said; not render or reproduce the visible' (Deleuze & Guattari 2004b, p.377 italics in orig.). This is enacted by means of percepts and affects. Percepts can be found in the artwork itself. They are understood as non-signifying nodes of sensation as an intensity of colour or texture, physical fragments of the world residing in the artwork. Affects, on the other hand, materialize in the relation between the artwork and the body, again understood as non-signifying movements of sensation. Affects generate an unmediated feeling concurrent with an encounter with the artwork and can manifest as a flush, a shiver, a racing pulse, a thumping of the heart. They are felt directly by the body, in the body, across the skin, along the nervous system. They create changes, of varying magnitude, from the imperceptible to the manifest, of for example, temperature, posture or breathing.

Deleuze and Guattari begin their reflections on art with the animality of the refrain. Content is composed by the arranging of elements (leaves) in a territory and gives rise to expression in the refrain. We go from the chaos of nature to the space of a territory in a refrain – the abstract machine of art deterritorialises in a line of flight scrambling the refrain to introduce an outside to lived experience. This is the diagrammatic function of art. It flags the construction of the real 'yet to come' a virtual potentiality for a qualitative change (ibid. 2004b, p.157)..

An abstract machine in itself is not physical or corporeal, any more than it is semiotic; it is *diagrammatic* ... It operates by *matter*, not by substance; by *function*, not by form. Substances and forms are of expression 'or' of content. But functions are not yet 'semiotically' formed, and matters are not yet 'physically' formed (ibid. 2004b, p.156 italics in orig.).

The diagram does not conform to any identity given by substance or form, but instead addresses the dynamics of matter. This diagrammatism appears as the problematisation of the work of art's own medium. The diagram then is the movement from accepting a certain arrangement of

elements as it is usually perceived to some novel disarrangement and rearrangement that admits different perceptions. This is achieved in a bloc of sensations through the distribution of affects and percepts.

Artists then are creators and presenters of affects, 'they not only create them ... , they give them to us and make us become with them' (Deleuze & Guattari 1994, p.175). Art is a singularity that exists within its own terms of reference as a bloc of sensations that is composed of sensory affects and has affective capacities. It offers the potential to extend the body's limits in the way that a body can understand, create and connect to an outside. 'Art preserves and it is the only thing in the world that is preserved' (ibid. 1994, p.163). It has the independence of an autonomous being. It is future oriented, its affects persisting long after any encounter.

Art then enables the formation of new bodies; bodies which perceive in new ways, which are composed in new ways, and which have the potential to connect to others in new ways. This is what Deleuze and Guattari are referring to when they say that art has the power to bring forth a 'people to come' (ibid. 1994, p.218).

Deleuze & Guattari attend to the process of art-making, they remark, 'A method is needed and this varies with every artist and forms part of the work' (ibid. 1994, p.167). In later work Deleuze pays particular attention to visual artists such as Cezanne, Van Gogh and most particularly Bacon (Deleuze 2005). He attends to the style that makes imperceptible forces palpable. In Bacon he finds expression for the imperceptible forces that act upon the body through distorted figures whose contours and boundaries are blurred, smeared into the background. These figures never entirely dissipate. They retain a recognizable form that is uneasy and uncomfortable. Bacon labours the body to relinquish stratifications, significations and subjectifications to reveal the invisible forces that surge through the body. These can encompass violence, terror and hysteria as in *Study After Velázquez's Portraits of Pope Innocent X*, or discomfort and animality as in *Portrait of George Dyer Talking*. Bacon succeeds by

'making these forces visible through their effects on the flesh' (ibid. 2005, p.x). Bacon is concerned with forces not normally found in portraiture, 'sometimes with an inner force that arouses them, sometimes with external forces that traverse them (ibid. 2005, pp.160–161). These figures are deformed, contorted, animal, bestial with eyes closed and mouth gaping. They are leaking bodies spreading out in all directions – approaching their limits. They invoke the BwO an 'intense and intensive body' (ibid. 2005, p.32). The BwO is distinguished from the body with organs, as the organization of organs in the organism. The body then is a nonorganic life composed of thresholds or levels, rather than the organism we see that imprisons life.

However, Deleuze does not valorize art over any other social practice. He warns of the error of cliché, which can stratify and limit aesthetic possibilities. Deleuze identifies clichés in figuration (i.e. the narration and illustration of representation) and faciality (the association of meaning with gestures of expression in signification). These limit the possibilities for aesthetic outcomes through a preoccupation with reproducing that which is already visible, communication of a story, use of symbolism and the production of a pre-determined identity by reference to a recognizable face. These form the parameters for what it is possible – foreclosing artistic potential.

Artists begin their work with the weight of art history on their shoulders through the operation of historical cliché. They must in some way unburden themselves of the weight of this history and cliché. Deleuze describes strategies adopted by Bacon to break free from this mantle deploying the concept of the diagram. He claims that according to Bacon the law of the diagram is this; 'one starts with a figurative form, a diagram intervenes and scrambles it, and a form of completely different nature emerges from the diagram' (ibid. 2005, p.109). The figural disrupts the figurative through disassociation from narrative and illustrative functions by mechanisms of random marks, scrubbing, asignification (giving rise to traits of sensation) and isolation (ibid. 2005, pp.70–71). In the

figural we find art sitting between the figurative known, and the chaotic unknown. This *diagrammatism* is not particular to the pictorial and can be extended to other fields of art as well, its function being to disrupt and extend the space of potential of a given art assemblage

These strategies are singular just as artistic method is singular, 'Bacon does not claim to dictate universal solutions' (ibid. 2005, p.65). Artworks are singular constructing their own plane of composition concurrent with the work as it progresses, step by step. Deleuze and Guattari conceptualise the work of art that, '...entails a plane of composition that is not abstractly preconceived but constructed as the work progresses, opening, mixing, dismantling, and reassembling increasingly unlimited compounds' (1994, p.188). Furthermore artworks are historically and socially contingent. As Cull cautions in her study, *Theatres of Immanence*, they are not 'exemplary models to be reproduced' merely 'singular solutions to highly specific problems' (Cull 2012, p.21).

The work of art takes place on a plane of composition, therefore the artwork only makes sense in relation to a plane or cultural territory. Deleuze and Guattari illustrate this attribute of locatedness in art. 'The problem in art is always that of finding what monument to erect on this plane, or what plane to slide under this monument, and both at the same time' (1994, p.196). The work of art through a bloc of sensations is a contextualised local event of timeless duration. It emerges from and reinscribes or reconfigures a specific cultural terrain by arresting the development of cultural clichés, dissolving regimented sameness. This leads to an understanding of the work of art as an assemblage of varying components, which can comprise, genre, historical styles, context and cultural function (amongst others). Deleuze and Guattari emphasize the heterogeneity of art.

In no way do we believe in a fine arts system; we believe in very diverse problems whose solutions are found in heterogenous arts. To us, art is a false concept, a solely nominal concept; this does not, however, preclude the possibility of simultaneous usage of various arts within a determinate multiplicity (2004b, p.331).

Each art form and each artwork presents as a response to a particular problematic.¹⁵¹ Yet Deleuze and Guattari caution against a phenomenological 'fleshism' that binds art to an expression of the lived, rather they affirm that it is the correlate of indeterminate non-organic life, of a life rather than *my* life or *the* life (Deleuze & Guattari 1994, pp.178–180). In the next section I turn to the work of O'Sullivan who develops a particular formulation of expanded arts practices as an aesthetics of affect.

5.5.1 AESTHETICS OF AFFECT

In this section I foreground a contemporary reading of an expanded arts practice. This is necessary because when writing about visual art, Deleuze and Guattari selected very specific modernist practices. O'Sullivan draws from Deleuze and Guattari to establish a significant body of work in which he theorises some forms of contemporary art as an expanded and complex practice, beyond the politics of representation.

In attempting to go beyond the quagmire of representation and critique, he attends to the affirmative and creative aspects of Deleuzian thought in a future oriented aesthetics of affect (O'Sullivan 2007). What is of interest to him is not what an artwork means, but what this artwork can do. He lays out a programme for political art practice, which is not just about institutional or ideological critique, but also about the active production of our own subjectivity. As power has become decentred to virtual centres through our own subjectivity, then the battleground against power becomes ourselves (O'Sullivan 2007, p.88). From this perspective

¹⁵¹ If there are any unifying factors to be found in artworks, it is in the medium of sensation and the milieu of the plane of composition.

everything is or has the potential to be connected to everything else. He suggests we might use art as a name for these pragmatic processes of connectivity and interpenetration, fostering transversal connections (O'Sullivan 2007, pp.11–17), a form of territorialisation that gives rise to the conditions for deterritorialisation (O'Sullivan 2007, p.62).

Thinking art rhizomatically involves foregrounding those art works that have a specifically affective function (O'Sullivan 2007, p.20). Understanding an arts practice rhizomatically then entails attending to what we might call its performative aspect; what it does and what it makes us do (O'Sullivan 2007, p.20). Drawing our attention to the interventionary or simply bothersome nature of art practice, O'Sullivan (2007) observes that an art practice might involve the positioning of an object in such a way that it disrupts the situation that surrounds it. Art can be like the pebble dropped in still water; large effects rippling out from an apparently minor event. Questions of strategy become important here. Does this object work for this milieu? Does this milieu demand a different object? Where to drop the pebble? (O'Sullivan 2007, p.26). The conjunction of arts and health is an exemplar of the principal of connectivity implicit in the rhizome, by its smearing of distinct and discrete milieus and registers. Indeed O'Sullivan suggests that;

Writing on art might itself be a rhizomatic project; after all why not connect different signifying regimes together, smear the new sciences over into the humanities for example ... by blurring discrete categories ... new kinds of thought become possible (O'Sullivan 2007, p.18).

Referencing the way in which these concerns might be invoked in a healthcare setting O'Sullivan cites Guattaris work at the La Borde Clinic as a project of rhizomatic remapping - that is the ability individuals have to remap their world. Patients from poor backgrounds were invited to take up plastic arts, drama, video, music etc., which had until then had been unknown to them. On the other hand, bureaucrats and intellectuals found themselves attracted to material work in the kitchen, garden, pottery and horse-riding club. The important thing here is not only the confrontation with a new material of expression, but the constitution of complexes of

subjectivation involving multiple exchanges. These complexes offer diverse possibilities for recomposing their existential corporeality to flee repetitive impasses and in a certain way to resingularise themselves. This recomposition need not apply solely to human subjectification but also to other bodies such as for example the normative codes of medicine and the discursive fields of health sciences. Deleuze and Guattari's long time colleague Dr Jean Oury stressed the importance of a heterogeneous context, rather than the homogeneous space of hospital establishments. Bemoaning the accumulation of regulation, Oury remarks that 'the hospital is ill' (Reggio & Novello 2004, p.3); the hospital needs to be treated in order to treat the patients. Thus the healthcare setting, healthcare staff become as much a milieu for an arts practice as any patient or service user.

The possibility of making transversal connections between people is not so much a cure, but a means by which individuals can reorganize or resingularise themselves in a creative affirmative and self-organizing manner (O'Sullivan 2007, pp.27–28). The potential for, and practicalities of, reconfiguring our subjectivities is a pragmatic, and specifically materialist project. We can open up new universes of reference - new ways of seeing and being in new kinds of world - through involvement with certain materials of expression with groups and individuals. The La Borde clinic operated as just such a site, encouraging new relationships and new experiences. The objective was not to reintegrate a 'cured' individual back into society, rather it was an encouragement to become involved, to participate, in one's own self creation. O'Sullivan (2005c) suggests that this is an appealing framework for rethinking collaborative and collective art practices of today. These art practices might be seen as producing communities and subjectivities in precisely this sense. This field of expanded practice does not require spectators as such but participants - who are 'transformed' through their interaction with the practice (O'Sullivan 2005c).¹⁵²

¹⁵² At this point of the thesis I want to introduce an artwork expressive of O'Sullivan's aesthetic of affect. At the 2012 Bealtaine Conference 'Creating a New Old' held at IMMA in May 2012, a video was screened at the introductory plenary. It documented an art project that had been undertaken

The watchword in this rhizome project is caution. It is not a question of completely abandoning structure or following an absolute deterritorialisation, indeed, in such cases you might work or move too close to chaos. By this I mean that there is not a total reorientation, rather there are subtle shifts that can go in any direction. Organising specifically affective encounters through experimentation leads to an increase or a decrease in a body's potential to act in the world. For example, a joyful encounter will lead to an increase in a body's potential to act in the world, whereas sadness will diminish this capacity. Such are the ethics of an expanded arts practice (O'Sullivan 2005a). Nevertheless, O'Sullivan (2005b) cautions that dissent is important. Simply celebrating the world as it is abdicates criticality, being nothing more than an acceptance of the status quo.¹⁵³ This calls for two strategies: one of dissent (a strategic withdrawal as a form of engagement, or a strategic engagement itself), and one of creativity (the production of new forms).

This dissertation investigates the notion of arts practices in healthcare settings through an art practice that questions, comments and criticizes the very institutions involved in its production, display and mediation. This whole inquiry is at the limit of what I can do to introduce a body of work to nurture resistance to hegemonic knowledge practices by staking out new coordinates within which to locate practices. It emerges as an, 'immanent critique' carried out within the territory itself, using its languages and tools. It has been a constant negotiation in a process of collaboration, both within and across institutions, through relationships of varying magnitude and consequence. This expanded practice operates at multiple levels to establish a nexus of levers, which can be deployed as critique, as part of

with the Skibbereen Active Retirement Group with artist Paul Cialis. The group met over a period of time to gather stereotypical clichés of aging, e.g. 'over the hill' etc. Participants individually painted these slogans onto glass sheets. The video recorded the last day of the project when each participant - wearing safety goggles, workmens leather gloves and wielding a hammer - stepped forward behind the painted glass, to violently smash it. Each individual approached the glass differently, some even looking for permission to break the glass, but as each did, it was evident from the look on their faces that they were doing something they would never have done nor dreamed of doing and they were enjoying this freedom with abandon.

¹⁵³ Concerns with consensus dominating arts processes and practices are shared with Bishop who avers that 'In insisting upon consensual dialogue, sensitivity to difference risks becoming a new kind of repressive norm' (Bishop 2012, p.25)

and apart from the institutions with which it engages (health, art, academic) and simultaneously as an escape from that weighty burden.

These affinities establish the parameters for research practices. Chapter 6 establishes how this research report itself was grafted through its methodology. The last two sections in this chapter turn to an elaboration of art critical concepts in terms of art's own self-understanding of itself in the critique of creativity followed by that of institutional critique.

5.5.2 CRITIQUE OF CREATIVITY

Moving to a post medium notion of art practice reconfigures questions from asking 'what is art', to foregrounding what a particular art practice can do.¹⁵⁴ Its function is to transform, even if only for a moment, our sense of ourselves and of our understanding of the world (O'Sullivan 2001). By attending to the specificity of an art work and the specificity of the milieu in which it operates opens up the possibility of attending to the aesthetics of affect.

I have already referred to the way in which art practices in healthcare settings are dominated by concerns associated with evidence-based medicine. This techno managerial mode of interpretation is strongly linked to the overarching narrative of the knowledge economy that inscribes value only to those activities that have economic value (Kenway et al. 2004; Rossiter 2010). A different formulation of the knowledge economy is found in the critique of cognitive capitalism. Theorists of cognitive capitalism reflect on the developments and transformations of societies in which knowledge-based activities mould economic conditions. Cognitive capitalism is a radical critique of knowledge-based economy discourses associated with post-Fordist society in which immaterial, creative, cognitive and affective labour are deployed as central concepts (Dyer Witherford 2005).¹⁵⁵ This exploitation of human capabilities can be

¹⁵⁴ The term 'post-medium' is borrowed from Krauss (2000)

¹⁵⁵ The University has become a central site for conflict as its role is narrowed to providing research and training required for the creation of intellectual properties and technological subjectivities necessary

understood as a social pathology, as it internalizes processes of subjugation through internalised forms of conditioning and social control. This new 'society of control' is disseminated by the *commodity form of the new* (O'Sullivan & Zepke 2011, p.4 italics in orig.). Distinguishing between the new as commodity and the new as difference has been the subject of considerable reflection.

Creating Worlds investigated the relationship between art production and knowledge production in the context of the transformations and crises of contemporary capitalism characterising the ambivalent deployment of creativity as both a) molar and b) molecular forces;¹⁵⁶

- a) a modulating procedure in cognitive capitalism and societies of control
- b) an emerging political dimension of creativity as political imagination and invention of new lines of flight, new struggles, new worlds.

Raunig et al. (2011b) resist these molar modulating procedures offering creative practices to provide solutions for the intractable problems of capitalism; 'old notions of art and "the artistic" are being replaced, even as they are absorbed, by the new concepts of creativity and creative industry' (Raunig et al. 2011b, p.1).¹⁵⁷ Instead they formulate a critique of creativity that goes beyond gestures of negation and rituals of rejection through diverse critical practices. For example, Nowotny suggests a creative critique in which the effects of critique are immanent to creative activity, finding modes of subjectivisation engendered in forms of creative critique (Nowotny 2011, p.17). But the origin of this creative activity cannot be considered independent from the institutions and forms of governmentality in which it operates. Here Nowotny is referring not just to the physical places of institutions, but also ideas such as artistic autonomy

to the regime of post-Fordist accumulation – see also (Aranda et al. 2011) and the discussion in section 5.4 Artistic Research.

¹⁵⁶ This project was implemented under the auspices of European Institute for Progressive Cultural Politics. See <http://eipcp.net/projects/creatingworlds/files/about>

¹⁵⁷ See also Osborne (2003) who suggests the cultivation of a kind of ethical philistinism in order to escape moralizing injunctions to be creative and Oliver (2009) who suggests that in contrast to narrowly framing creativity as innovation, implying a reproducible product, creativity characterised as improvisation offers the possibility of thinking in terms of a situational, embodied and temporal process.

and the institution of the project, which although structureless and flexible are linked with instrumental purpose-orientation (Nowotny 2011, p.19).

Contemporary arts practitioners are not insulated from such molar influences. They can creatively self-precaritise as they engage in the transitory productive relations networked as projects (Aranda et al. 2011).

Artists provide a useful model for precarious labour since they have a work mentality based on flexibility (working project by project, rather than nine to five) and honed by the idea of sacrificial labour (i.e. being predisposed to accept less money in return for relative freedom) (Bishop 2012, p.16).

Artists become complicit in their own self-exploitation as power becomes decentred to their own subjectivity (O'Sullivan 2007, p.88). Opportunities for artists to engage in healthcare contexts may afford aesthetic opportunities yet simultaneously they may also signal an anaesthetic character, in which arts practices are sought-after for their somatic impacts (Scanlon 2005). Thus the radicant infiltration of contemporary arts practices to the domain of healthcare can be read simultaneously as both molar and molecular forces.¹⁵⁸ Esche observes; 'if we reject artistic activity as a catalyst for change elsewhere in the creative field then we end up, at best, as entertainers for the successful minority in an immutable social order' (Esche 2005, p.26). When novelty and creativity become part of the logic of capitalism through its interiorisation of all that lies outside the economic field, the prescient question then is, how do we distinguish 'between the new produced in and by our contemporary form of capitalism and the construction of new forms of dissent, of new mechanisms of resistance?' (O'Sullivan & Zepke 2011, p.4). Not only that, but 'how to make room for such activities within institutions, against institutions for those acts for which there pre-exists no knowledge? How can one help 'institute' what remains 'outside' the institutionalisable rules of sense?' (Rajchmann 2011, p.83)

¹⁵⁸ | draw on the work of Bourriaud (2009) who deploys the term radicant to describe the way in which artists are no longer defined by where they are from, but instead by where they go, as roots in motion.

These questions are of significance for the inquiry as they expose creativity to a realm beyond innocence, to a political landscape in which the 'euphoria of creation' permeates the everyday as favoured slogan of capitalism's new entrepreneurial class. This instrumentalisation and control operates by the absorption and instrumentalisation of art and aesthetics by the market (O'Sullivan & Zepke 2011, p.3). Consequently, critiques that sought to expose the ideologies and power structures underlying the circulation, display and discussion of art within art institutions, characterised as institutional critique, is relevant to this discussion. These will be referred to in more detail in the following section.

5.5.3 FROM INSTITUTIONAL CRITIQUE TO INSTITUENT PRACTICE

Institutional concerns loom large over this inquiry. In recent history, arts practices have engaged with tensions in relation to art institutions of the museum, gallery and the art market in a practice referred to as 'institutional critique'. This self-awareness prompted many artists to flee the art institution to find new sites of engagement and exhibition, such as public space and indeed, healthcare settings. Artists associated with institutional critique have demonstrated; 'how the meaning and value of art are deeply conditioned by its institutional framework of display, exchange, and publication' (Foster et al. 2011, p.743). From this perspective, the seemingly inescapable subjection of art to ideological interests inevitably leads to arts practices in healthcare settings being understood in terms of clinical outcomes. Thus institutional critique becomes of significance for the inquiry.

Institutional critique has had varied orientations since it first emerged in the late 1960s. Artists deployed gestures of dissent challenging the authority of cultural institutions.¹⁵⁹ Alberro (2011) observes that there was an expectation that critical arts interventions would lead to a change in power relations. Artists intended to transform the institutions of art by exposing the deeply problematic intersections of political, economic and

¹⁵⁹ Artists such as Michael Asher, Hans Haacke, Daniel Buren, Robert Smithson and Marcel Broodthers are attributed with initiating this line of inquiry in art practice (Raunig 2009c).

ideological interests that intervene and interfere in the production of public culture. Strategies of negation, inclusion and the creation of alternative institutions were adopted functioning in parallel with social movement paradigms of multi-culturalism, feminism and environmentalism (Steyerl 2011).

This was followed in the late 1980s and early 1990s by a second phase concerned with an exploration of economic and epistemological linkages that sought to insert the “Other” in museological representation allied with a subjectivising turn that recast ‘external power hierarchies as ambivalences within the self’ (Holmes 2009, p.37).¹⁶⁰ This approach failed according to Fraser (2005), claiming that artists whose work is informed by institutional critique are ‘trapped’ as they themselves constitute the institution as embodied and performative individuals. Indeed she avers, that the practices that were associated with institutional critique ‘have come for many, well, to seem institutionalised’ (Fraser 2005, p.278).¹⁶¹ She argues that the apparatus of the museum and market have become all encompassing with the complicity of artists that attempt to evade it. Incursions into the everyday expand it’s frame by bringing more of the world into it, ‘every time we speak of the “institution” as other than “us”, we disavow our role in the creation and perpetuation of its conditions’ (Fraser 2005, p.283). Recognising this, she asserts that rather than being anti-institutional, ‘It’s a question of what kind of institution we are, what kind of values we institutionalise, what forms of practice we reward, and what kinds of rewards we aspire to’ (Fraser 2005, p.282). Raunig and Ray (2009) take the view that the canonisation of institutional critique in art history depoliticises these practices making necessary a distinct third phase of institutional critique that can respond to the question, which form of institutions and instituting do we need? ^{162,163} This new form of

¹⁶⁰ Andrea Fraser, Christian Phillip Muller, Renee Green and Fred Wilson are artists associated with this second wave of institutional critique (Raunig 2009c).

¹⁶¹ Fraser is referring to the 2004 Daniel Buren exhibition at the Guggenheim, an institution which had in 1971 censored the work of both himself and Hans Haacke.

¹⁶² See (Negri 1999) for a discussion of the conflict between ‘constituent power’, the democratic force of revolutionary innovations, and ‘constituted power’, the fixed power of formal constitutions and central authority.

¹⁶³ See (Parkinson 2012a) who describes arts and health as a small scale global phenomenon

institutional critique is characterised as instituent practice described by Sheikh (2011) as follows;

When thinking about institutions we should not be focusing on set, already instituted ways of sociality, political relations, linguistic codes and imaginaries of possibility, but rather on changing the ways how we institute. Our instituent practices should escape the established modes of institutionalization, escape the horizon of our instituted practices ... Our problem is lack of other horizons, of alternative visions, of possibility of different worlds, and it is here that instituent practices – such as artistic practice with its re-ordering of the material organization and ways of perceiving – can produce a break with the existing (Sheikh 2011, p.unpaginated).

As traditional understandings of institutions have crumbled, instituent practices flag sites of tension, not in opposition to the institution but fleeing institutionalization and imagining new forms of institutionality. Raunig reformulates institutional critique as a critical attitude and as an instituent practice (Raunig 2009a, p.4). He asserts that it is necessary for institutional critique to link with other forms of critique in a transversal exchange (both art and non-art) to avoid a paralysis induced and constrained by rules. Alberro too discerns that these transversal practices evade the official art world by developing art practices, tactics and strategies outside the confines of the museum and art market;

Art in these cases is connected to a much larger political and ideological project – it is more a means than an end. The stated end is nothing short of confronting and contesting, “the rising intensity of authoritarian culture” (Alberro 2011, pp.15–16).

Thus we find that many contemporary art practices overlap with agit politics / social movement practices. Raunig cites *Park Fiction* as an exemplar of instituent practices in its various arrangements of self-organization that promote broad participation in instituting.¹⁶⁴ Participants newly compose themselves again and again in animated and persistent ways unhindered by established practices and protocols. *Park Fiction* originated as an urban planning intervention to prevent proposals to develop space along the Elbe River in Hamburg. Disparate adjacent communities joined together with a fake proposal for a park. Yet overtime

¹⁶⁴ <http://parkfiction.org>

this fiction itself became the machine through which the ordered process of consultation in local government planning was abandoned in favour of 'a wild process of desire production' (Raunig 2009b, p.182). Rather than analyzing needs in striated space, the project unleashed boundless desire;

from bird voices on tape and a boxwood hedge trimmed in the shape of a poodle, a tree house in the shape of a ripe strawberry, mailboxes for young people whose mail is monitored by their parents at home, an open air cinema, an exercise hall with a green roof and wooden palms on rails, a women pirates fountain, platforms on rails for sunbathing and barbecuing, rolling sections of lawn, a boulevard of possibilities for which there is no room in the street, tea garden and fruit tree meadow, benches, flowers and a fire-breathing Inca goddess as a cooking sculpture, a dog racing track, a water slide into the (then clean) Elbe, all the way to a trash park made of the garbage of prosperity that is not further destructible, which would mirror the conditions in this part of the city (Raunig 2009b, p.183).

The process of realising the park arises from multiple and diversely composed instituting events. These arrangements of self-organising engender broad participation in instituting, as arrangements newly compose themselves iteratively. Such practices arise as responses to institutions that perpetuate problems according to Bell Yank (2011) who refers to the work of Public Matters a Los Angeles based interdisciplinary artist-run collective that has worked with various institutions and neighbourhoods.¹⁶⁵ The group exists in indeterminate space, although they understand themselves as an artist collective, their partners instead view them as liaisons embedded in communities. The boundaries between art and non-art are fluid becoming labels of conveniences in projects. This ambivalence to definition is adopted as a tactic reflecting interdisciplinary, shifting and hybrid nature of the group. Bell Yank (2011) attributes the success Public Matters to instituent practices in the way they create instituting events bringing together community organisations, schools, governmental agencies, universities and individuals. She asserts that this plurality counters closure of processes because of the capacity for these groups to re-arrange themselves according to their own needs.

¹⁶⁵ Bell Yank describes the Public Matters youth media project in collaboration with The South Los Angeles Healthy eating Active Communities Initiative and high school students at the Accelerated School.

In an attempt to define this new phase of institutional critique, Holmes (2009) refers to contexts and modes of cultural and intellectual production. In this inquiry 'arts and health' is theorised as a problem idea. Part of the problem might be accorded to the proliferation of interdisciplinary discourses, which, according to Holmes (2009), in tandem with an indiscipline that endlessly repeats and remixes, precludes the possibility of any significant inquiry. This theoretical deficiency is simultaneously exacerbated by an evident desire that pushes more and more artists to work outside the limits of their own discipline. These outbursts have been characterised diversely as net.art, bio art, visual geography, space art and database art (Holmes 2009).¹⁶⁶ Given the disciplinary conflation leading to naming conventions, it follows that arts practices in healthcare settings is yet another manifestation of these outbursts, as artists seek to work in social and health contexts outside gallery spaces. Yet the problem remains: how can an inquiry of significance emerge from and for these practices? Holmes attempts to go beyond the familiar modernist trope of art drawing attention to itself, to an 'immanent critique' carried out within the territory itself, using its languages and tools.

The transversal quality of artistic institutional critique does not only challenge and thwart the borders of the field of art; the strategies and specific competencies of art can also be deployed to spur on a general reflection on the problems of institutions, the predicaments of critique and the openings for new 'instituent practices' (Raunig & Ray 2009, p.xvii).

Although removed from conventional figurations of activist practices healthcare spaces might be read as places where art can operate a modest 'tactical quietism' distinct from an art that operates through loud 'copycat gestures' that 'fetishise politics' (Adajania 2012). This sentiment resonates with the work of Esche (2005) who formulates the idea of modest proposals which are at once speculative and concrete as, 'artworks that make more impact when using existing objects, existing

¹⁶⁶ See also Kester (2011, p.7) who characterises a "paradigm shift *within* the field of art, even as the nature of this shift involves an increasing permeability *between* 'art' and other zones of symbolic production".

proposals, existing conditions, existing situations and manipulating the elements into different, more aspirational, or purposeful configurations' (Esche 2005, p.25).¹⁶⁷ They are realised in the concrete mundanity of the everyday (symbolic, physical and discursive spaces) as speculative endeavours. As traditional understandings of institutions no longer have currency, instituent practices flag sites of tension, not in opposition to the institution but fleeing institutionalization and imagining new forms of institutionality.¹⁶⁸ Recall in section 2.1 discussion of the negotiations that accompany each arts project implementation in a healthcare setting, a key characteristic of these practices and which can be said to be part of the artwork itself in the sense that each is in an example of instituent practice. Art and health are re-combined as a becoming-other, in a practice that is both resistant to and engaged with arts institutions and health institutions as part of and apart from these institutions. But as Rogoff remarks, it is not just the moment of instituting that characterises an instituent practice, it is also 'the plurality of activities involved, the fragmentation of one clear goal and protocol into numerous registers of simultaneous activity ... which thereby refuse the possibility of being internally cohered and branded' (Rogoff 2010b, p.45). Consistent with this analysis, the arts projects cited as part of this thesis are intended to demonstrate plurality of practices, fragmentation of intentions and resistance to appropriating narratives (see also Chap 9).

In this section I have introduced institutional critique as a concept in artistic practice. I have briefly referred earlier phases of institutional critique, which have now passed into the received wisdom of the art cannon. I have drawn attention to the way in which some contemporary art practices are distinguished as a third phase of institutional critique characterised by what is called instituent practice – a persistent practice that does not seek to represent through established protocols, operating rather, as part of and apart from institutions in arrangements of

¹⁶⁷ Here modesty refers to 'dealing with real stuff, and with the pragmatics of day-to-day life' as the quality that defines the limits in expression, rather than the scale of the issue involved, or the absence of grand ambition (Esche 2005, p.25).

¹⁶⁸ See also (Jackson 2013) for an analysis that challenges the view that artistic radicality can be measured by its degree of anti-institutionality, instead Jackson makes a claim for arts practices that imagine sustainable social institutions.

organisation assembled and reassembled. It may seem somewhat contradictory for artists to relinquish the bonds of art institutions in exchange for the constraints of health institutions, yet I have positioned arts practices in healthcare settings as modest proposals, dealing with concrete everyday practices, that seek to imagine new forms of sociality and material composition through instituent practice.

5.6 RECAPITULATION

This chapter has related the diverse approaches followed during this inquiry which shifted from foundational principles as *Interpreting Arts and Health*, to a more strategic provocation as (Mis)Interpreting Arts & Health: What (Else) Can an Arts Practice Do? It was not by choice that such a circuitous route was taken, rather it was the lived experiences of practices that necessitated this intellectual wandering and wondering. I introduced key concepts derived from the work of Deleuze and Deleuze and Guattari, laying a ground of immanence by which to understand their pragmatic philosophy. I then proceeded to look at the way in which the chaotic disciplines of art, science and philosophy encounter chaos to lever variations, variable, varieties of life, distinguishing them from each other by the nature of their encounter. I introduced a way of talking about health and art that has currency in both domains, shifting focus from aetiological concerns to ethological ones. I foregrounded art critical concerns with creativity discourses and the current phase of institutional critique found in instituent practice. These critiques shape the inquiry in terms of the questions asked and resources deployed. The challenge of this inquiry in asking, 'what (else) can an arts practice do?' lies in the problematic, 'how to maintain the repetition of difference, as the production of the new, while resisting the gravity of the circle of recognition and its representations? (O'Sullivan & Zepke 2011, p.1). 'How' questions find their answer in method. In the next chapter, I will address this 'how' in terms of broad interpretative methodological issues and in more specific concerns related to how I understand my own arts practice and the way in which this has been extended to the writing of this thesis.

6 METHODOLOGY

The inquiry seeks to trouble the conjunction '*and*', to explore its multiple meanings and conjecture what it might be able to do as a 'mutating centre' (Zepke & O'Sullivan 2010, p.10 italics in orig.) .

The conjunction of arts *and* health presents as a complex encounter that warrants greater attention than cooption through evidence based narratives. This chapter presents consequent challenges to methodology and documents a diverse nexus of interests. Methodology plays a critical part in the evolution of this thesis as it moves from being an operative component to being at the core of conflict over knowledge claims. The chapter begins by situating the research within a qualitative frame presenting a seemingly irresolvable narrative concerning knowledge conflicts. It attends to the research assemblage as a posthumanist approach to understanding research of, and within immanence, which includes a specification of my own practice. This is followed by reflections on rigour in research and the way in which this research sought to find such rigour within its community of interest. This is followed by a discussion of the intertextual methodology applied a posteriori and a consideration of disciplinary practices. These moves reflect the ongoing and dynamic nature of the work eschewing straight line before and after approaches.

6.1 QUALITATIVE RESEARCH

There are two distinct approaches to addressing how we can know anything, broadly construed as quantitative and qualitative research. The qualitative approach adopted in this inquiry is congruent with the theoretical framework outlined in the previous chapter. Denzin and Lincoln (2005), while noting its contingent nature, offer a definition of qualitative research as a situated activity that locates the observer in the world and consisting of a set of interpretive material practices that make the world visible while transforming it. They remark on the wide range of

practices that can render a different view of the world and consequently the deployment of multiple interpretative practices responding to questions emerging from research contexts. Consequently practices are not necessarily chosen in advance. The researcher becomes a bricoleur engaged in research practices that are pragmatic, strategic and reflexive. As a set of interpretive practices no single methodological practice is privileged over any another.¹⁶⁹ Yet, as with any other research inquiry, knowledge claims need some form of validation.

Denzin and Lincoln (2005) propose a chronology of eight historical moments in qualitative research, whose most recent manifestation 'confronts the methodological backlash associated with the evidence-based social movement' (Denzin & Lincoln 2005, p.3). Validity, reliability, and generalisability are the 'holy trinity' of the natural sciences becoming the definitive test of all research despite the epistemological and ontological differences between positivist and interpretivist research that differ in their understandings of truth. The anxiety about methodology in research stems from an anxiety to establish legitimacy in an academic world that is still tied to positivism and keeps interpretative researchers searching for replicable, verifiable and generalisable solutions. But 'methodological criteria no matter how rigorously applied to qualitative work will not produce the objectivity required by positivist researchers' (Angen 2000, p.379).

An interpretative perspective requires a reformulation of the scientific understandings of rationality, objectivity, and validity into understandings that are more appropriate to how we live our lives and how we conduct research. Angen (2000) suggests the following reformulation of terms: Rationality becomes the logic of intelligible human experience and action. Objectivity is accorded by a, 'fidelity to phenomena', a faithfulness necessarily inclusive of our own experience and the

¹⁶⁹ The notion of a field of practice refers to the 'total nexus of interconnected human practices', which comprise 'knowledge, meaning, human activity, science, power, language, social institutions and historical transformation' (Cetina et al. 2000, p.2).

experiences of others. And validity becomes located within the discourse of the research community.¹⁷⁰

Little can be gleaned from an indication that this thesis adopts a qualitative approach as qualitative research has been embroiled in discussion regarding research methodologies following the destabilization of positivist epistemologies. Post positivist epistemologies assert that observations are not 'givens' or 'data', but are always the product of interpretation in light of our background assumptions. Post-positivist epistemologies emphasize that: there is no neutral knowledge, there may be many answers to a question, beyond the confines of dualistic thinking, and that at its core research is an ethical endeavour, (Angen 2000; Engelke 2008; Florczak 2011). Such assertions do not always sit well in an knowledge community that accords truth value to science, leading to tortuous demands for methodological purity. Chamberlain argues that this preoccupation with the methodological is fuelled by a concern with 'proper' or 'correct' methods; a focus on description at the expense of interpretation; a concern with issues of validity and generalisability and an avoidance of theory and critique (Chamberlain 2000, p.285). This privileging of the methodological through slavish attention to selecting and defending methods has been coined 'methodolatry', a combination of method and idolatry (Janesick 1994). According to Daly (1993) this 'tyranny of methodolatry hinders new discoveries. It prevents us from raising questions never asked before and from being illuminated by ideas that do not fit into pre-established boxes and forms' (Daly 1993, p.13).

6.2 THE RESEARCH ASSEMBLAGE

Unsurprisingly then, formulaic approaches to methodology are an anathema within the research inquiry as conceived. It follows a nomos which rather than proceeding from universals, keeps close to events as

¹⁷⁰ Establishing orders of truth, or what is accepted as 'reality' in a given society are practices confined to a particular discursive formation.

they unfold. The practice of nomos can be said to have attained a true experimental method since it is unlike the logos which presumes results in advance in the form of global presuppositions (Roffe 2005, p.190).

Such an approach carries with it an understanding of the way in which human agency and subjectivity has taken precedence over non-human factors. This bias finds its origins in the binary oppositions of social structure/human agency and the social/natural realms and according to Fox & Aldred (2014) risks anthropocentric re-territorialisation. Instead attention shifts to transient and unstable assemblages or relational networks that exist exclusively in relation to one another in the way they affect and are affected.

An assemblage is not a random arrangement of components, rather it exists in so far as it has the power to affect and increase the power of acting of its constituent parts. An assemblage then is 'an intermingling of bodies', material and semiotic, which undergo processes of strengthening or disassembling its current identity (Deleuze & Guattari 2004b, p.95), but it is only in those instances which bring about a change in their parts that they can be considered as really forming an assemblage. Furthermore, although we can categorise the properties of an assemblage, its capacities to interact with other assemblages are not determined. This capacity is the dimension of the virtual. So for example, although in theory we can exhaustively index the properties of a human being assemblage, we cannot give a complete account of the capacities of that human being to affect and be affected.

This inquiry exists as a research assemblage in the way that it connects disparate elements together to introduce a novel approach to the way in which arts practices in healthcare settings can be understood. Following (Fox & Alldred 2014), the research assemblage in this inquiry is comprised of; multiple encounters in the field of practice, research tools (workshops with healthcare professionals, installations at particular points of interest, conferences), recording and analysis techniques (primarily camera based

work and website); theoretical frameworks and hypotheses; research literatures and findings; and me as a researcher. It also includes contextual elements – physical spaces and institutions in which the research takes place; the philosophies, cultures, traditions and ethical protocols of the research institute; as well as a plethora of research outputs found in academic literature and the associated editors, reviewers and readers (Fox & Alldred 2014).

As an artist researcher the inquiry has led to a greater specification of my own practice through an engaged reflection on my own work and the work of other artists and accompanied by following the unfolding literature on artistic research. This was realised through encounters with a professional artist mentor, participation in an International Summer School for Artist Researchers, an international seminar, *Medicine in Art: Illness as Creative Inquiry*, as well as continuing professional development days and by following the literature as it became available.^{171 172 173 174} These reflections also took the form of texts and talks engaging with the work of artists in Ireland and abroad.^{175,176} O'Sullivan (2005a) ascribes four characteristic moments / movements for an expanded arts practice which I find useful to think through in terms of my own practice. They are:

1. In *collaboration* an expanded arts practice is a work in progress whose dimensions change as it proceeds. Composed solely of relations it is an alliance based on affinity and strategy.

¹⁷¹ Doctoral students in academic institutions pursuing practice-based research were invited to submit applications to the International Summer Academy for Artist-researchers that took place in Finland on August 22nd-31st 2011. The aim of the Summer Academy was to clarify, discuss and develop emerging themes and issues arising out of the individual projects of the participants within the developing discourses of art practice and research.

¹⁷² Organised by doctoral researcher Lisa Erdman, Dept of Art, Aalto University School of Arts, Design & Architecture, March 22-23 2012.

¹⁷³ Facilitated through Waterford Healing Arts Trust in association with Create

¹⁷⁴ Artist Marie Brett became my mentor in 2010 through the Connect Professional Development Mentoring programme funded by the Arts Council of Ireland and administered by Create and Common Ground

¹⁷⁵ Marie Brett <http://www.mariebrett.ie/>, Colette Lewis <http://www.colettelewis.ie/>, Ciara McMahon <http://www.artsandhealth.ie/artists/ciara-mcmahon/print/>, Jennie Moran <http://www.jenniemoran.com/>, Denis Roche, <http://www.publicart.ie/main/public-art-directory/directory/view/open-window-a-clinically-useful-artwork/ea4b1455a7dbaa25dd27c4a24b045d49/>

¹⁷⁶ Martijn Englebregt <http://www.egbg.nl/>, Tim Wainwright & John Wynne <http://www.thetransplantlog.com/>, David Critchley, Dr Liz Lee & Susie Freeman <http://www.cradletogrove.org/>

2. *Ethics* brings questions; what is a body capable of? What is this body of work (as a collectivity) capable of generating? Will it lead to more or less potential in the world?

3. *Politics* operates at many strata in an expanded arts practice. It is not only the politics of the institutional body and the politics of the world-body (and subjectivity), but also the politics of the arts practice itself.

4. *Virtualities* bring a future orientation to bear on an expanded arts practice aware of past moments and movements but also future possibilities and potentialities. (O'Sullivan 2005a, p.68)

When taken together these capacities could be said to be tautological with nomadic research. Fox addresses himself to nomadic research which 'acknowledges the impossibility of gaining unmediated knowledge or truth, yet offers possibilities for practice informed by exploration' (Fox 1999, p.178).¹⁷⁷ He asserts that nomadic research is collaborative, characterised by local and contingent processes that make it difficult to establish research questions until a clear understanding of the context has emerged. It is ethical in that is constitutive of difference. The research should not limit the ways in which the subjects of the research will be understood. It is future oriented in that research questions should be developed in such a way that theoretical consequence will be of practical relevance - theory should be related to practice (Fox 1999, p.190). These three affinities can be found in the sections that follow.

6.2.1 COLLABORATION

Throughout this thesis I have tried to make clear the alliance of interests involved in the inquiry. These are not typically what would be understood as collaborators in terms of a durational site-specific piece of collaborative artwork. I claim them as collaborators as without them this piece of work would have a different form. In the first instance I am

¹⁷⁷ Fox (1999) distinguishes between the modernist researcher deploying the icon of the detective, seeking the truth through observation and deduction, and a post modern nomad researcher who struggles with a longing for certainty, mistaking constructions of reality for truth.

referring to CA+HP and Create who have had an advisory role from the very start. At different times each has had a different contribution to make, at times talking through ideas and concepts on other occasions providing practical resources. Tait (2009) makes the case for shifting from a generalised 'ideal' of participatory practice in favour of what he terms molecular collaboration. These are uniquely manifested through a particular set of relations, particular participants, and particular spaces whose parameters are fixed by the choice of setting. Rethinking the idea of collaboration to involve institutions changes the dynamic. Their movement is slow yet still movement is possible. As O'Sullivan notes;

And these participations will not always be with art, or even 'within' the practice, indeed they might precisely (and productively) be with an *outside* however this is theorised (which is to say that notions of an inside/outside of/to the practice are always negotiable and strategic) (O'Sullivan 2005a, p.68).

It would not be possible to work in the way that I wish without these relationships. There is no formal agreement; there are no formal meetings to determine strategy and responsibility, yet by reaching out and involving these agencies the inquiry has increased in its breadth. I cannot say that any of these collaborators share a common agenda, however a sufficient affinity allows me to proceed. I don't overlook the fact that Institutions are made up of individuals. I had a previous association with Create through the artist in the community scheme and also with CA+HP through professional contacts. These associations made it possible for me to run collaborative workshops with healthcare professionals who had commissioned or implemented an arts project in their healthcare setting.

178 179.

At the time I was concerned with how arts practices were perceived within the institutions of health service delivery by healthcare professionals,

¹⁷⁸ These workshops took place on 20 Jan 2011 and 24 March 2011 at Crawford College of Art in Cork. According to the *Guidelines for Good Practice of Participatory Arts in Healthcare Contexts*, healthcare professionals are viewed as arts and health practitioners if they have a professional role in the preparation, delivery and evaluation of work (White 2009b, pp.5–6).

¹⁷⁹ It could be said that the increasing prevalence of arts practices in clinical settings meant that healthcare professionals take on the role of cultural producers as they commission, implement and mediate arts projects in diverse healthcare settings.

being confined to the specific, materials, knowledges and territories. A cohort of nine healthcare professionals from eight different healthcare settings participated in the project (Acute Hospital - Cardiology & ER, Community Hospital, Maternity Hospital, Administration, Disability, Mental Health & Community Work).¹⁸⁰

The CA+HP assisted in identifying healthcare professionals who had a role in mediating or implementing an arts and health project. This participant profile was selected as the healthcare professionals needed to have had professional practical experience of having been involved in arts project delivery. The support of CA+HP was invaluable, as many projects do not have a public profile and it would have been very difficult to find these healthcare professionals otherwise.¹⁸¹ Nine healthcare professionals agreed to participate in two daylong workshops.¹⁸² A full description of what happened at the workshops can be seen in Appendix 12.11.

For example, in Workshop 2, the participants worked with greater freedom and autonomy than previously, performing voluntarily self-assigned and shifting roles related to the assembled corpus of evidence and later in the afternoon, literally taking over the session in a spontaneous and frenetic action. I stood back while the participants designed, decorated and made a large box-like object with long kite-like tails which they then filmed as it was thrown out of the window of the second floor concrete building in an attitude of delightful, unrestrained and uncontrolled abandonment. The fluidity of that day is hard to capture in words. I like to think of it as an uprising where participants cast off responsibilities, transgressing their roles to assert a temporarily nomadic subjectivity.

¹⁸⁰ Artist Marie Brett provided mentoring support re collaborative practice during the project with the assistance of Arts Council Ireland Connect Mentoring Programme managed by the arts organisations Create and Common Ground.

¹⁸¹ Meeting the participants in advance of the workshops gave me access to the healthcare setting in which they worked and provided me with an opportunity to learn about arts practices in those settings. These host sites are a huge resource as repositories of practice and knowledge.

¹⁸² Their professional roles were as follows: Nurse Practice Development Facilitator, Hospital Arts Coordinator, Community Worker, Senior Executive Officer, Community Mental Health Nurse, Nurse Planner, Art Therapist and two Acting Directors of Nursing. They came from diverse healthcare backgrounds: eldercare, mental health, maternity hospital, disability, community work, acute hospital and administration.

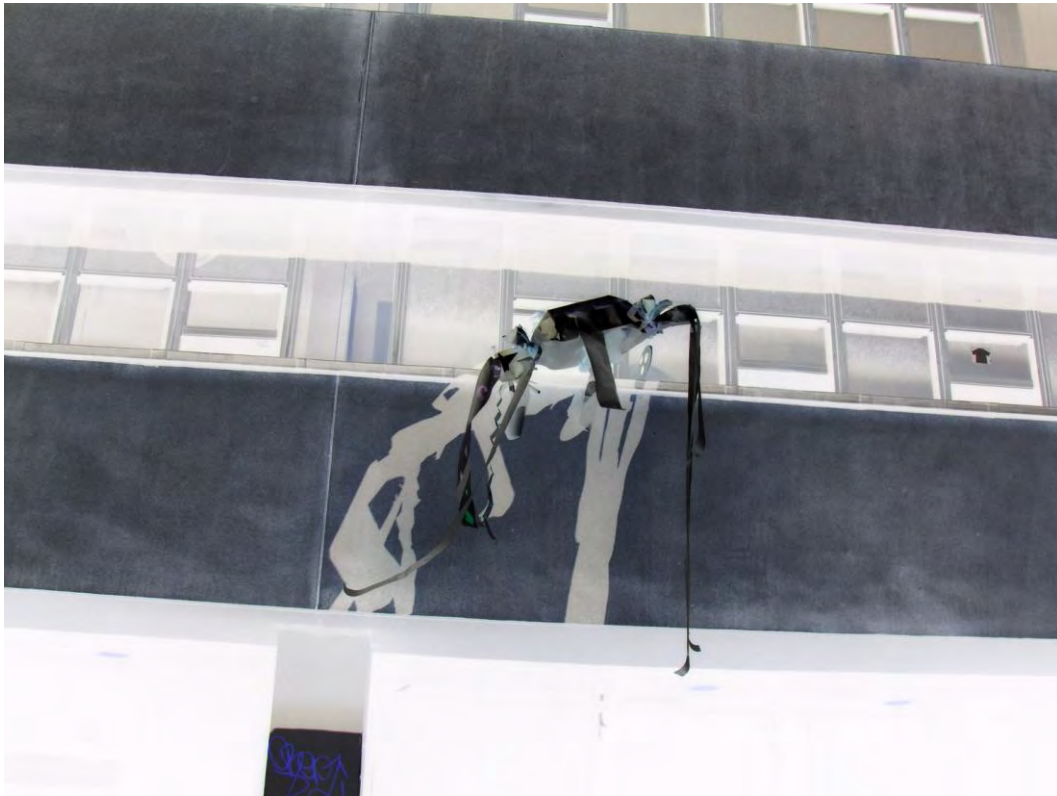


Figure 22 Sheelagh Broderick Workshop Documentation¹⁸³

6.2.2 ETHICS

This research is driven by an ethic that is constitutive of difference. Rather than engaging in negative critique it seeks to take the form of affirmation. Echoing the sentiments of Fox:

The intertextual and collaborative nature of practice based research ... breaks with the traditional model of a dispassionate and detached researcher. Its transgressive character introduces the notion that research should be constitutive of difference: that it should engage with a wider project of resistance to power and control (Fox 2003, p.89).

As Gibson (2006) observes, the connectivity of dependency can be reconceived as an alternate approach to ethical engagement (Gibson 2006, p.195). This ethic is not premised on the rights of a generalised autonomous subject, which limits engagement, rather it directs the becoming self to acknowledge difference through recognition of its own vulnerabilities and dependencies (Gibson 2006, p.188). Critique then is ethical when it has a capacity for differentiation and for the embodiment

¹⁸³ All documentation relating to these workshops was altered so that participants would not be identifiable.

of difference (Raunig et al. 2011a, p.2). It remains to be seen whether this inquiry is ethical as, Malins asserts that, 'an assemblage becomes ethical or unethical depending on the affects it enables and the potentials it opens up or blocks' (Malins 2004, p.104). It is not possible to know in advance what this body of work can do. Yet my cartography calls me to account for present conditions as I find them, to be worthy of what happens to me, and acknowledge the effects of power as both repressive, *potestas* and resistant, *potentia* (Braidotti 2011).¹⁸⁴

6.2.3 POLITICS

Politics connects different regimes of life together. An expanded arts practice will connect art to the wider social milieu and indeed position itself as part of, the wider social and economic fabric (in this case health and social care settings). Referring to the shift from disciplinary societies to societies of control, Deleuze remarks:

In the crisis of the hospital environment as enclosure, neighbourhood clinics, hospices and day care could at first express new freedom, but they could participate as well in mechanisms of control that are equal to the harshest confinements (Deleuze 1992, p.4),

The point here being that, forces of liberation and coercion coexist and confront each other. 'An expanded practice in this sense is both, and at the same time, a critique of the present and a call to the future' (O'Sullivan 2005a, p.68). The task at hand is not to fear or hope but instead to find ways to focus attention, disclosing regimes of dispersed domination consequent to the crisis in institutions. Rather than working apart from institutions, the practices originate from an inside, opening up to an outside through experimentation and speculation. They are future oriented involving the production of collaborations and collectivities providing resistance to the present in the form of imagined communities and prototype subjectivities that also include myself, therefore it involves a politics of dissent and affirmation.

¹⁸⁴ A cartography is a politically informed map of one's historical and social locations, to enable the analysis of situated forms of power and hence the elaboration of adequate forms of resistance.

Consequently the inquiry breaks with current discourses to reorient practices and scholarship. I understand my practice to 'stutter and stammer' in the way it breaks with the major, with the operation of 'order words' and without a fluency that comes with the familiar.^{185,186,187} The minor works to pave the way for a community that is yet to come by invoking its own audience. It seeks out indeterminacy to bring forth a new subject from that, which is already in place.

Again returning to the practical example of the workshops their politics lies in working with institutions from the inside out. By working with healthcare professionals a collectivity was exposed that had previously had no self-awareness of itself. The healthcare professionals had been unaware of each other as they worked in different disciplines and locations. Their conjunction brought an awareness of their common bond and the prospect of future collaboration.

6.2.4 VIRTUALITIES.

O'Sullivan (2001, p.127) distinguishes between the virtual and the possible. The former, possessing a full reality itself, undergoes actualisation through divergence and differentiation while the latter, already resembles the real in its realisation and thereby sets its own limits. In actualising the virtual any and all materials and any and all manipulations of these materials may be deployed on and with a redefined performative and collective/connected body. Understanding the virtual as the realm of

¹⁸⁵ O'Sullivan summarises three characteristics of a minor practice based on the book *Kafka* by Deleuze and Guattari as follows; 1. A minor literature should deterritorialise the major language. It does not occur apart from a major literature; rather it operates from within, using the same elements in a different manner. It infers a processual operation in the sense of becoming minor, producing movement from within the major and being coeval with it. 2. In a minor literature everything is political, connecting different regimes and in particular connecting art with a wider social milieu. Here political is not understood in the usual sense, but rather refers to making connections between different aspects of life (individual or social) so as to produce new pathways of experimentation. 3. A minor literature is always collective and future oriented calling forth new kinds of community (O'Sullivan 2007, pp.71–75).

¹⁸⁶ The major here is used to refer to a 'model that you have to conform to', figured in this inquiry as the model of evidence based practice in its application to arts practices in healthcare settings (O'Sullivan 2007, p.76).

¹⁸⁷ 'The "order-word" is a function immanent to language that compels obedience ... Order-words are not restricted to commands. They are also the relation of every statement with implicit presuppositions and speech-acts that are realized in statements themselves' (Coleman 2005, p.198).

affects, art locates itself on the borderline between the actual and the virtual, involving a moving beyond the familiar in a self-overcoming. Throughout this project, the way in which I have described both myself and my work has been along the following lines: as an artist and researcher developing projects through interactive and collaborative processes, my current project is being developed within the framework of a doctoral programme for research in and as artistic practice. It is a living inquiry that addresses the question of how art practices are and can be related to issues of contemporary politics and culture, specifically as they are manifested in the domain of health and in which the work of art acts as an intervention to life as lived. Interventions can take diverse forms as texts, talks and installations. Situating myself at the crossroads of individual and institutional concerns, I seek out a lingua franca by deploying recognisable cultural forms that will provide an opportunity for participants to critically engage with the practice of everyday life and the embedded challenges of a deep rooted anaesthesia.

This practice places me at the edge of many borders: institutional and individual, science and humanities, art and research. The work operates in and across these borders on the cusp between the present and the future, 'it is "made" in the present, out of the materials at hand, as it were, but its "content" calls for a something yet to come' (O'Sullivan 2010b, p.205).

I situate my practice both theoretically and practically within an institutional framework.¹⁸⁸ The PhD anchors the research inquiry with institutional support and supervision. Advisors to the research are institutionally based. The research takes place in diverse institutional settings, with people who work in those settings. The research is being done not only for myself, but also for an intentional adjacent community of peers and colleagues. I place myself in the everyday of institutional arrangements, the hustle and bustle of meetings, negotiations, alliances,

¹⁸⁸ I have used the totemic sheelaghmag to refer to myself as the researcher who turns herself inside out in an attitude of contemplation that provokes discomfort among those adjacent – not to mention myself.

and allegiances, populated not by drones, but by people. I frame my work in the familiar spaces, artefacts and processes that instil confidence among participants and seek to place a question that is relevant, and prescient.

This dissertation investigates the notion of arts practices in healthcare settings through an art practice that questions, comments and criticizes the very institutions involved in its production, display and mediation. This whole inquiry is at the limit of what I can do to introduce a body of work to nurture resistance to hegemonic knowledge practices by staking out new coordinates within which to locate practices. It emerges as an, 'immanent critique' carried out within the territory itself, using its languages and tools. It has been a constant negotiation in a process of collaboration, both within and across institutions, through relationships of varying magnitude and consequence. This expanded practice operates at multiple levels to establish a nexus of levers, which can be deployed as critique, as part of and apart from the institutions with which it engages (health, art, academic) and simultaneously as an escape from that weighty burden.

Fox and Alldred (2014) suggest that an eclectic data collection machine that does not rely entirely on qualitative methods will reduce the tendency of research to territorialise. Diverse empirical data sources can be dredged to identify relations and affects in assemblages and assess emergent capacities. According to Duff (2014), Deleuze's 'transcendental empiricism' makes possible an experimental method of real experience (Duff 2014), but one in which difference is never captured and understood once and for all. Nevertheless, although Fox and Alldred (2014) express a preference for formalised analytic machines, they also identify other rhizoanalytic approaches deployed in research literature more congruent to this inquiry in its re-reading of materials.

The idea of Deleuzian 'methodology' is complex. As Colebrook suggests "method" is problematic in Deleuzian thought, simply because his whole philosophical project resists the idea that we should approach problems

with ready-made schemas, questions or systems. Philosophy, especially, ought to be creative and responsive, forming its questions through what it encounters. If Deleuze has a method it is that we should never have a method, but should allow ourselves to become in relation to what we are seeking to understand (Colebrook 2002: 46). O'Sullivan echoes this view that 'The desire to outline a Deleuzian methodology is ... somewhat wrong-headed ... One might be able to extract such a method or system, but this would be to render Deleuze's thought inoperative, to freeze it in, and as a particular image of thought, to capture its movement, precisely to represent it' (O'Sullivan 2006: 3).

As this research assemblage has progressively interacted with its object of study, flows of affect have deterritorialised it, to create a line of flight from essentialist analyses, and negative critique. Instead, it introduces an ontology of immanence with which to understand practices as a tactic. Not only that, the research assemblage also produces me as a subject in which I adopt an approach that privileges practice that is emergent and experimental. This inquiry has more in common with a schizoanalytical approach in that it holds potential for engaged intellectual and creative work within institutional frameworks, and carries the immanent possibility of change (Biddle 2010).¹⁸⁹ Validation of practices is derived within the discourse of the research community as discussed above. This was not always straightforward as for example with the difficulty in obtaining ethical approval.¹⁹⁰

6.3 ESTABLISHING RIGOUR /AUTHENTICATION

The shifting theoretical nomos is not inconsistent with a PhD inquiry that

¹⁸⁹ Schizoanalysis is not confined to a specific form or technique, it is a rejection of the authority of method, Biddle (2010) characterises it as situated, playful, experimental and generative. See also (Masumi 2004b)

¹⁹⁰ Establishing legitimacy was an ongoing concern. In order to proceed with workshops with healthcare professionals it was necessary to get the approval of the DIT Research Ethics Committee. Here too the unrelenting echo of knowledge conflict was heard. My application for ethical approval was turned down on the basis that I could not establish data validity as the participants were not a representative sample and that I might coerce the participants (amongst other claims). The ethics committee could not understand the nature of this project and I had not adequately explained it on the pro forma application for ethical approval (see Appendices 10.4,10.5 & 10.6).

asserts academic rigour.¹⁹¹ Theories are understood to be underdetermined while at the same time facts are known to be theory-laden ;

Theories are logically constrained by facts, but are underdetermined by them; that is, while to be acceptable, theories should be more or less plausibly coherent with facts, they can be neither conclusively refuted nor uniquely derived from statements of fact alone and hence no theory in a given domain is uniquely acceptable (Hesse 1980, p.187 cited in Lincoln 1985 p114).

How is this relevant for my inquiry? Any collection of 'facts' is subject to meaningful interpretation within any number of possible theories through an inductive proof that relies on persuasiveness (and in distinction from the conclusiveness of deductive proof). But facts themselves can only be construed as facts within some theoretical framework; facts in and of themselves have no absolute meaning. The inquiry is caught between these poles in a position of indeterminacy where the inquirer can never hope to 'know' anything with certainty. The indeterminacy does not mean that knowledge cannot be pursued within some limits, as some grounds will be found to be more persuasive than others. Selecting which grounds to attend to is a matter of judgment. The extent to which the inquirer interacts with a phenomenon over a period of time is a warrant of their judgment. It is impossible to divest an inquiry of some human judgment if theories and facts are not independent. A balance between 'facts' which support the proposed theory and the proposed theory not over determining facts is found through a continuous and intensive interaction of research (Lincoln & Guba 1985). The shifting grounds found in this theoretical nomos are indicative of engaged and prolonged encounters and is consistent with the rigour expected within a PhD.

Throughout, I have endeavoured to carry out research in as collaborative and open a manner as possible. Publishing work, presenting at conferences, attending and contributing to professional development

¹⁹¹ It's easy to write these words, whereas in practice they caused much anxiety. Field notes from this period note; 'I am not feeling too good - head dizzy, stomach tight. Feel a heavy burden of responsibility, feel shy, I feel overwhelmed. Part of the reason I feel dizzy is that I am moving from a position of assumed authority to a position of ignorance.

seminars and working on installations in public spaces has meant that I have been open to peer feedback on an ongoing basis. In the final phase of this project as I retreated to write it up, I sought the support of a peer thesis feedback group, composed of advisors in Create and the HSE, an artist and a curator/cultural collaborator. All had been involved closely in this work for a considerable period of time.¹⁹²

6.4 INTERTEXTUALITY

This research inquiry became a speculative endeavour going beyond the concrete outcomes of the research data, by deploying an intertextual methodology a posteriori:

As an assemblage, a book has only itself, in connection with other assemblages and in relation to other bodies without organs. We will never ask what a book means, as signified or signifier; we will not look for anything to understand in it. We will ask what it functions with (Deleuze & Guattari 2004b, p.4).

Deleuze and Guattari distinguish between the noble book that imitates the world and the book as assemblage with the outside, an outside that is without image, signification or subjectivity. Rather than starting at the beginning with a clean slate, they proceed from the middle, 'coming and going rather than starting and finishing' (Deleuze & Guattari 2004b, p.28). The middle is the between, unlike a pendulum moving back and forth, it is a transversal movement in a perpendicular direction sweeping all away in its path just as a stream might undermine its banks while picking up speed in the middle. They assert that, 'Writing has nothing to do with signifying. It has to do with surveying, mapping, even realms that are yet to come' (Deleuze & Guattari 2004b, p.5).

¹⁹² Feedback from these peer feedback sessions was an important driver in completing this thesis with comments like 'the work you have done is so progressive and energizing and liberatingI was buzzing after it' and 'you have done some very important and pioneering work in connection with Arts and Health practice in Ireland. I'm also glad that you have the support in the room on Friday, you've earned it' (personal email communications).

Intertextuality captures the intention of this project as a collaborative construction of narrative that is uncertain and contingent.¹⁹³ In its unravelling it is clear that what follows is an a posteriori view of practices. It is claimed that the act of reading, rather than being concerned with the interpretation of one work, engages the reader in discovering a network of textual relations:

Reading thus becomes a process of touring between texts. Meaning becomes something, which exists between a text and all the other texts to which it refers and relates, moving out from the independent text into a network of textual relations. The text becomes the intertext. (Allen 2011, p.1)

Text has become synonymous with other non-verbal codes, thus anything can be considered a text and interpreted. Intertextuality then refers to the way in which texts gain meaning through their referencing or evocation of other texts. Foregrounding concepts of relationality, interconnectedness and interdependence, intertextuality disrupts notions of meaning resistant to 'ingrained notions of uniqueness, singularity and autonomy' (Allen 2011, pp.5–6).¹⁹⁴ Although intertextuality has inspired various critical positions, it is a term by no means exclusively related to literary works or written communication. Critics of non-literary art forms, such as painting, music, architecture, photography or even film, have adopted intertextuality and through its deployment in other art forms, traits of society or periods of history can be captured not only in the written form, but also by using visual imagery. The concept of intertextuality dramatically blurs the outlines of texts, making them an 'illimitable tissue of connections and associations' (Barthes 1981: 39). Moreover, strictly speaking, a text is constituted, only in the moment of its reading. The reader's own previous readings, experiences and position within the cultural formation also form crucial connections, and open new doors to intertextuality (Simandan

¹⁹³ This research inquiry aims to weave a different narrative through intertextual and collaborative practices, with the intention to extend the terrain of critical engagement and to encourage the occupation of other positions. Fox suggests that, '*intertextuality* is a feature of the deterritorialisation of subjectivity and nomadism which underpins ...resistance' (Fox 1999, p.181 italics in orig.). Julia Kristeva first introduced the term "intertextuality" in literary linguistics. Breaking from traditional notions of author's influences and text's sources, she argued that all signifying systems are constituted by the manner in which they transform earlier signifying systems. A literary work, then, is not simply the product of a single author, but of his/her relationship to other texts (both written and spoken), and to the structure of language itself.

¹⁹⁴ Structuralists have used the term intertextuality in a contradictory fashion to argue for critical certainty. See Chapter 3 in (Allen 2011)

2010). It entirely depends on the reader's sensibility and background knowledge to make all the necessary connections in order to get the most out of a text. One also has to take into account historical and social determinants, which themselves, transform and change literary practices as in the case below in relation to academic texts:

The logistics of bringing together a text that meets academic requirements and has the possibility of making sense to readers is forever 'steering' us in the 'direction' of producing a 'linear' text – an 'ordered' 'progression' of 'theoretical ideas' and 'practical applications' that 'leads' to a 'coherent' 'conclusion'. All of these concepts are potentially problematic to rhizomatic thinking as it works to overcome binary polarisations, to go beyond dichotomous thought and linear thinking, instead working towards producing points of intersection, overlaps, convergences, twisting and weaving through infinite folds and surfaces (Honan & Sellers 2007).

In this thesis I refer to intertextuality in its characterisation as an anti-narrative in which statements are theorised as a network of fragments that refer to still other statements. Text then became the fabric with which I weave.¹⁹⁵ Fox (1995), when exploring the possibility for research writing, rejects distinctions between 'real' and representation as all texts become fabrications of contested truth claims deriving from the fundamental undecidability residing in language and its continual deferral of meaning. The consequent approximation of reality stands apart from a logocentrism, which claims unmediated knowledge of the world, through bracketing other claims to knowledge.¹⁹⁶ Fox (1995) argues that 'intertextuality is a means to demonstrate the limits of discourse, but also, significantly, a stratagem by which it becomes possible to challenge and resist discourse - to open up the possibilities of becoming other' (Fox 1995, p.1). Intertextuality underpins the theory of resistance posited by Deleuze and Guattari, exemplified in *Thousand Plateaus*, a book that refuses a chain of signification, by offering a text that can be read in any order and placing an imperative on the reader to write themselves. Rejecting distinctions between real and representation, all texts are fabrications;

¹⁹⁵ Its etymology deriving from the latin *textus* meaning a tissue and which in turn is derived from the word *texere* to weave having associated connotations of spinning and webbing that finds a resonance with contemporary scholarship of intertextuality.

¹⁹⁶ Fox bases his claim on Derrida's analysis of difference (Derrida 1976, p.65).

including research texts like this one. In this mode, research writing becomes narrative work carrying with it an implicit critique of logocentrism. This inquiry has taken on the task of unsettling foundational claims for arts practices in healthcare settings to rethink the ambit of its practices from a transdisciplinary perspective. It is a commonplace to expect a conclusion of a thesis to report the outcomes of the research inquiry; that there is an end to the research that is reported as a result. This expectation finds its origin in the scientific method (Game 1991). But when research is understood as writing (or inscription by whatever medium), attention is drawn to the process of textual production, which is the research as opposed to the final writing up (hence the inclusion of all texts in the associated website of documentation).¹⁹⁷ As Barthes claims, it is 'fiction that research is reported not written' (Barthes 1986 cited in, Game 1991, p.27). Instead of treating method as founding privilege, its necessary component is of responsibility, critique and self-critique of the research discourse. In this way, method becomes part of the writing, rather than the deferred writing once a result has been found. It is characterised by a reflexivity that can displace both reader and writer as researchers consider, 'Under what institutional and historical constraints is this speaking, writing taking place?' (Clifford, 1986 cited in, Game 1991, p.31). Challenging the authoritative voice of science, intertextuality, opens up possibilities for a research practice that eschews efforts to attain a transparent mediation of knowledge. This nomadic practice inevitably confronts the researcher with an incitement to act, to change to become (Fox 1999, pp.180–181).

¹⁹⁷ www.sheelaghmagig.net/artsandhealth

Fox (1999, p.184) articulates the implications for research practice as follows;

1. Intertextual approaches break the distinction between researcher and researched. The researcher becomes part of the world, which is being explored and translated into text. The significance of the researcher's intertextual links in documenting the world must be recognised, and distinctions between the personal and professional responses of researchers in the field elided. Chapter 4, , pools a series of texts, artworks and talks, based on professional and personal research encounters.
2. Researchers become part of an intertextuality such that they can no longer stand apart from the research setting: their relationship with 'subject' must be acknowledged as part of a wider social and political engagement. Consequently the researcher must adopt an ethical and political position which structures the engagement with a commitment to becoming other underpinned by a concern with resistance and change. Disclosure of the situated contingency of researcher comes early in this thesis (in section 1.3) and is evident throughout this sprawling text as I struggle with the reorientation of the research inquiry, its intention and myself.
3. The significance of writing research reports changes from efforts to represent or to persuade, to a reflection upon the relationship between that text and other texts, to the possibilities of deterritorialisation and nomadism. Researchers may choose their form as fiction or fact. Inevitably the research becomes part of the setting it is exploring and the ethics of the research become inextricably tied up with wider issues of political engagement, struggle and resistance to power and injustice. This text spreads widely to include broader narratives and deploying diverse voices, moving between academic critique and everyday commentary in texts, talks and installations.

Latour (2004) urgently exhorts the critic to assemble - not debunk; to offer arenas for gatherings - not deconstructive world-defeating corridors. Speculating on what such a critique would do, he suggests that it could be associated with more, not with less, with multiplication, not subtraction as a generative future oriented practice. Part of the difficulty in articulating this research project is that rather than relying on a logos in which intelligence comes *before*, this research works on the immanent principle that intelligence comes *after* (Bryx & Genosko 2005). It is a becoming text; always partial, because it is one strategy among many in an overall research project that does not anticipate forgone conclusions and that remains open to a multiplicity of readings. Writing this text itself is a rhizomatic practice, connecting different signifying regimes, by blurring discrete categories, weaving thought and feeling into text.

In choosing to include this text I am attending to disputed claims concerning artistic research already discussed (see section 3.4). Borgdorff has asserted that by intending an arts practice as research the artist inscribes that work into artistic research discourse transforming it from an artistic product to an artistic argument with the potential for knowledge and understanding. Furthermore as Steyerl (2010a) notes, a claim for artistic research to be unique rests on it setting up its own field of reference and logic. The artwork is conceived as a process, understood in a variety of ways, but in this case as a theoretical investigation working outside traditional sites of art production and reception (Stewart 2012). Hence, it is intended that this writing operate as artistic research in the way that it brings a particular perspective into circuits of expertise by resisting the demands of knowledge protocols for outcomes, outputs and impacts (Rogoff 2010a).

In this section I have explained how in writing the work of the thesis I adopt an intertextual approach. Rather than dig deeply, it spreads widely to float on a smooth surface of texts. During the initial period of research I sank deeper and deeper in text and theory, the research practices propelled me upward to float lightly supported by what is below. This

depth is available to the reader through footnotes and references, but it is my aim to bring the reader with me across this surface without sinking.

The next section looks at the spatiality of arts and health practices in the way they have been designated interdisciplinary practices, rather than as transdisciplinary practices as this project understands itself.

6.5 DISCIPLINARY PRACTICES

This section calls into question the mode of practice. Arts and health is often termed an interdisciplinary practice, but what is at stake in such a designation? What follows here is brief characterisation of disciplinary practices, and the way that they shape research processes and outcomes. This is of significance for the inquiry because it self-consciously situates itself as a transdisciplinary practice.

In a generalised sense interdisciplinary studies have been characterised as; emerging from a perceived need for new knowledge and as strategies to incorporate new subject areas that have emerged outside the university but which are related to aspects of pre-existing university studies.¹⁹⁸ Arts in healthcare emerged from a grassroots response to perceived shortcomings in healthcare provision environments that led initially to arts in hospitals programs (White 2009a). The existence of these programs became a comment on the types of services provided and as a consequence inevitably became a new focus of interest within the university. As with any new field of inquiry, once established mechanisms of institutional reproduction become essential in order to sustain it. This includes strategies such as having a specialised lexicon characterising the specificity of the discipline allied with an understanding of the PhD as the institutional instrument of disciplinary reproduction. While the latter is becoming more evident through programs based at specialised research

¹⁹⁸ See (Wilson 2006) and in particular chapter 3 *The Disorder of Disciplines*.

units,¹⁹⁹ there remains considerable incoherence with respect to a lingua franca. One of the primary reasons for this lack of fluency is consequent to the necessity of having a body of intersubjectively acceptable knowledge with which to support interdisciplinary inquiry. Dileo and Bradt (2009) remark on this suggesting that although arts in healthcare is inherently interdisciplinary, challenges remain in organising a 'coherent, identifiable and unified discipline' (Dileo & Bradt 2009, p.169). Bishop too recognises that participatory art requires new modes of analysis 'no longer linked solely to visibility'. She avers that 'interdisciplinarity parallels (and stems from) the ambition and content of the art itself' (2012, p.7) Furthermore, Raw et al. (2011) assert that the lack of consensus on a conceptual home for practices is due to the complexity of the interdisciplinary intersection between health, social sciences and arts research. They argue that extant methodological disputes between disciplines have the potential to paralyse progress toward establishing academic understanding and increasing reputational estimation.

This is hardly surprising given that medicine and art have evolved as discrete disciplines. The articulation of medicine as a discipline over a period of three centuries, governs the current possibility of its experience and structure of its rationality. The clinic formulates the discourse of disease within specific epistemic boundaries (Foucault 1976). The trajectory which art has taken over the same period is markedly different, in particular in relation to validation practices.²⁰⁰ Accordingly, tensions arise in their encounter with each other.

What does art know of healthcare disciplines and indeed, what do they know of art? This type of reflection finds limited traction in academic scholarship (Macneill 2011). The more typical formulation is commonly expressed as the value of the healing arts in clinical outcomes and improved wellbeing. This formulation finds its logical conclusion in attempts

¹⁹⁹ Sydney de Haan Research Centre for Arts and Health, Canterbury Christchurch University (UK). Arts for Health, Manchester Metropolitan University, (UK). ArtsHealth at the University of Newcastle, Australia.

²⁰⁰ Constructions of contemporary arts are disputed widely, see (Aranda et al. 2010; Hlavajova et al. 2011; Hlavajova et al. 2008)

to apply the techniques of systematic review and randomised control trial to arts interventions in healthcare settings, casting them in unreasonable doubt (Broderick 2011a). The conventions of the scientific method call for the production of reliable, replicable and generalisable knowledge, conventions that do not apply to art processes and outcomes, which are singular by their very nature (see section 3.4).

A further reflection on the use of the word discipline as deployed by Foucault relates to his analysis of the internalised systems of self-management integral to modern subject construction and the production of what he terms 'docile bodies'. By this he refers to the various forms and techniques of discipline including those exerted over oneself characterised by an unreflected upon, self-imposed self-restraint (Foucault 1995). Contemporary arts practices are concerned with discourses of power and knowledge, clusters of authority and tradition as well as experiences of embodied subjectivities and would seem unlikely 'docile bodies', but in accepting validation through clinical research practices they are internalising the knowledge/power regime of medicine.

Gandolfo (2006) distinguishes interdisciplinary approaches from transdisciplinary approaches by the use of metaphor. She thinks of interdisciplinary exchanges as the way in which friendly neighbours might meet to share gossip over a fence. Although they may exchange new ideas, they return to their own bounded spaces. She thinks of transdisciplinary exchanges on the other hand as transgressive; highlighting the arbitrary nature of the fencing, transdisciplinary exchanges trouble the placement of boundaries as historically, politically, culturally and/or economically contingent. Dismantling these boundaries to create spaces is part of the transdisciplinary imagination opening up the possibility of creating heterotopic spaces.

In what Holmes (2009) characterises as a phase changing strategy, transversal art practices theorise assemblages linking actors and resources from an art interior, with projects and experiments that extend beyond

and elsewhere. These practices exist as border crossings circulating between disciplines and consequently jeopardise their assignation as 'art' (Holmes 2009). The incursion across borders finds disapproval in each territory. Recall the already referenced Arts Council of Ireland (2004) publication following the 2004 arts and health conference which noted;

1. Arts and health projects were perceived to be undervalued by the health sector because of the prevailing biomedical approach to health and illness.
2. Arts and health projects were perceived to be peripheral by the arts sector by virtue of the fact that they exist outside traditional venues for art display in galleries, theatres and concert halls.

The reluctance to accept these transdisciplinary practices in 'home' territories is unsurprising, being based on a principal of difference rather than a shared rationality. Throughout this thesis then there is a shuttling between practice and theory, which following Deleuze exist in partial and fragmentary relation rather than as a totality, 'Practice is a set of relays from one theoretical point to another, and theory is a relay from one practice to another' (Foucault 1980a, p.206). In this case the arts practice is both one of resistance and affirmation; resisting totalising discourses by moving fluidly across transdisciplinary contexts, the project seeks to refocus and re-fuse (Gibson 2006), affirming open-ended possibilities for arts practices.²⁰¹ Transdisciplinary practices work with what already is in place, what is happening, in order to expedite new and different circumstances, in a refusal. As will be shown in chapter 7 this research inquiry has established competence across a range of disciplines (arts practice, sociology, medical humanities, arts and health) to draw on resources from each to establish a transdisciplinary approach.

²⁰¹ The conversation that emerges illuminates the contingency of the research endeavour and the reflexivity attendant to the researcher. This text that you are reading now has been written at the end of the research process, which may give the impression that specific outcomes were anticipated and inevitable. But this is not the case. This text has been arrived at through many formulations and iterations and quite definitely could have been written otherwise.

This section has briefly referred to different disciplinary practices to shed light on this inquiry's own self-understanding of itself as a transdisciplinary research project.

6.6 RECAPITULATION

This chapter has sought to establish the methodological concerns that shaped the emergence of the research inquiry. This has been achieved by looking at contemporary issues relating to qualitative research and in particular the validation of practices and assertion of rigour. I invoked the schema outlined by Fox & Alldred (2014), whose exploration of the materialist notion of a 'research-assemblage' comprised researcher, data, methods and contexts. I discussed intertextuality as a strategy in arriving at a collaborative construction of narrative that is uncertain and contingent. Finally I considered the consequences of deploying interdisciplinary and transdisciplinary approaches. These moves reflect the ongoing and dynamic nature of the work. As Ringrose and Renold observe; 'Rather than conceptualising analysis as something which occurs post-fieldwork, we foreground how meaning making emerges over time: before "research" begins, during live research encounters and afterwards' (2014, p.2). This approach eschews straight line before and after approaches and instead adopts the middle, revisiting, refiguring and refusing.

The next Chapter moves on from the tracing of previous chapters in Part 1, to commence an experimental mapping in Part 2 of this thesis as the concept of assemblage is used to think through different art projects.²⁰²

²⁰² Deleuze and Guattari distinguish between 'tracing' which describes existing relations, and 'mapping', as an experimental future oriented activity (2004b, p.13). Tracing, refers to the world 'as-it-is', providing a specific orientation by drawing attention to problems and inconsistencies within relations. Mapping, on the other hand, refers to experimental processes anticipating new trajectories and connections

PART 2

7 ART ASSEMBLAGES

What distinguishes the map from the tracing is that it is entirely oriented toward an experimentation in contact with the real ... The map is open and connectible in all its dimensions; it is detachable, reversible, susceptible to constant modification ... It can be drawn on a wall, conceived as a work of art, constructed as a political action or as a meditation ... the map has to do with performance (Deleuze & Guattari 2004b, pp.13–14).

Chapter 7 opens Part 2 of this thesis as a mapping in the sense referred to by Deleuze and Guattari. It refers to experimental processes anticipating new trajectories and connections by applying the analytical tools elaborated in Part 1.

Art as assemblage is located as a heterogenic practice whose production, distribution and reception can be understood in actual terms, as content and expression, and, in virtual terms as a line of flight. Art then is the freedom to experiment, opening up the possibility of deterritorialisation.

Lodge yourself on a stratum, experiment with the opportunities it offers, find an advantageous place on it, find potential movements of deterritorialization, possible lines of flight, experience them, produce flow conjunctions here and there, try out continuums of intensities segment by segment, have a small plot of new land at all times. It is through a meticulous relation ... that one succeeds in freeing lines of flight. ... Connect, conjugate, continue (Deleuze & Guattari 2004b, p.178)

In other words, Deleuze and Guattari urge us to flee the limits of recognition and the already known. Nevertheless they urge caution too. Absolute deterritorialisation is to be avoided, so they advocate 'dosages', to ensure reterritorialisation can follow (ibid. 2004b, p.177). Art is the freedom to experiment: to explore, to create novelty, but also to give 'something to us', that is, not to annihilate the object or the subject completely via absolute deterritorialization. In a successful work of art something new is produced in a new sensation. Out of the level of content emerges expression. Yet, this emergence cannot be determined

or calculated in advance, as it is due to the virtual potential of the assemblage. The effect of an artwork cannot be predetermined on the basis of its material components as affects can be actualised in various ways. If the assemblage proceeded from content to expression in a predictable manner, there could be no expression of difference, it is only when the work breaks with the predictable that it achieves a level of novel expression.

In this Chapter I turn to lived experience in the form of two different arts projects selected on the basis of their having had an affect on me – that is not that they triggered an emotional response, rather they increased my power of acting. This will be followed by a looking at the specificity of location and space in relation to two further projects.

7.1 THE MAGICIAN AND THE SWALLOWS TALE

In 2012 The Arts Council of Ireland awarded Galway University Hospital Arts Trust an Arts Participation Project Award for a year-long arts programme in the haemodialysis unit at Merlin Park University Hospital, Galway.²⁰³ The artist Marielle MacLeman paid weekly visits to the Haemodialysis Unit which led to an exhibition and catalogue *The Magician and The Swallows Tale* (MacLeman 2013). The project does not make any grand claims for itself. The subtitle of the catalogue, from which this analysis is drawn, is titled, '*pictures, words and messin' from dialysis*'. It's own self professed ambition was to physically enhance the clinical environment and to celebrate the ephemeral things that humanize it. Above all, participatory workshops offered patients more positive and productive experiences during dialysis.

²⁰³ As a designated supra regional centre comprising, University Hospital Galway and Merlin Park University Hospital, Galway University Hospitals serves a catchment area of approx. 1 million people. In the specialty of Nephrology it operates a 22-bed haemodialysis ward and a peritoneal facility at Unit 7 in Merlin Park University Hospital. A 3 bed acute unit at University Hospital Galway complements these services.

The art assemblage at Unit 7 did not arrive preconstructed with MacLeman the first day she started. Assemblages exist in all scales from the macro of the hospital and beyond through to the micro of the body and its composing parts of sinew and bone and to the pico level of cellular activity. Therefore assemblages are nested physical, chemical, biological, cultural and technical parts. Unit 7 is comprised of many other existing assemblages from the macro scale of HSE service planning and budget planning through to the ward assemblage to the micro scale of parts of the body and of health, and recreation. The intermingling bodies in an assemblage undergo processes of assembling or disassembling and in the process express what they can do. An art assemblage does art, but for that to happen parts need to come together to form relations of affect. From the narrative below I hope to show the emergent qualities of the art assemblage. But to start let us remind ourselves of the Spinozist dictat : that we do not know in advance what a body can do : encounters may have joyful or sad affects. For example, one of the participants observed previous changes at the unit wrought about by an improvement to services also degraded the connection between patients.

One time, before in the beginning, we were all connected. The unit was smaller and we didn't have TVs back then, we got to know one another and we talked and talked all the time. Now with the unit so big, there is not the same interaction during dialysis (MacLeman 2013, p.9).

This unanticipated outcome reminds us that affects can have both a positive and negative character.

The physical space of the Unit and the equipment that surrounds it as well as the journey to the hospital and the frequency of their visits – these inanimate materials and routines – would become important elements in the art assemblage (as we will see later).

For some travelling to Unit 7 their journey is long ... their route is trekked thrice weekly as part of the relentless burden of haemodialysis. When they reach their destination the habitat is clinical with a soundscape of beeps and alarms (ibid 2013, p.20).

Establishing a network of relations, drawing parts of an art assemblage together takes time. Starting in winter some patients preferred to sleep after long journeys rather than participate in any arts activity. MacLeman would not cajole or wheedle. The choice to participate, to face the unknown of art, remained with each participant.

Resolving to approach bedside only once after the information sheet, it was a slow road in for those with a fear of the unknown. Some were interested but resigned to the challenges of isolation of their dawn rise. In the winter months, darkness obscured the breathtaking views of their long road in and ensured they slept soundly throughout their stay (ibid 2013, p.22).

Nevertheless MacLeman was reconciled to the process of parts coalescing to form an assemblage at its own speeds. She waited, watched, connected and affirmed relations as they emerged.

Like their asphalt route to the unit, the road into their creative exploits was seldom direct. Conversation without expectation and affirming interactions with others were essential in ensuring the participant was navigator of their own trip (ibid. 2013, p.21).

But relations were not unidirectional or assured. MacLeman herself had to find a way of working within the routines and clinical practices of the Unit.

Still, watching her paint after a series of steep lessons in the challenges of dialysis, I felt sure that the only way was up. Until then, my time on the ward had been short-lived. Preparatory discussions and demonstrations stalled by slumber or punctuated by alarms (ibid. 2013, p.22).

Furthermore, as an 'extra' on the ward, she often found herself in ancillary locations, from where she could observe the rhythms of human and non human interaction.

Relegated to the corridor or waiting room I heard the kind words of staff reverberate and witnessed the close bonds of those waiting patiently for their travelling companions ... I thought about the warmth that pervaded the clinical trappings of a place that was not yet home (ibid. 2013, p.22).

These observations and conversations, led MacLeman to think of the participants in terms of what they could do – so instead of using standard pseudonyms as is the case in most projects, patients on the ward were called wonderfully descriptive names; The Woman Who Loved Doon Hill,

The Set Dancer, The Songbird, The Cake Decorator, The Angler, The Box Player. These names removed the identity tag of patient or healthcare professional and instead substituted a power of acting for each one. Now MacLeman and the participants could form relations that would increase both their powers of acting.

The Woman Who Loved Doon Hill decided that painting was no longer practical she made a series of digital works from the original watercolour. The shapes she introduced to them revealed a love of flowers. I began photographing flowers in the hospital grounds and surrounding woods and when we worked together The Woman Who Loved Doon Hill made patterns with them on the laptop ... A silver-leafed Cinneraria became the snowflake décor accompanying the first exhibition in the waiting room (MacLeman 2013, p.23).

The Woman Who Loved Doon Hill, the limitations of being bed-bound, the possibilities of using a laptop, a preference for flowers, an institution with a garden, an artist motivated to source materials, a collaborative working together, previous experience of pattern making and an opportunity to show work were all parts of this art assemblage. It moved with different speeds not toward any anticipated conclusion, but rather in a process of exploration working through circumstance and contingency to find what all these parts could do together. This unfolding character of the work points to the immanence of the artwork and anticipates the assertion that although we can list the properties of an assemblage we cannot know in advance what it can do. But it was not finished, there was more, as there is always more. Unsurprisingly, this first exhibition of work did not go unnoticed and in fact piqued the interest of other dialysis patients, The Set Dancer in particular;

“Isn’t it awful hard though?”, she said as her eyes skimmed over the waiting room wall. “And you say she’d never painted before?”, she continued. The newly hung artwork had prompted a series of questions from those who had previously declined and none more resolute in their rebuff than this woman. Yet as she shifted uneasily beside me, it seemed her thoughts were swaying too (ibid 2013, p.29).

The exhibition of work had the affect of increasing the power of acting of The Set Dancer. She was curious and nervous at the same time;

In the weeks that followed she selected a series of pictures from palm-sized books which I duly rendered as she looked on. These first demos took place in the waiting room and, when she was ready, she made her first marks at her daughter's bedside under the pretext of 'play'. "Not bad for messin'!" she said.

The Set Dancer was moving past the weight of art history and judgment to play with materials, to share creatively with her daughter on dialysis. Messin' was her diagram.

"We fix the messes with mistakes she would say" ... "First Class!" she proclaimed. Though she mocked herself, I felt she might even be starting to believe it. Our painting sessions became increasingly buoyant. Saturdays were for dancing but on Tuesdays she travelled the world, tracing skylines of great planes, peaks and parks with a brush (ibid 2013, p.30).

The materials to hand became a part of the art assemblage as the discarded wrapping of surgical gloves found life, as acrylic paintings of a karst landscape and then again found new life as transitory paper sculptures that would appear whimsically across the limestone floor of the hospital. New relations were being established transversally for example when the Woman Who Loved Doon Hill captured Merlin Park's falling blossom in a design, MacLeman made a stencil of it, from which The Cake Decorator made a rug of icing sugar on the floor of a patient cubicle – blending hospital garden flower with hospital environment through relations established between humans and non humans; flower – laptop - stencil – icing sugar – floor - art - The Woman Who Loved Doon Hill - The Artist - Hospital Arts Committee and Ward staff. The art assemblage was drawing in new parts as staff in both their professional role and in their personal time began to take note.

Now and then others would join our lunchtime antics, some just watching. They perched in pop-up studios in various nooks chirpily discussing the art and their lives outside their blue or claret uniforms (ibid MacLeman 2013, p.46).

Not everyone wanted to paint and the long journeys to Unit 7 circuitously became part of the project work. The Box Player would recount stories of roads travelled in all parts of the country and together with MacLeman, they would explore them through Google Earth.

It was in fact the laptop, not painting that had sparked The Box Player's interest in the project. Since explaining that setting up a Facebook account was not what I had in mind, we had used it to provide an illustrated backdrop for his extensive tales of the West. ... That's my boat said The Angler calling an abrupt halt to our trip back to Oughterard. We zoomed in and admired her upturned hull set against a calm Corrib ... He shook his head slowly and wagged a finger at my laptop. I can't believe my boat is inside there said the "Angler" (ibid. 2013, p.86).

Together the three of them brought the past into the present but not as it was, instead it acquired new features being seen from above through the lens of Google Earth. It was the same but different in an echo of the eternal return.

Following the flow of matter brought MacLeman to a significant episode within the project that released affective flows. The work emerged following the interest of one participant in tying flies for dry-fly fishing. Together she and The Angler explored their way through swarms of flies all neatly stored and catalogued in their cases. They worked in weekly exchanges that 'became a mixture of words, photographs and newspaper cuttings' (ibid. 2013, p.80) and together they formatted a book, *The Rising Trout*, as a guide to fly-tying for the Corrib Lake, celebrating the sportsmanship and craftsmanship of the fly-tying angler. This following of flow places the material in a different relation to the artwork substituting the imposition of a pre-given form upon previously passive matter, with an approach that concedes a nomos to the material (Deleuze & Guattari 2004b, p.451). Furthermore, the untranslatability of this material nomos overturns the logic of representation. A work of art, if it is to function as *art*, must provoke an encounter with the senses rather than recognition of a common form in cliché. To follow the flow of matter then is intuition in action. It is to itinerate, to ambulate. In her work with the



Figure 23 Josephine Kavanagh with Marielle MacLeman *Sugar Love* (2013)



Figure 24 Josephine Kavanagh with Marielle MacLeman *The Peaks* (2013)

Angler, MacLeman followed threads of an interest in fly-tying, through conversation, making flies, research, photography and eventually book-making.

The conditions of possibility for this project are dispersed. A commissioning process, an arts coordinator, a Hospital Arts Trust, an Arts Council of Ireland award, a receptive staff, curious participants, an openness to materials and making, an experienced artist who knows how to wait for chance and achievable objectives. The commission had set itself the objective of physically enhancing the clinical environment and also to celebrate the ephemeral things that humanize it. This was more than successfully achieved. MacLeman herself was given the pseudonym of The Magician when The Cake Decorator described her as follows;

The magician came one day every week, with her she brought a bright light of encouragement, passion, energy and compassion, even the staff were not free from her spell. She used her power to make people believe in themselves and this produced so much talent. (ibid. MacLeman 2013, p.120)

Although MacLeman herself was uneasy about acquiring 'magical powers', she could not censure the work of the participants and acceded to the inclusion of this appellation in the catalogue. The legacy of the art assemblage, now disassembled, lives on after the participatory workshops, in the subsequent exhibitions at Galway University Hospital and Galway Arts Centre, in the catalogue documentation and also in the becomings of those affected. It has duration : that is it is both past and present in its affects. When I first encountered the *Magician and the Swallows Tale* it leapt into life before me. It so clearly documented the process and outcomes of a durational art project so eloquently. It drew me in to be with the participants in their explorations and with the artist and staff in their negotiated alliances, which did not always run smoothly. It increased my power of acting by inspiring me to recommence my thesis endeavours to find a narrative commensurate with practices.

7.2 MAC

An earlier iteration of this research project had similar affects. It emerged following the collaborative workshops carried out with healthcare professionals about their understandings of art practices in healthcare settings (see Appendix 12.11).²⁰⁴ The *mac* (Broderick 2011d) installation was situated at the Jennings Gallery, Faculty of Medicine, University College Cork, because it offered the possibility of cross disciplinary encounters with doctors, nurses and allied health disciplines, at all stages of their training and professional development in an institutional site that was both a repository of disciplinary knowledge and a site of knowledge production. There were a number of different elements, including a wheelchair theremin, an atrium platform occupied by intravenous trolleys linked in relay by plastic tubing and a screened alcove that held a motion sensitive trolley bed and a webcam that recorded activity in the alcove. Rather than focussing on the healthcare patient, *mac* is an address to healthcare professionals, creating an unscripted encounter that offers the possibility of reconfiguring hospital apparatus (or not). Healthcare professionals are difficult to access because of the nature of their busy work schedule; the work then was planned as a brief intervention.²⁰⁵ Nonetheless it sought to provide a platform for an emergent collectivity beyond codified categories and groupings located at physical, discursive and virtual sites.²⁰⁶

This discussion will focus on the archived material recorded in an alcove of the gallery. *Mac* is a very simple installation, a curtain separates the space

²⁰⁴ What follows here places particular emphasis on a specific part of the *mac* project, which is open to discussion because of the online archive, but neglects other aspects such as the wheelchair theremin (hardwired by the relentlessly supportive Rob O'Leary), and the IV trolley grid, as it is not possible to comment on the degree of interaction generated.

²⁰⁵ Brief Interventions is also used as a term to describe dissemination of health promotion messages.

²⁰⁶ By use of this phrase I am referring to Rogoff's (2002) characterisation of collectivity as 'something that takes place as we arbitrarily gather to take part in different forms of cultural activity such as looking at art. If we countenance that beyond all the roles that are allotted to us in culture, roles such as those of being viewers, listeners or audience members in one capacity or another (there are other emergent possibilities for the exchange of shared perspectives or insights or subjectivities) we allow for some form of emergent collectivity. Furthermore, that performative collectivity, one that is produced in the very act of being together in the same space and compelled by similar edicts, might just alert us to a form of mutuality which cannot be recognised in the normative modes of shared beliefs, interests or kinship'. Reflecting on this formulation of collectivity Pierce and Fletcher (2005) observe that the shared site of an art space has the potential to produce affinities beyond essentialising communities.

from other parts of the gallery.²⁰⁷ On entry you are confronted with a hospital trolley. Suspended an inch over the mattress is an opaque Perspex screen underneath which are laid out motion sensitive lights. The lights will not be activated unless there is intentional movement across them. A webcam records each visit into the space and relays the video feed in real time through a projector to an adjacent wall and daily to an archive online.²⁰⁸

People walking into the room can see themselves projected on the wall opposite the bed. Some will walk in and around the trolley and walk out again, perhaps thinking the projection of their image is all there is to see. Others will walk in see themselves and move around the space exploring what else it might offer. Tentatively some begin to play with the lights. The position of the projected video and the trolley make it impossible to look at your play face on and look at the lights on the trolley simultaneously. The healthcare professional is offered an unscripted encounter during which they can contemporaneously watch their own performance in the space. A warning sign outside draws attention to the webcam (which is also activated by motion) and the daily archiving of video material online. The *mac* installation emerged from and sought to extend the conversations begun at the workshops with healthcare professionals. It incorporated the themes raised during the workshops in diverse ways:

Censorship and Ownership Issues: A warning notice on a screen outside displayed all information in relation to data protection protocols. By entering the room the participant was giving consent for their image to be recorded and kept on an online archive.²⁰⁹ Details of how to make a request to delete archive records were also displayed.²¹⁰ Surgical garb hung at the entrance, was made available to those who wished to participate but who wished also to preserve their anonymity.

²⁰⁷ I recommend viewing the gallery online www.medicineasculture.com/gallery in order to get a sense of how the installation worked

²⁰⁸ Adrian Legg contributed significantly to the video recording archive interface.

²⁰⁹ I had consulted with the Office of the Data Protection Commissioner (see section 11.20).

²¹⁰ There were no requests to delete video record from the online archive.

Evidence: Each visit to the *mac* installation was projected in real time in the room so that the participant(s) could see their own performance. This material was recorded and uploaded to an online video archive where material was stored by date and time of visit. A bracelet, similar to patient id bracelets, with the website address and QR code printed on it had space for the date and time to be self-recorded. The recordings become evidence of participation.

Isolation / Peer Networking: The online website also had a forum area and a linked Facebook page *The Society for Medicine as Culture*. This aspect of the project was not successful. It was not used.

Art Therapy vs. Arts Practice: *mac* was installed at the Jennings Gallery at the Medical Faculty of University College Cork. Its primary claim was that it was an arts project for healthcare professionals. By this I mean that it uses recognisable materials and artefacts to create a situation with which participants would be familiar and at ease, at the same time displacing the conventions of their use. As such it can be seen as 'a becoming minor' in the way it operates from within, drawing on familiar elements, but manifested differently. It was up to the individuals themselves how they might complete the work through their own performance. It was an invitation to think, to play and respond. All the foregoing refers to the territory, the gridded regimented representations of the world 'as it is'. Yet the work of art does not lie in the what is, it is in the creation of a bloc of sensations in a zone of haptic engagement as characterised by Kristeva,



Figure 25 Sheelagh Broderick *mac* detail (2011)



Figure 26 Sheelagh Broderick *mac* installation view (2011)

In an installation it is the *body* in its entirety, which is asked to participate through its sensations, through *vision* obviously, but also *hearing*, *touch*, on occasions *smell*. As if these artists, in the place of an 'object' sought to place us in a space at the limits of the sacred, and asked us not to contemplate images but to communicate with beings. I had the impression that the artists were communicating this: that the ultimate aim of art is perhaps what was formerly celebrated under the term of incarnation. I mean by that a wish to make us feel, through the abstractions, the forms, the colours, the volumes, the sensations, a *real experience* (cited in O'Sullivan 2000, p.106)

The *mac* installation was placed in an alcove recessed from a corridor. The alcove provided a shelter from the busy work of the medical faculty. The installation does not immediately reveal its potential. Of course anyone walking in might react to the physicality of a trolley and the projection of their own image on the wall, but the real work of art lay in the participant moving their own body in the space to access the responding light beams that enrapture, confuse and disturb. As noted above the feeling body is perceptive to colours, volumes and sensations as real experience. The *mac* installation offered this, but only to those who could move beyond their habitual behaviours.

In the space of this installation there is an actual and a virtual. The actual resides in the form of the objects placed there. The virtual lies in its potential to proliferate capacities. As Massumi notes, the virtual as a limit isn't a mere drop or a pool but a whole ocean of calm and turbulence that combine and cancel each other out or indeed amplify.

What interactive art can do, what its strength is in my opinion, is to take the situation as its "object". Not a function, not a use, not a behaviour, exploratory or otherwise, not an action reaction, but a situation, with its own little ocean of complexity (Massumi 2008, p.13).

What we see in the archive of video recorded as part of this installation are drops of the ocean, of varying character. *Mac* draws from its territory, in the assemblage of health and composes its elements in an expression of forms – but this is not a being of sensation, this is not affect or percept. What is required is chance – the good dice player who is willing to try their luck to experiment and explore. This is an uncontainable and

indeterminable quality that cannot be known in advance.

Every relationship of forces constitutes a body—whether it is chemical, biological, social or political. Any two forces, being unequal, constitute a body as soon as they enter into a relationship. This is why the body is always the fruit of chance. (Deleuze 1986, p.40)

The installation can only function as an artwork by chance. No instruction is given. The actions taken within the space of the installation are random and although in some cases segue into the pedagogical and the playful. In looking at the digital archive it can be seen that the diagrammatic power of the art assemblage is to change its consistency and kind: to become something new. What is novel is the increased power of acting for some participants. Movement into the space activates the webcam and the projection of the video feed, further movement is required to activate the lights on the trolley. The coincidence of animate and inanimate vibration creates the conditions of deterritorialisation, a shift away from the territory of origin to an unconfined space. A line of flight can be followed which temporarily brings new dimensions of experience and perception. This line of flight may be found in the movement of the light beams that can confound and disturb the senses drawing participants in to engage or causing them to leave. The question then shifts from concerns with what participation is, to what kind of participants does participation produce. There are two possibilities – for those for whom the encounter increased their power of acting – it is a joyful and good encounter. For those whose participation led to a decrease in their power to affect or be affected it was a sad and bad encounter. The latter might include participants who came in and walked out again without activating the sensors.

The encounters recorded were diverse: some people came in and left again without any play happening; others engaged as individuals and still more engaged in groups. Some were happy to be identified in play; others took advantage of the clinical accessories that disguised their identity. Some played the bed as if it were an instrument. Others assembled round it as a consultant and her team would around a

patient's bed, gesturing and palpating the prone body. Others found it a technical quiz and sought to understand how it worked, peeking under it, looking at the adjacent computer driving it, observing all the different elements, camera, projector and lights. Other encounters appeared more like a tutorial, as individuals demonstrated how it worked.

NOV 11 16:48 sees a participant exploring the lights in gesture and rhythm – hers is a slow and contemplative engagement so fully involved in the interaction with the trolley that she does not even look at her own projection on the wall.

NOV 11 17:43 the participant walks in and out without activating the lights – she returns – perhaps someone has told her what to do and she activates the lights - but the sight of her own projection doing so disturbs her sufficiently that she leaves abruptly.

NOV 12 15:47 a lone participant plays one handed with lights while holding the id bracelet in the other hand in a kind of muted exploration of the trolley and the space.

NOV 13 12:42 Two participants enter. On seeing his projection on the wall one of them turns to face his own image – although now it is only his profile being projected – and activates the lights using the projection as his key for movement – both try to figure out how it works by looking underneath and one unselfconsciously give the thumbs up sign.

NOV 17 14:09 participants in this case treat it very much as if it were a standard clinical consultation with experts assembling at the bed to conjecture on what it might be, rather than in participating in what it does. Similarly NOV 15 12 34 shows one participant enter and the leave to call a colleague, then they both look at and test the apparatus but in an analytical mode only.

Nov 18 13:15 Three participants enter and spend the next 8 minutes creatively exploring together what they and the installation can do as Massumi notes 'The body is capacitated, but the capacity has nowhere else to go' (Massumi 2008, p.6). The power of acting is not increased for a particular purpose – there is no purpose other than living life more intensely as a life.

NOV 18 15:53 participant enters in full scrubs and wanders around taking in all aspects of the space, leaves and returns with another clinically dressed figure – they both leave again and return

NOV 22 13:33 the participant enters and investigates the apparatus to find out how it works to the point of shifting it – she haphazardly activates a few lights but is more interested in her own projection on the wall.

NOV 21 16:37 Two participants enter dressed in white coats but not to disguise their appearance as their faces are visible Participant 2 leaves several times but participant 1 stays is engaged through first investigating by moving the trolley around and then proceeding to move, think and look at her projected image.

NOV 25 10:03 Two participants enter full dressed in scrubs and gloves – they investigate by sound and touch before they realize it is movement activated and seeing the projection wave to the camera

If art operates through its affects, then it is the faculty of sensibility first and foremost that is activated and only afterwards representations of thought, formed by the faculty of reason follow. It is only the shock of sensation that opens eyes and ears to inhuman worlds to engender new thoughts. The description of the encounters above clearly shows that for some the shock of sensation did not prevail and that the encounter remained within the realm of the known, yet for others it is evident that indeed they were subsumed by sensation and revealed in its affects.

The assemblage of participant – sensor - light – projection – online archive gives the project a durational quality in that it exists both in the past and the present. Furthermore affect and expression are not confined to humans, but concern the non-organic life of matter itself. Artworks can operate as a conduit for a world that is not created for human needs. There are interesting clips of video archived when a wind has blown the screening curtain activating the camera and a vibration has activated the lights – there is no one, no human, in the room to activate the sensors yet they glimmer regardless. There is no one in the room to see the

projection in real time, yet it happened and I see it after the event in the online archive, in a new event of perception.

Art claims the right to having no manifest utility, no use-value and in many cases even no exchange-value. At its best, what it has is event-value (Masumi 2008, p.14).

The events of *mac* have an uneven distribution, in some cases amplifying, and in others cancelling out affects. As an exploration in engagement it is something that draws me in ineluctably, to consider what else I can do, this is a beginning. Healthcare professionals do not have time to engage in an 'ideal' durational participatory or collaborative projects but that does not mean they are precluded from a tactical (as opposed to strategic) participation in what has been figured by Tait (2009) as molecular collaboration. According to Tait, the setting chosen by the artist is a key factor in determining the parameters of participation. The *mac* project negotiated institutional permissions to gain entry to activate a space and an emergent collectivity. The *mac* installation offered the possibility of many different configurations of relations and affects, but without the intervention of participants had no productive capacity. This type of interaction cannot be found through textual engagement alone. Instead *mac* offered an embodied and haptic experience in finding the limits of what else a body-institution-technology assemblage could do. Beech has set out a programme for art's new publics in which it is not only the body of the public (in the collective sense) that has to be transformed, 'but also the body – and the senses – of each and every member of that public' (Beech 2010, p.18). When I review the online 'evidence' in some of the footage, I no longer see autonomous prior selves; as Gibson (2006) observes, the connectivity of dependency can be reconceived as an alternate approach to ethical engagement (Gibson 2006, p.195). This ethic is not premised on the idea of a generalised autonomous subject, which limits engagement, rather it directs the becoming self to acknowledge difference through recognition of its own vulnerabilities and dependencies.

This sense of vulnerability dependency emerged in the workshop offered to accompany the installation with the support of Katherine Atkinson of

Create, who acted as facilitator.²¹¹ Some of the responses expressed a sense of 'not having precise control', and 'interacting with a system that doesn't understand/allow for human response', 'you're never sure what going to happen', 'it's an act of faith'. Others found it confrontational in the way that boundaries were imposed by the space of the work, 'you are in a confined space with it, you can't escape'. Such testimony reveals the way in which participants inhabited the space. Their words express the very real affects of the artwork and the adjustment required of their perception to allow the everyday objects within the space to act as percepts, physical fragments of the world residing in the artwork.

The next section extends the discussion to include consideration of the healthcare setting as a context for molecular collaboration, which as Tait (2009) has pointed out is manifested through a particular set of relations, particular participants, and particular spaces and whose parameters are fixed by the choice of setting.

7.3 UNFOLDING SPACES

We are not in the world, we become with the world (Deleuze and Guattari 1994: 169)

In this section I consider how spatial contexts modulate the capacities of bodies to affect or be affected and how an arts intervention might change these capacities. I refer to Deleuze and Guattari's writings on space to explore the relations between artists, participants, healthcare professionals, healthcare institutions and spatial context.

The ways in which healthcare spaces are imagined and experienced varies widely depending on whether you are a service user, a healthcare professional or a member of the public. For some it is their home (permanent or temporary), others their workplace, and for still more people they are places to be avoided. The spatial context informs the identity of its occupants and their social relations in a relation of reciprocity. The spatial context then is a key concern for arts practices in

²¹¹ Create is the National Agency for the Development of Collaborative Arts in Ireland

healthcare settings, which to date has been overlooked in favour of a focus on individualised pathologies and health outcomes.

As already discussed in Chapter 5 within critical art history there is a lingering sensitivity to the context of creation and circulation of an artwork, referred to as institutional critique. In part this awareness has led artists to seek extra art institutional spaces for their work. The interest in creating art in healthcare spaces can be seen as part of this orientation to break away from the confines of art institutions. Yet as Fraser has pointed out there is no escape and no outside (Fraser 2005). The spaces in which art positions itself do not become inert because they are void of art historical references. The healthcare setting is not an empty container with physical dimensions autonomously standing apart, rather it is a nexus of complex material, procedural, and social relations that are fluidly configured and reconfigured with the bodies that occupy it (Barad 2007). This entangled confluence of forces stems from an ontology that differs from a worldview populated by discrete objects. Instead it offers a potentiality in which, bodies are not fully determined by the spaces they occupy but neither are they capable of acting with unrestricted agency. Put simply a patient need not always assume the identity of the docile individual,²¹² but neither do they have the freedom to act beyond the particularity of their attachment to a healthcare setting – this also applies to the healthcare professional and indeed the artist. Spaces and bodies are entangled in their becoming.

Deleuze and Guattari cartographically suggest that '*a body is defined only by a longitude and a latitude*' (Deleuze & Guattari 2004b, p.287 italics in orig.). A body is the sum total of its material elements (longitude) and the sum total of its intensive affects (latitude). Space too is attributed with having both extensive (having dimensions) and intensive (indivisible)

²¹² Deleuze identifies a shift from disciplinary societies to societies of control exercised through different systems, school, prison, and hospital. His remarks on control anticipate digital medicine and discourses of well-being. 'In the *hospital system*: the new medicine 'without doctors or patients' that identifies potential cases and subjects at risk and is nothing to do with any progress toward individualizing treatment, which is how it's presented, but is the substitution for individual or numbered bodies of coded 'dividual' matter to be controlled' (Deleuze 1992, p.7).

qualities such as temperature, colour and sound, that are not always perceptible. Space becomes malleable when lived, composed of vectors and speeds in continual motion. The relation between extensive and intensive space is thought of in terms of sedentary striations and nomad smoothings – but they do not conform to any binary logic as they constantly translate from one to the other. Deleuze and Guattari's emphasize that they 'exist in mixture' although not symmetrically (2004b, p.524).

Striated spaces are characterised in terms of their extensive dimensions, rather than their intensive forces: they are clearly defined and arranged through measurement, order and, structure emerging as gridded sedentary spaces in which only limited pre-determined possibilities can occur. Although Deleuze and Guattari use the example of the city, I suggest that hospitals and healthcare settings are good examples of this type of space. We are all familiar with the signage that confronts an individual entering a healthcare space directing people through predetermined paths to a destination. Although there may be many ways of finding one's way to a specific corridor or office we are managed in making our way along the pre-determined route. But the logos of striated space is not static, rather Deleuze and Guattari acknowledge that the smooth and striated are not simply opposites, but more like preconditions for each other. Striations although limiting are necessary in order for smooth becomings and transformations to emerge. Without some order, without some rules and structure, lines of becoming would almost certainly splinter to lines of pure chaos (consequently no space is ever entirely smooth, no space completely striated and rather than conceiving of spaces with fixed attributes they are better understood by their tendencies and trajectories).

Order as a precondition is evident in the lengthy protocols and practices that have to be gone through to establish an arts project in a healthcare setting. Without this structure it would be impossible for an arts project to take place. The *Transplant* project had 5 layers of official hospital

structures to negotiate prior to project commencement (and subsequently the very many other protocols around clinical practices e.g. ward rounds). As such it could be deemed to exhibit properties of striated space in the regimentation of behaviours.

Transplant (Wainwright & Wynne 2008) was a project based on the experiences of heart and lung transplant patients and outpatients at Harefield Hospital, London.²¹³ This facility cares for patients who are seriously ill and who will not recover without a transplant. The arts project was subject to the standard protocols operating in the hospital. A project specific advisory group was set-up composed of a patient, psychologist, social worker, transplant coordinator senior sister for transplantation, to guide the project through the arts, ethics, clinical risk and management committees. Having gone through this rigorous process, the project was still initially only run as a trial for 6 weeks before it was finally approved to run as a year-long residency.

During that residency both sound and image were recorded leading to variety of outcomes. One of which *ITU* is a video and sound recording of a post-operative patient in the recovery room through a drawn translucent curtain. Wainwright recalls that he was struggling to find things to photograph when he noticed the curtain (Carlyle 2008, p.19). The film foregrounds the inanimate and technological. Central to *ITU* is Wynns recording of alarms and auditory warnings stemming from his interest in acoustic ecology. He remarks on the way his practice has changed to no longer view recordings as sonic material divorced from context. The artwork does not seek to recreate the acoustic environment of the ward, the selected clips of audio abstract from the totality. The perceived discrete boundaries between person and space, between animate and inanimate dissolve visibly in the film. The curtain seamlessly blends forms visually and the synthesis of audio lays out a soundscape of clinical

²¹³ Sources for the *Transplant* project include professional development and artists talks at Waterford Healing Arts Trust, an edited book of critical essays and DVD (Hume et al. 2010) and the project blog.



Figure 27 Wainwright & Wynn *ITU* video screen shot (2007)

machinery, mumbled words, alarm signals exposing vulnerabilities and dependencies across a range of relations. More mundanely these vulnerabilities and dependencies find expression in everyday ward gossip. For example according to hospital arts coordinator Hume, the prospect of new fridges was keenly anticipated. Living in close proximity to the fridge in each isolation room imbued it with intensive potential as it rattled and hummed (or not). Such a close and invested connection in part demonstrates the 'problematic dissolution between the person and the institution' (Hume 2008, p.8). It is impossible to think of the healthcare space separately to its occupants, equipment, social and institutional practices. This dissolution of self is most evident in the way that patients become dependent on technology for life support. One individual who had passed on the opportunity to participate changed his mind following a TV programme about transplant. He allowed Wainwright to photograph the Ventricular Assist Device (VAD) that was attached to his abdomen. In this photograph the boundaries between man and machine are eliminated. The man machine connect was echoed by the artists themselves. Wainwright observes that

we both used equipment that needed to be setup so there was a process to go through in front of the patient that was almost meditative the whole slow construction of an audio-recording picture taking environment enabled something. It is almost like

there was a way in which the setting up of equipment registered the beginning of the communication process and relaxed all the participants. It was if they shared in the construction (Carlyle 2008, p.12).

Here both artist and patient can be thought of as locating themselves in striated space, finding a place from which they can creatively find and follow a line of flight in smooth space.

Smooth spaces are populated by intensive forces, movements, and trajectories having directional rather than dimensional properties. 'It is a space constructed by local operations involving changes in direction ... It is a space of affects, more than one of properties' (Deleuze & Guattari 2004b, p.528). Smooth space is open to creative lines of flight in any direction rather than a movement limited and determined by structures or categories. Deleuze & Guattari discuss striated and smooth space through a number of examples: textiles, music, marine navigation, mathematics and aesthetics. In their discussion of an aesthetic model they attribute the smooth space of nomad art with properties of close-range vision and haptic space and the striated space of royal art with distant vision and optical space (with the caveat that transitions from one to the other are both necessary and uncertain) (Deleuze & Guattari 2004b, pp.543–544). Here we can see a different local orientation to the work of art distinct from the gaze of the gallerist. Although Deleuze and Guattari could not have commented on contemporary collaborative practices their observations are still relevant. When referring to close-range vision, they speak of being so close as to no longer be able to see, 'to lose oneself without landmarks in smooth space' (ibid. 2004b, p.544). Afterwards striation, may re-emerge and then dissipate again opening the way for another smooth space, and another striated space and so on. Close-range vision precipitates haptic spaces as it precludes seeing from a distance. This necessitates orientations, landmarks and linkages that are continuously changing. A map is of no use when you are too close to see distant points of reference. In haptic space it is not possible to take the position of an outside observer. Instead there are many observers who

create a network of responsive references and consequently shifting orientations. Such a position requires a transitory ethics of ethology.

The Post Room Project (Archer 2010) emerged during a six-month residency at Waterford Regional Hospital. Adapting existing structures and materials Archer infiltrated the hospital through its post room. The post room is the place through which all hardcopy communications travel it supports lines of communications between all departments inside and outside the hospital. Anything from get-well cards, to X-rays and blood samples are sent, received, sorted and delivered. The hospital internal mail envelopes are a major source of traffic. They pass through the post room in specially designed envelopes with spaces for numerous addresses for the transfer of information from staff member to member. As such it typifies gridded and regimented striated space merging people, place, rule and convention.

Archer 'set out to harness this method of communication and use it to introduce an element of playfulness and creativity into the working day of the hospital' (Archer 2011). She infiltrated the hospital postal system with a series of special internal mail packages, each containing a different drawing, story or other artwork. An enclosed letter invited each recipient to contribute something and post the envelope onto someone else in the hospital. As each of these special mail envelopes passed through the post room each new contribution was recorded. Ultimately leading to a series of short animations that were installed in small, wall-mounted post boxes for an intimate one to one viewing experience.

This project occupies the close-range vision and haptic space of smooth space. By this I mean that during project implementation it was impossible to see what was happening at the level of individual responses to envelope contents. The local orientations, landmarks and linkages that pre-existed and were created through the project gave it its own terms of reference that were not universally visible. The space of the project existed in the inter-relations between peer-to-peer networks, in the

materials shared through those networks, and in the subsequent rehearsal of those moments. Those glimpses revealed and shared in talk, 'Guess what X did in his envelope?' or in silent unshared outposts of reflection. Subsequently the animation installations deliberately made distant-vision impossible as each could only be seen at close-range by individual viewers. As an outside observer my points of reference for this project are limited because I was not part of it. I rely on the available documentation, but this is a representation of what was and consequently I am occupying a striated space in which distant vision and optical space seek to ferret out and categorise the project. Bishop (2012) has remarked on the difficulty of writing about projects without having direct involvement, going to great lengths herself to follow durational projects. Yet even in the selection of such projects it whips them out from close-vision haptic space to distant-vision optical space.



Figure 28 Emily Robyn Archer *The Post Room Project* (2010)

Deleuze and Guattari insist, 'smooth spaces are not in themselves

liberatory. But the struggle is changed or displaced in them, and life reconstitutes its stakes' (Deleuze & Guattari 2004b, p.551). The sprawling conviviality of *The Post Room Project* provided an opportunity for healthcare professionals to momentarily move beyond their professional categories, to make rhizomatic connections in a different register that foregrounded intensive potential, but 'never believe that a smooth space will suffice to save us' (ibid. 2004b, p.551).

7.4 RECAPITULATION

Chapter 7, moves on from the tracing of previous chapters in Part 1, to commence an experimental mapping in Part 2. The concept of assemblage is used to think through two different art projects. The first, *The Magician and The Swallows Tail* (MacLeman 2013), is set in a dialysis unit of Galway University Hospital. The second, *mac* (Broderick 2011d), was installed at a University Medical Faculty intended for healthcare professionals. I consider how spatial contexts modulate the capacities of bodies to affect or be affected and how an arts intervention might change these capacities in discussion of a UK arts project with transplant patients, *Transplant* (Wainwright & Wynne 2008) and a project based in a regional hospital, intended for healthcare staff, *The Postroom Project* (Archer 2011) .

8 WORMHOLES: CONNECTING ART HEALTH AND RESEARCH

In this chapter I turn to ways of connecting art and health without either of them losing their specificity through regimentation in striated space. In this section I turn to Balkema's professed interest in the 'concept of multiplicity or multiple connected space' which is sparked because of its capacity to analyse figures of thought and its capacity to connect various worlds (Balkema 2004, p.60).²¹⁴ What I have in mind here is a connection between the world of health, entailing the concept of the BwO which we have established as a limit of what a body can do, and the world of art, and the diagrammatic function of art in establishing the real yet to come and the consequences of making these connections for research practices by distinguishing between creativity and art.

Balkema (2004) suggests that multiple connected spaces can be viewed as parallel worlds ordinarily not intersecting, between which however wormholes can be opened up enabling a form of connection and augmenting their dimensions.²¹⁵ She postulates that any worlds without such connections can become stuck in flat, compressed and two-dimensional Euclidian universe. A parallel world in which repetition comprises serial movement without any modification, constitutes a 'pure substitution of the same' (ibid. 2004, p.62). Instead she invokes a space that is no longer flat – as in a sphere where parallel lines always meet, or in saddle and trumpet shapes, from which an infinite number of lines can originate.²¹⁶ This sort of space implies a tunneling of wormholes to other

²¹⁴ Balkema indicates that she uses the word 'world' where Deleuze would use the word 'plane'.

²¹⁵ A wormhole is a hypothetical feature much like a tunnel with two ends, each in separate points in space-time.

²¹⁶ Barad explains, 'Geometry is concerned with shapes and sizes (this is true even of the non-Euclidean varieties, such as geometries built on curved surfaces like spheres rather than on flat planes), whereas topology investigates questions of connectivity and boundaries. Although spatiality is often thought of geometrically, particularly in terms of the characteristics of enclosures (like size and shape), this is only one way of thinking about space. Topological features of manifolds can be extremely important. For example, two points that seem far apart geometrically may, given a particular connectivity of the spatial manifold, actually be proximate to one another (as, e.g., in the case of cosmological objects called "wormholes")' (Barad 2003, p.826 n.32).

worlds and other dimensions.²¹⁷ It is not merely an anchoring of parallel worlds that cling to each other 'disgracefully'.

Already in relation to site-specific art, we have seen Kwon refer to the site as a 'fragmentary sequence of events and actions *through spaces*' (Kwon 1997, p.95, italics in orig.). In public health too, steps are being taken toward an integrative framework in which science, ethics and aesthetics and their emergent forms are postulated in integrated form (Hanlon et al. 2012).

I reformulate Balkema's question, 'how can the notion of a multiple connected space play a role in the worlds of visual art and artistic research' to include a third parallel world of health (ibid. 2004, p.60). She directs the creation of novel lines, digging fresh tunnels, pumping up peculiar tubes to connect all kinds of worlds into different dimensionalities. She cautions too against the prospect of worlds becoming anchored in parallel, as more of the same.

Looking to the worlds of art, health and associated research, it is possible to see attempts to anchor them in parallel through the application of methodologies arising in health sciences. As Balkema has noted, such a clinging will not give rise to any novelty. We have seen that both health and art can be looked at in ethological terms, as increasing the power of acting or as an aesthetics of affect. These are the same and not the same. In the sections that follow I aim to look at how art, creativity and health can overlap without extinguishing their difference, by attending to the conditions of possibility for the creation of the 'new' in art, health and research. In order to do this I address the question of novelty in the work of Deleuze.

²¹⁷ Balkema cites the discipline of biomimetics as an outcome of such transformative connection, comprising biology, technology, design and management. The intersection of these made possible refugee tents with water sensors designed for desert environments inspired by Namibian beetles ,or the technology for producing hard ceramic substances at low temperatures for use in bone implants from shellfish and crustaceans. Such outcomes were only possible by a shift in problem solving in which technological problems find their solution in the biological world.

8.1 THE DIAGRAMMATIC FUNCTION OF ART

According to Smith (2012) one of the fundamental questions in contemporary thought is concerned with the conditions for the production of *novelty* (following Bergson) or *creativity* (following Whitehead). Deleuze finds the answer to this question in the principle of difference, which is not to be confused with transformation, change causality, determinism or emergence in which the new appears as a secondary effect. His investigations into the conditions under which something new can be produced, as the conditions of real experience, leads him in several directions, to molecular biology, differential calculus and artistic creation. In this section I turn to the diagrammatic function of art whose function is not to represent, 'but rather constructs a real that is yet to come, a new type of reality' (Deleuze & Guattari 2004b, p.157).

O'Sullivan asks, what else besides the recombination of matter is needed to produce the new? Drawing from Bergson, he suggests a move beyond the horizontal plane of matter – the what-is, to access something 'outside' of the present plane of existence (O'Sullivan 2011b, p.92). He suggests that this is not so much a place, but a time, opening to a vertical temporal axis intersecting with the horizontal plane. It is the time of the pure past, the virtual realm of pure potentiality. This potential can only be actualised through a break in habit, a gap between the clichés of action and thought allowing for a multiplicity of stimulus response pathways. (O'Sullivan 2011b, p.92). We are so caught up with the actual, in the world of utility, this slowing down is necessary to create a gap between stimulus and response. It is a slowing down that allows creative response. The new then is not merely a recombination of matter; rather it is a turning away from matter to a 'different realm' and drawing from this source to affect the world of our existence.²¹⁸ The new then is characterised as freedom from habit and the present plane of utilitarian interests. It is an escape from fixed habits and impasses of the present through recourse to a 'time'

²¹⁸ O'Sullivan notes a caveat that such a turning away from matter may also necessitate putting in place the material conditions to create a gap.

undetermined by that present, a pure past, with the paradoxical possibility of determining a different future.

Furthermore O'Sullivan suggests that time spent with art requires consideration. By this he refers to the time it takes to make art, the time of day and/or season in which art is encountered. By opening up to a plurality of different temporalities, we can access different durations. The encounter configured as an active participation with, rather than a passive reception of, art, then not only refers to the production of difference, but also our engagement with that difference (ibid. 2011b, p.99).

Lastly O'Sullivan insists that art can never be totally planned. It requires contact with an outside to chance, beyond any conscious control or habitual subjectivity. Art then is a recombination of matter and at the same time it is that which the recombination of elements allows. Neither of which can be planned and must always involve contact with chance.

In summary then, O'Sullivan establishes the diagrammatic features of art in establishing the real yet to come as follows;

1. Arts practices, however they are stylistically constituted, put in place the material conditions for a 'slowing down' of habitual thought and action.
2. Although constituted in the actuality of everyday experience, projects require a turn from 'what-is' to connect with the virtual.
3. The durational quality associated with the projects encompasses an active engagement with participants (typically over a period of months but possibly for years).
4. Projects include the element of chance as a technology of contact with an outside.

Revisiting the *Magician and Swallow*, in the light of these features, firstly the conditions of possibility for a slowing down of the habitual, are wrought by the introduction of an artist with associated institutional supports and material artefacts such as paint, paper, camera, laptop. Secondly, although each of the project episodes originate in concrete material practices e.g. cake decorating or angling they turn from them as they are currently constituted in everyday interaction in experimental

exploration of materials and practices through a variety of media. Thirdly, the project, was funded for a period of 12 months during which time the artist visited the Unit on a weekly basis. The active engagement of participants took some time to establish, before it can be said that the project acquired a durational character, suspending actual time. Lastly, the artist allowed a space for chance to intervene in the project as it progressed. If the Set Dancer had not seen the exhibition, if the Set Dancer had stuck to her original intentions then she would not have participated in the project, yet chance intervened and she did participate, exposing an outside to herself previously unknown and in the process exposing the diagrammatic function of art in establishing the real yet to come.

The locatedness of the art project in its milieu and the style of the artist lend very particular characteristics to any participatory process. These differ across projects, but in most commentary about participatory art practice success is predicated on participation in terms of numbers. A project's success is defined by its ability to build consensus and to produce a participatory community, either within the work, or in the gallery. There is an expectation of convivial relationships that make few demands of their participants and remain within the parameters of what is comfortable for everyone. However, an art practice that stays within acceptable boundaries of what is comfortable, comprehensible and safe for its audience, participants or co-participants does not fulfill the diagrammatic function of art. The possibility of dissensus is necessary (Charnley 2011)

As already discussed the concept of the 'body without organs' (BwO) enables us to think of embodied health not as a state but as an active process with a fluctuating nature. We can think in terms of 'becoming-healthy' or alternatively as a 'healthing' body (Fox 2012a, p.12). Always thinking of the body within a network of relationships offers a theoretical nexus, concerned not with what a body *is*, but with what (else) a body

can do (2012b, p.205). What if we revisit the *Magician and the Swallows Tail* to review its practices and processes in terms of the BwO.

Recall The Set Dancer, who had initially resolutely declined the opportunity to participate in the project. One could say that this rebuff was a practical demonstration of the biological, cultural and social limits of the embodied subjectivity of the woman. But the BwO as both a set of practices and a limit that gives rise to a 'territorialisation', may also be 'deterritorialised' to open up new possibilities for embodied subjectivity. The first project exhibition in the waiting room initiated a line of flight for The Set Dancer that would deterritorialise the BwO. This change was even physically evident. MacLeman observes; 'as she shifted uneasily beside me, it seemed her thoughts were swaying too (ibid 2013, p.29)'. The construction of subjectivity is in the dialogical play of social processes and affirmative, creative and embodied experimentation/engagement with the world. The Set Dancer began a process of experimentation with materials and processes under the rubric of, "messin'", being affirmed by the artist in their exchanges to the extent that after a few weeks The Set Dancer could proclaim her work to be 'First Class' (ibid 2013, p.30). The freedom conferred by these new practices allowed her to escape the actuality of waiting for her daughter on dialysis to roam the globe 'tracing the skylines, of great plains, peaks and parks with a brush' (ibid 2013, p.30). The practice developed even further as mother and daughter collaborated on paper 'they birlled their brushes round in iridescent swirls like their skirts twirling on a Saturday night' (ibid 2013, p.31).

Deleuze and Guattari invite us to 'sing with your sinuses' and 'see through your skin'. The BwO is a site of experimentation, 'you always carry it [the BwO] with you as your own milieu of experimentation' (Deleuze & Guattari 2004b, pp.181–182). From this perspective human beings are active and motivated rather than passive and determined 'docile bodies', incorporating their engagement with the world through an ongoing work of 'experimentation' (Deleuze & Guattari 2004b, p.166). The BwO is the unattainable limit of capacities, which the body continually drives back to

increase the quantum of what it can do, to increase its *power of acting* (Duff 2014). 'It is a conduit from the actual to the real' (Buchanan 1997, p.88).

So far we have established the diagrammatic function of art in establishing the real yet to come and the BwO as a conduit from the actual to the real. Now we can revisit the claim made by Fox (Fox 2012a) introduced in section 5.4.3, by seeking to add a specific art sensibility to the claim that creativity and health are tautological.

8.2 CREATIVITY AND ART

Fox (2012a) has made an important link claiming that both art and health are concerned with the proliferation of capacities to affect and be affected and therefore can offer an explanatory framework to explain the beneficial outcomes of arts interventions for health. Although Fox has considered various psychological and sociological approaches to creativity, he does not distinguish between an art practice and creativity, or refer to art critical discourses. In this section I add these dimensions to the sociological analyses of Fox.

Arts practices operate within a context that has exposed and continues to expose the operations of power within art institutions through institutional critique, leading some artists to work beyond the boundaries of the gallery and the museum. Artists working in healthcare settings do not lose this awareness because they are situated in non-gallery spaces. Indeed for some this is part of the challenge of working as part of and apart from the institution. Institutional critique and the critique of creativity alongside the social turn in arts practice are significant influences in contemporary arts practice (see section 5.5.2, 5.5.3). To ignore their place in the art assemblage is to risk cliché.

Bishop observes and reflects on the conjunction of art and creativity;

What emerges here is a problematic blurring of art and creativity: two overlapping terms that not only have different demographic connotations but also distinct discourses concerning their complexity, instrumentalisation and accessibility' (Bishop 2012, p.16).

She avers that the elitist activity of art is democratised, through the creativity discourses. Consequently Bishop claims that the 'dehierarchising rhetoric' associated with projects that seek to facilitate creativity mimics identically government cultural policy directed at the twin shibboleths of social inclusion and creative cities. However in doing so she claims that artistic practice loses its ability to sustain contradiction and critical negation, which cannot be reconciled with these quantifiable imperatives.²¹⁹ For Bishop, artists and works of art operate in an antagonistic relation with society as whole, but this critical tension is lost in the ideological discourse of creativity. These creativity discourses operate through consensus, rather than in dissensus.²²⁰ Bishop is critical of a drift toward the sociological at the expense of the aesthetic.²²¹ This drift can be seen in the conflation of discourses of art and creativity in which she claims the criteria for assessment is essentially sociological and driven by demonstrable outcomes. Despite any social (or health) gains claimed for arts projects, she asserts;

the point of comparison and reference for participatory projects always returns to contemporary art ... The aspiration is always to move beyond art, but never to the point of comparison with comparable projects in the social domain (Bishop 2012, p.19).

This position is supported by the distinctions made between art, science and philosophy by Deleuze and Guattari (1994). The purpose of the boundaries drawn between philosophy, science and art is not to exclude (see section 5.3). Indeed often what is most interesting is the exploration of the interferences of each in the others. Yet as Amott puts it, 'the intention

²¹⁹ As already outlined in section 3.1 the social turn in arts practices are keenly contested – what is presented here relates to a particular view, one that is disputed by Kester who disavows 'the snares of negation' (Kester 2004, p.112)

²²⁰ Bishop is referring to work of Ranciere who links the aesthetic and political regime in dissensus.

²²¹ She cites the commentary by Esche on the Superflex project *Tenantspin*, which concerns its effectiveness as a tool, its major achievement being, a 'stronger sense of community in the building' (2012, p.17).

is rather to demarcate, to show that no one of these forms is reducible to the other, and that any attempt to blur the boundaries is to be resisted' (Amott 1999, p.49). For example when a philosopher attempts to create the concept of sensation or function, or when a scientist tries to create a function of sensation, or when an artist creates sensation from concepts or functions, then, 'the rule is that the interfering discipline must proceed with its own methods' (Deleuze & Guattari 1994, p.217). As an example they refer to the 'intrinsic beauty of a geometrical figure' and insist that 'so long as this beauty is defined by criteria taken from science ... then there is nothing aesthetic about it' (Deleuze & Guattari 1994, p.217). It follows then that if a project claims to be an art project then regardless of its social or health outcomes it must be considered in relation to the criteria asserted by art. Deleuze and Guattari clarify that these interferences are extrinsic as 'each discipline remains on its own plane and utilises its own elements' (1994, p.217).²²² This is the case unless there is a dissolution of all three chaotic disciplines in chaos, in which case concepts, sensations and functions become undecidable, just as art, science and philosophy become indiscernible (Deleuze & Guattari 1994, p.218). It is an absolute deterritorialisation inconsistent with practices under discussion here (see also Section 5.5.3).

This problematic blurring of creativity and art occurs across the literature on arts and health, the two words 'art' and 'creativity' are glossed as if they were interchangeable. Art is a social practice constructed by a discourse, with specific knowledges, languages, institutions and practices that set apart some work as 'art' and others as 'not art' (Nead 1988, cited in, Rose 2011, p.190). Art's history is one of periodic reassessment so that for example, Bishop considers the social turn in arts practice is actually a 'return to the social', claiming that within the last century there have been three redefining moments 'synonymous with political upheaval and movements for social change'; in the avant garde circa 1917, the neo-

²²² Deleuze and Guattari clarify that such distinctions are operable only while disciplinary thinking proceeds. They draw attention to the chaos that lies between disciplines and the complex plane that arises when there is a sliding or slippage in the plane of immanence. They draw attention to the potential for collapsing disciplines into chaos with the prospect of extracting 'the shadow of "the people to come" ' (1994, p.218).

avant garde 1968, and the resurgence in participatory art following the fall of communism in 1989. (Bishop 2012, p.3). The way art is produced, consumed and debated, has been revised during each of these periods, rethinking art's relation to the social. ²²³ Aranda et al (2014) suggest that the question of 'what is art?', must be left open as it would be 'insane to suggest that a central authority *should* form a central criterion of aesthetic judgment' (Aranda et al. 2014 unpag.). Ultimately the best art creates problems not solutions, by troubling accepted narratives, including those on creativity (see section 5.5.2).

Arts practices in healthcare settings align themselves with this broader trajectory for arts practice described by Bishop (2012) as an expanded field of post-studio arts practice operating through various modes; elective practice, self-organised activities, documentaries, transdisciplinary research practices, participatory and socially engaged art. This orientation is characterised by 'the artist ... as collaborator and producer of situations; the work of art as an ongoing project ... while the audience ... is now repositioned as a co-producer or participant' (Bishop 2012, p.2). As more and more artists choose to work outside the limits of their own discipline and institutional frame to create new conjunctions such as arts and geography (Hawkins 2013), arts and science/technology (Gardiner & Gere 2010) and arts and health, they become dispersed as net.art, bio art, visual geography, space art and database art (Holmes 2009). The range of practices available in contemporary art increasingly defies categorisation. Rogoff (2012) observes this shifting ground in contemporary art that ranges from the standard recognizable forms of collectibles, displayables and catalogueables that fit neatly into institutional foundations, to the expanded practices of 'artists working in the community field making complex the simple minded politics of representation' and practices that operate through;

²²³ Following the distinctions made by Rancière, Bishop elaborates a chronological unfolding of regimes of art. First in the ethical regime of images and the Platonic denigration of images, second, is the representative regime of arts which continues until the academy system was ushered in with the Enlightenment and thirdly, the aesthetic regime which continues until today in which everything has the potential to be a subject or material of art and encompassing the aesthetic as an autonomous form of life (Bishop 2012, pp.28–29)

new modes of research by which artists enter the areas of archival knowledges ... a group that has set itself up as a time bank or a migrant smuggling agency or the fake representatives of multi-national corporation or ... a small group of a young people reading smudged zeroxes insistent to know something of urgency to engage with the world. Art has opened itself up to inconclusive processes whose outcome might be learning, conversing, gathering, researching, or bringing a new perspective into circuits of expertise (Rogoff 2012 unpag.)

For Deleuze and Guattari art is 'always a matter of freeing life wherever it is imprisoned or of tempting it into uncertain combat' (1994, p. 171), in the expanded field, art practices have been opened up to life as a work in progress recognizing the degree to which art worlds and social worlds are not autonomously 'self-governing' (Lynch & O'Sullivan 2007). This is where arts practices in healthcare settings can find some critical traction.

For Deleuze as a philosopher of life;

life is variously conceived as ceaseless creativity and change, as the production of difference or novelty, as a proliferation of encounters between differing forces of affect, as a multiplicity of presents; in a word, as immanence (Cull 2012, p.3).

It is impossible to think of life without the thought of that life, so thought itself is creation and so too everything in and of it. 'For immanence is pure only when it is not immanent to a prior subject or object, mind or matter' (Rajchmann 2001, p.13). The thought of creativity is not prior then, just as, as Rajchmann continues, we are 'anybodies' before we are 'somebodies'. For example; Foucault, preferred to use the word 'experiment' rather than 'creativity' and the word 'laboratories' for art institutions (Rajchmann 2011, p.85). Deleuze used terms interchangeably developing them over time to perform for certain problems, based on what they were being used to do, for which problem they were being deployed (Patton 1996). As Colebrook remarks, 'Deleuze's terminology does not consist of simple, self sufficient and definable key terms' (2002, p.xviii), in affirming the dynamism of life, the process of writing of that immanent life acquires many forms.

In his essay, *What is a Creative Act?* (2007), Deleuze links creativity and art as an act of resistance to the problem of the control society.²²⁴ The control society establishes order-words and cliché images that confine what we see and say.

Information is communicated to us, they tell us what we are supposed to be ready to, or have to, or be held to believe. And not even believe, but pretend like we believe. We are not asked to believe but to behave as if we did (Deleuze 2007, pp.325–326).

It is the work of art to resist the control society; 'there is a fundamental affinity between a work of art and an act of resistance' (Deleuze 2007, pp.327–328). That work entails calling on a people to come. Art then enables the formation of new bodies; bodies which perceive in new ways, which are composed in new ways, and which have the potential to connect to others in new ways. This is what Deleuze and Guattari are referring to when they say that art has the power to bring forth a 'people to come' (1994, p.218). Deleuze concludes the essay by asserting that; 'The act of resistance has two faces. It is human and it is also the act of art. Only the act of resistance resists death, either as a work of art or as human struggle' (Deleuze 2007, p.329). Introducing human struggle as a site of resistance makes it an ally for art. It also underscores a molecular understanding of creativity that is resistant to molar forms. O'Sullivan (2007) gives a detailed analysis of how this works in practice in an exposition of how desire operates in and is created by the art assemblage.

O'Sullivan resists the polemics of aesthetic and art critical theory described already (section 3.1) in his ethological reading of what art does. He enjoins, 'it is not just our art-machine that produces these [aesthetic] effects but our art-machine in conjunction with a subject-machine' (O'Sullivan 2007, p.22). What we experience as 'art' and as an aesthetic effect is 'produced by the coupling of two very specific kinds of

²²⁴ Deleuze (1992) describes the transition from a disciplinary society in which order is exercised through institutions, such as school, prison and hospital, to a control society. In the control society order is exercised through modulating codes as in for example currency operating on a floating exchange rather than within a gold standard, or as in the case of the individual who becomes a 'dividual', valued for their data.

machine' in a machinic assemblage (O'Sullivan 2007, p.22).²²⁵ ²²⁶ Deleuzo-Guattarian machines are not metaphorical. They produce real material effects, defined by how they connect and transform, by what they do, rather than being a means to an end. O'Sullivan avers that the machinic paradigm escapes the problems of definition that we have already seen in relation to discourses on contemporary art. He claims;

We are moving towards a notion of the art experience, of art practice, whether it be making it, seeing it, or writing about it, as complex and expanded. No longer the static production, distribution and consumption of an object, but art practice as a process, as a 'desiring machine', always 'in' production (O'Sullivan 2007, p.24)

As such, desire is machinic, it is continually forming connections with other assemblages, flowing in different directions with different potentials, to both revolutionise and sediment. For example in Malins work on the drug using body she remarks on the deterritorialising potential of the drug-using body assemblage, but all drug-use assemblages do not share this potential (Malins 2004). In habitual drug-use a reterritorialization of the drug-using body can occur, the drug-use assemblage may become stratified, rigidified and codified. Similarly the art assemblage has deterritorialising potential, but if it becomes habitual, it will lose this capacity to affect. Desire must be free to flow 'without reference to any exterior agency' (Deleuze & Guattari 2004b, pp.170–171). According to Deleuze and Guattari (2004a), art then is, 'the pure process that fulfills itself, and that never ceases to reach fulfillment as it proceeds – art as "experimentation"' (2004a, p.405). They insist, following Cage (1961) that experimentation is not simply a descriptive act to be judged later, rather, it is the an act whose outcome is unknown. Experimentation releases desire for progressively more connectivity, affirming escape from 'societal limitations and habitual restrictions'. The art machine inevitably then is at odds with sedimented forms of organization, and stays ahead (just) of the apparatus of capture. In terms of arts practices in healthcare settings, as we have seen the potential for deterritorialisation inheres within art

²²⁵ O'Sullivan cautions that other machine coupling with the subject machine can produce similar affects, e.g. Drug machine – Music Machine etc (2007, p.22).

²²⁶ O'Sullivan (2007) uses the phrase 'aesthetic effect' interchangeably with 'affect'.

projects, but Deleuze and Guattari would say that this is only the case while it is a process of experimentation and exploration. If art becomes captured and codified it loses that essential experimental component and can no longer be given the name of art. After all, 'Once a rhizome has been obstructed, arborified, it's all over, no desire stirs' (Deleuze & Guattari 2004b, p.15), desire then is both constitutional and constitutive;

Assemblages are passionate, they are compositions of desire. Desire has nothing to do with a natural or spontaneous determination; there is no desire but assembling, assembled, desire. The rationality, the efficiency, of an assemblage does not exist without the passions the assemblage brings into play, without the desires that constitute it as much as it constitutes them (Deleuze & Guattari 2004b, p.400)

It is not my intention to privilege art – there is plenty of bad art in circulation.²²⁷ My intention rather, is to provide an orientation for art practices in healthcare settings that resists codification through its annexation as a service. In art we can find the conditions of real experience, rather than the conditions of possible experience determined by the actual. Taking into consideration these characteristics what are the possibilities for connecting arts practices, health institutions and artistic research in which none find themselves anchored to any other? What I have in mind here are connections entailing the concept of the BwO which we have established as a limit of what a body can do and the world of art in the diagrammatic function of art in establishing the real yet to come. Any attempt to codify their logic by regimenting practices for clinical outcomes will result in disruption to flows of desire rhizomatically connecting people, institutions, things. The challenge of this inquiry in asking, 'what else can an arts practice do?' lies in the problematic, 'how to maintain the repetition of difference, as the production of the new, while resisting the gravity of the circle of recognition and its representations?' (O'Sullivan & Zepke 2011, p.1). In effect, how can arts practices in healthcare settings remain outside the domain of uniform service provision as a device of control? Referring back to the work of Balkema who posited connecting worlds through wormholes, I suggest

²²⁷ A recent e-flux editorial laments 'everyone is bored sick of the waves of inflationary and depressive episodes of large-scale, bombastic zombie exhibitions' (Aranda et al. 2014).

that this is a way to conceive of the way arts practices in healthcare settings might conjunct as they plug in and plug out as wormholes.²²⁸

In this section I sought to extend the work of Fox (2012a) by bringing an art sensibility to the discussion of art and creativity. I have exposed the sensibilities of art to discourses of creativity and trammled through the exigencies of art history as a social practice shaped by discourses, knowledges and institutions. We have seen the centrality of creativity to Deleuze's vitalist project and his conjunction of human struggle with art as resistive practice. Lastly we have seen the machinic connection between art and subjectivity and noted how attempts to codify the flows of affect will alter their constitution. There is a danger that the conflation of arts practices with health institutions will lead to a diminution of its potency, as art is an experimental and resistive practice constituted by and constitutional of desire. Equally there is a danger that art as a discourse will dismiss such interventions as services rather than arts practices. The next section will address these concerns in turning to the way in which these practices can be addressed in research.

²²⁸ Other historical circumstances have led to similar arrangements, for example in the work of the Artist Placement Group (APG) which negotiated with government departments and national industries to place artists within the organization working to an 'open brief' in the period 1968 - 1975. Bishop (2012) has described the contemporaneous emergence of APG and of community arts initiatives, casting them both as attempts to rethink the artist's role in society. The APG sought to work inside diverse institutions such as the Hille Furniture Company, the National Coal Board, British Steel, health institutions such as Clare Hall Hospital, Cambridge and high security hospitals at Broadmoor and Rampton. The artist placement was distinguished from a residency in the way that it characterised the artist as an incidental person in the organization whose role was to interact at all levels within the organization. The influence of the APG continues to be seen today in the work of intervention-based artists and curators.

8.3 DETERRITORIALISING RESEARCH

Marie Brett *The Amulet (2009-2013)*

A collaborative research project with bereaved parents and HSE midwifery and arts and health specialists, to creatively explore the idea of the amulet as an object signifier of ethereal farewell particular to pregnancy and infant loss.²²⁹

Pauline Keena *The Green Room Project*

Specifically I wanted to look at the vocabulary of the bereaved mother whose baby has died, the presence and process of her grief as embodied state, how it might be made available to look at, to engage with and to observe... In this way a certain mapping of the maternal imaginary could be materialised into an art making that arises out of and is informed by the process of grief as embodied state (Keena 2006, p.6)

The above quotations refer to two examples of recent artistic research projects. In this section I will look at artistic research as a complex assemblage of relations that can give rise to both territorialisation and deterritorialisation.

The research assemblage for each of the above projects will differ as they are constituted by different parts, relations, materials, research tools, recording and analysis techniques, theoretical frameworks, research literatures and findings, researchers and contextual elements such as institutions, practices and protocols (Fox & Alldred 2014).

These differences remind us of the distinction made already in section 3.4 by Steyerl (2010a) who claims that artistic research leads to clashes between specificity and singularity. Artistic research is singular in that it can only have coherence within its own terms of reference, giving rise to a 'proliferation of parallel universes' (Steyerl 2010b, unpaginated). On the other hand, specific practices relate to paradigmatic research made

²²⁹ The Amulet was a national, multi-site participatory arts project initiated and led by artist Marie Brett as a community collaborative programme following a two-year research phase based at Cork University Maternity Hospital. The work was supported by The Arts Council via Create Artist in the Community Awards, The HSE (South) Cork Arts + health Programme and Cork University Hospital Arts Committee; with multiple partners and advisors. For more information see www.mariebrett.ie

within an academic disciplinary context with particular truth procedures. While the latter generates a shared terrain of knowledge that is appropriated by power, the former results in a proliferation of parallel universes – inaccessible to power. Steyerl suggests that artistic research can operate in both registers simultaneously when it is deployed as an aesthetics of resistance, resisting the demands of knowledge protocols for outcomes, outputs and impact, and instead forms new and unexpected alliances in numerous directions producing relations and agendas that do not emanate from shared identities, shared ideologies or shared belief systems (Rogoff 2010a). This resistance sidesteps dialectical positions and the likelihood of becoming ensnared in representational systems. Such an aesthetics of resistance can be deployed in a multiplicity of styles and instances, but can be marked by the way in which it affects deterritorialise the artistic research assemblage bringing about a qualitative transformation within it.

Reflecting on the path of this PhD research assemblage and its nomadic route through sites of practice, I note for myself the way in which resistance to current discourses in arts and health research led me to a limit beyond which I could not reach until chance introduced me to a literature that could connect practices. This sparked a line of flight and a deterritorialisation of the assemblage in which relations shifted in their intensity and consequence. The close 'haptic' vision with which I could 'see' the project left me bereft of any landmarks, in a perpetually shifting vista, uprooting any idea of position in the landscape. As Braidotti comments;

The fact that thinking is a nomadic activity, which takes place in the transitions between potentially contradictory positions, does not make it a view from nowhere. To be nomadic or in transition, therefore does not place the thinking subject outside history or time ... A location is an embedded and embodied memory; it is a set of counter memories, which are activated by the resisting thinker against the grain of the dominant representations of subjectivity. (Braidotti 2006, p.29).

The research assemblage is constituted by forces of territorialisation, deterritorialisation and reterritorialisation, hence the research assemblage

as a machine continues to attempt to 'plug in' or connect to other bodies, as literatures, arts projects and peers. The relations that disassembled and coalesced have led to its partial reterritorialisation at least. In its disaggregation it accessed a real yet to come, a thought without language (yet). Under such conditions how can anything be thought? Deleuze considers temporal and spatial constraints;

Thinking depends on certain coordinates. We have the truths that we deserve depending on the place we are carrying our existence to, the hour we watch over and the element that we frequent. There is nothing more false than the idea of "founts" of truth. We only find truths where they are, at their time and in their element. Every truth is truth of an element, of a time and a place (Deleuze 1986, p.110).

What if instead of seeking a truth to be shared, a situated ethics were to unfold? Then the production of the new would not rely on a test of truth rather it would emerge as something that can only be 'decided' upon experientially and experimental (O'Sullivan 2011b, p.100). Bishop too asserts the ethical as a 'fidelity to the singularity of each project'. This requires attending to the ruptures and affects it generates for participants and viewers, eschewing self-censoring pragmatism of pre-determined methods (Bishop 2012, p.26)

This view is shared by Duff (2014) who argues that the problem of determining the experiential content of health in the realisation of health and the mitigation of illness – should always be left to individuals and groups, to the assemblage itself, to determine. As a corollary 'the study of health and illness ought to shift from a moral to an ethical register' (Duff 2014 Chap 7 p.4).

These twin trajectories established independently in two different worlds establish a connection that may be fruitfully explored through artistic research. The wormholes posited by Balkema at the beginning of this discussion provide a way of thinking about these connections between these worlds and how the independent research projects by Brett and Keena cited at the beginning of this section might be understood.

Although both are concerned with a similar subject matter, that is where the similarity ends. Each finds a coherence that is established through experiential and experimental methods to find an ethic that is characteristic of their assemblages. The catalogue accompanying each project documents their singularity and the 'proliferation of parallel universes' already anticipated by Steyerl. A standard art history approach to these projects would necessarily be predicated on a vertical reading of practices that involve distant scrutiny (equated with transcendence). A radically different approach is required to the exercise of art history as an immanent horizontal becoming,

thus to exercise art history in the name of radical immanence would necessitate a new relation to art: a more direct relation in which the art historian opens herself or himself to encounter art as a parallel body-process (Kontturi 2012, p.142).²³⁰

Such a move is uncomfortable for those who have a vested interest in vertical reading practices in academia and elite art institutions, but even the critics admit their own inadequacy in the face of these practices.

Kester exposes the limits of art criticism for durational arts practices. He observes that while for object or event based art, the work of art, has a clearly bounded beginning and end separating the moment of production and reception, in dialogical art practices production and reception are concurrent, and reception itself re-imbricated as a mode of production. Kester advocates for new research methodologies

in which the critic inhabits the site of practice for an extended period of time, paying special attention to the discursive, haptic and social conditions of space, and the temporal rhythms of the processes that unfold there (Kester 2013).

Bishop likewise struggles with the foreclosure of critical distance noting that the retention of objectivity is difficult. She admits moving from a position of 'sceptical distance to imbrication' because of the formation of close personal relationships over long periods of time (2012, p.6).

²³⁰ Kontturi cautions that she is generalising complex analytical practices merely to make her point clear

O'Sullivan too comes to similar conclusions, but he is not simply advocating a turning away from critique. As we have already seen the production of the new necessitates the turning away from, or the refusal of, that which precedes it. O'Sullivan suggests that we become attentive to art's own logic of invention and creation, instead of attempting to marshal pre-existing reading strategies and interpretive paradigms, that capture art within our already established temporal frames and systems of reference. Advocating a more affirmative attitude towards 'the production of new combinations in and of the world which suggest new ways and times of being and acting in that world' (2010b, p.196). O'Sullivan, following Deleuze, following Nietzsche, rolls the dice deterritorialising the research assemblage as it is currently constituted but it is not possible to know how this line of flight might be constituted or which direction it might take – yet.

Rajchmann outlines some of the elements and relations that could coalesce to form a new research assemblage:

In what forms, to what degree, not simply in and with the arts, but also in art institutions can we invent today spaces and groups for the open kind of search and research, interference and resonance, learning and unlearning, which formed part of the whole idea of creativity for Deleuze-Foucault? In what ways do such practices and institutions set-up ways to research, groups and creativity, that exist prior to method, to *savoir*, to government policies, as concrete or local conditions for new ways of talking, seeing and acting on a 'transnational or 'global' manner? In what ways in short can they thus help create today the spaces and times in which thinking lives? (Rajchmann 2011, p.89)

Such a research agenda linking micro practices to macro affects, in a dispersed field of practices and institutions suggests a rhizome extending itself in all directions.

8.4 RECAPITULATION

In this chapter we have seen how an arts project such as *The Magician and the Swallows Tale* can exist in two assemblages simultaneously. We

saw that it existed in the art assemblage in the way features of the diagrammatic function of art inhere within it. We saw too how the project expanded the capacities of a participant through her participation in it, as an instance of the BwO in its struggle to push back the limits of what she could do. I then revisited the conflation of creativity and art and sought to add to the analysis of Fox (2012a). We then turned our attention to research as an instance in which wormhole connections between these worlds can be manifested, finding in their experiential and experimental processes the necessity to invent new local approaches to research.

9 TRACING THE MAP: AFFECT, TRANSVERSALITY, CONSISTENCY

Plug the tracings back on the map, connect the roots or trees back up with the rhizome (Deleuze & Guattari 2004b, p.15)

In Chapter 1, I cautioned the different movements within the thesis seen in the tracings of Part 1, (Chapter 1- 6) and followed by the mapping in Part 2 (Chapter 7 - 8). What remains is to replace the tracing on the map not as reproduction, but rather as an opening to possible lines of flight, after all we know that if 'the map or the rhizome have multiple entryways, then it is plausible that one could enter them through tracings or the root-tree' (ibid. 2004b, p.16). This chapter then presents this inquiry's self-understanding as an attempt to contribute to a minor literature through the unlikely encounter between artist, researcher, healthcare professional and institution. Such an encounter holds the potential for instituent practices, yet is overshadowed by polemical art critical discourses and appropriating health discourses. Rather than engage in such discourses, this chapter turns away seeking to navigate to a position of affirmation, to a position where connections can be understood in the way they produce affects, defined by how they connect and transform, by what they do, rather than being a means to an end. I look at the evolving relation between healthcare professional, institution, artist and researcher as a site for instituent practice in which collaboration creates the conditions of possibility for imagining new forms of instituting suggesting a people yet to come.

At the heart of this inquiry was an attempt to understand how health professionals (who are trained and work within a regime of evidence based practice) as individual champions for arts practices in healthcare settings could congruently go beyond their assigned clinical roles to commission and implement arts projects.²³¹ In answering this question I

²³¹ Constantly being asked throughout, why is this worth knowing? I would reply: Arts and health practices are characterised by their invisibility. They serve specific populations in specific contexts, far from the mainstream of arts activity and often bound by issues of confidentiality. A naming of actually existing practices will specifically identify healthcare settings as a site of arts practice opening up a

turn to the work of Uhlmann (2011) who describes how the two-sided nature of affect might be understood to be an expression, which, rather than coming from an inside and moving out, is in fact first caused by what is external and only then becomes imbricated with the nature of the person through whom it is expressed. In this way we can understand ethological interrelations in the contact we make with other bodies, with and through our habitat. He draws attention to the way in which Deleuze and Guattari turn to art to explain ethological interrelations;

First ... art itself involves the expression of affects and percepts. Second, art allows for transversal processes through which relations might be made between objects that are only apparently incompatible (and that are in fact connected): that is, art imagines, or creates, the possibility of becoming something other; ... As such art enables us to be moved by a feeling of understanding of this other, and our place in a larger environment. Art, then, not only shows us how one is affected ... it can also show the interrelated processes of affection that comprise habitats. Third, following on from this, art is capable of building passages which both construct or create territories and build networks of interrelations between territories: that is, art can create the consistency necessary to understand interrelations that are real but difficult to conceive. (Uhlmann 2011, p.159).

This understanding of ethology positions arts practices in healthcare settings not only in terms of affects that operate on the participant, but also in terms of creating transversal relations between bodies that might appear incompatible but have constitutive potential and finally in the way that art can create new territories and build interrelations between territories. These three orientations expand the scope for understanding arts practices in healthcare settings in terms of its habitat i.e.; constituted by the physical environment and the bodies that occupy it.²³²

new field of artistic endeavour for artists, health services clients and health services staff. Exploration of issues in relation to practice will yield insights, for professional artist training and practice (Moss & O'Neil 2009), and the role of healthcare services in supporting projects. It will open up new avenues of discussion that will be useful for all stakeholders. Motivations to provide arts projects in the healthcare domain differ, but typically are characterised as being 'good for you'. Arts and health practices operate in the epistemic domain of health. How can arts practices engage in these constructions of health and wellbeing leaving aside these normative claims? Artists engaged in social practice maintain an awareness of the exigencies of working with curators, galleries and museums informed by institutional critique (Alberro & Graw 2006). Similarly artists working in healthcare settings need to develop an awareness of the structures, politics and culture of healthcare institutions.

²³² This is not intended as a 'best' approach to discussing art practices in health care settings rather the approach outlined by Jun et al (2011), is the one most suited to the work under discussion. For other ethological approaches see Buchanan (2008) who provides an orientation that gives rise to an understanding of affect as ordinal, intensive and contextual; Anderson(2014) who looks at the

9.1 AFFECT

Section 5.5 established art as a singularity that exists within its own terms of reference as a bloc of sensations that is composed of sensory affects and having affective capacities. These capacities are distinguished from emotions and feelings as pre-personal intensities of a visceral nature. Anderson further specifies this distinction as follows; 'affects are augmentations or diminutions of a body's "force of existing" that are expressed in feelings and qualified in emotions (2014, p.85). In this way we can see how affect is mediated through signifying forces, being shaped by participants in an encounter. Such processes of mediation function in the way capacities have been formed through past encounters that repeat as well as in immediate encounters.

In reviewing the very many art projects which I encountered as part of this project, *Placebos for Art* (Engelbregt 2010) stands out as the most affective art-work for me (see section 4.3). I remember distinctly the feelings of consternation rising through my body, the almost unspeakable disbelief that such a project could exist, and the ensuing frustration at being unable to verbalise adequately the reason for such feelings. And then the glee that diffused warmth through my body, palpably relaxing muscles, when I discovered much later that the *Placebos for Art* proposal was indeed a ruse of dissembling artfulness. The artists at Circus Engelbregt had skillfully duped me into a whole range of affects with their artwork. It was my first confrontation with a procedural artwork of this kind without any foreknowledge. In not recognizing it as an artwork I did not have a repertoire of past encounters with which to mediate the encounter. This made the immediacy of the encounter with the artwork all the more visceral.

Recall the Spinozist dictat that a joyful encounter will lead to an increase in a body's potential to act in the world whereas a sad encounter will

mediation of the affective life through object-target, bodily capacity and collective condition and Duff (2014) who deploys an ethology of health and illness in the 'complex of affective and relational transitions within the various assemblages which express human life' (2014, p.53).

diminish this capacity, in tandem with O'Sullivan's (2005b) injunction that the pursuit of joyful encounters need not be an anodyne activity foregrounding the importance of dissent.²³³ ²³⁴ *Placebos for Art* was a joyful encounter and a dissenting one for me. The affects were not only felt on my physical body, but also in this body of research too. *Placebos for Art*, fortified my determination to continue this research in an ill-disposed climate where most resources and effort were being poured into proving the specific health benefits of arts practices. It gave me a very useful vocabulary for trying to describe this research project and galvanised support from those who could instantly recognize its potency. Although it is impossible to measure, *Placebos for Art* must have had an affect also on a wider collectivity of artist and researchers. Two hundred and one art placebo proposals were submitted from twenty-four countries. The names of these individuals were later exposed in the report that was published of submitted placebos. For many they will have laughed off such a prank, perhaps even admiringly so. But for others, particularly those involved in research, their inclusion might have had a different affect; a churning in the stomach, a cold sweat on the skin, burning cheeks. The manifold operation of affect arising from this project usefully demonstrates the way in which affects can have both favourable and detrimental valencies. It draws attention to the way in which throughout history art has been at the centre of debate regarding its good and bad influences (Belfiore & Bennett 2008). And therefore cautions that art cannot be bundled into a category without reference to its specificity. Nor can it be determined in advance as each body may encounter it in a different way depending on its history of past encounters and its current disposition. Indeed healthcare professionals expressed some concern about anticipated good and bad affects associated with art but disagreed on the issue of censorship (See Appendix 12.11.2). Affects then are not neutral and neither are they containable as they

²³³ According to O'Sullivan (2005b), simply celebrating the world as it is abdicates criticality, being nothing more than an acceptance of the status quo. This calls for two strategies: one of dissent in a strategic withdrawal as a form of engagement, or a strategic engagement itself, and one of creativity in the production of new forms.

²³⁴ See also (Raunig 2009a) who rethinks institutional critique as a critical attitude (in what he calls instituent practices). He poses non-dialectical forms of resistance through flight, betrayal, desertion and exodus.

circulate between bodies - in this case the researcher's body, the body of research and the collective body of arts and health practitioners as artists, healthcare professionals and researchers.

This section attended to a personal experience of affect, the associated impact on a body of research and also anticipated the likely affects of a wider collectivity of artists and researchers who position themselves with an interest in arts practices in healthcare settings. The next section attends to the transversal connections made possible by art in the relations established between objects that are apparently incompatible.

9.2 TRANSVERSALITY

Bogue (2007) in describing Deleuze's transverse way characterizes it as the activity of forming transverse connections intensifying differences and bringing forth new possibilities for life. Such activity gives rise to the formation of people to come.²³⁵ It originates in Deleuze's work on Proust in which between star-shaped crossroads a network of transversals is established connecting the incommunicable by intensifying rather than eliding it's difference. Guattari too, had separately deployed the term in relation to his work on hospitals, in which the difficulty in bringing about change in the structure and operation of psychiatric institutions was ascribed to vertical hierarchies of authority and horizontal modes of interaction. In this case transversality refers to communication that occurs between different levels and in all directions to form a group subject with the capacity of moulding itself to its own needs and desires. Both understandings of transversality together lead 'to a consideration of the social and political dimension of the arts' (Bogue 2007, p.3).

What are the transversal connections followed by an arts practice in a healthcare setting? At its most basic level arts projects can form a diagonal between horizontal and vertical coordinates within the

²³⁵ Bogue (2007) chronicles the deployment of the terms 'a people to come' and 'a group subject' as interchangeable in the work of Deleuze and Guattari, although the former is exclusively used in later work.

institution. Relationships are opened up that previously only existed in codified formats. Not only are there new inter-departmental alliances, but also mutuality develops across grades and between service user and service provider as both become arts project participants. In order for an arts project to succeed in an environment that hurls impediments in its way, the project must constantly negotiate for permissions, access and approval. For example, materials must be approved by infection-control, practices must not impede workflows and permissions must be sought to use equipment and spaces at particular times. The role of the healthcare professional in mediating such issues is central to the success of the project. Healthcare professionals expressed concern in workshops, that they might 'over-extend themselves in the process', but nevertheless continued to support project implementation because they believed there were 'huge benefits to participants'.²³⁶ They also indicated that such projects 'promotes connectedness and positive engagement'. While the healthcare professionals might have had the individual project participants in mind when giving such a view, I imagine such connectedness and positive engagement to exist as transversals in terms of the institutions through the interaction of staffs not only in the arts projects, but also through the operation of the arts projects themselves. The healthcare professionals, who carry a positive disposition toward these activities, actively seek to make the necessary connections in order to make a project work by sidestepping the vertical authority of hierarchy within the institution. This is only possible because the arts project exists outside current codified regimes of practice. Indeed the healthcare professionals expressed concern that too much systematisation could kill the creative root of arts and health work, and at the same time, felt cautious about adding such responsibilities to their current workload without additional resources. Such sentiments disclose the zigzag line of continuous variation as the healthcare professional operates in the provisional, in the meantime, meanwhile arts projects proceed without certainty or assured direction.

²³⁶ Quotations are not attributed to individuals in order to maintain confidentiality. The remarks quoted here are taken from the workshop feedback documented in section 12.11.

In the *Amulet* (Brett 2009) project we can see the vertical and horizontal shifts to accommodate an arts project that persisted beyond its originally anticipated timescale, its geographical reach and its evolution into a second phase as *Anamnesis*, through the support of a collectivity that moulded itself to follow its own needs and desires. The Arts and Health coordinator at Cork University Hospital describes it as follows;

This project is multifaceted in scope crossing so many boundaries by bringing together a community of interest in a deeply respectful and safe way. The artist Marie Brett worked both with midwifery and bereavement counselling staff, with former patients of the CUH hospital, and the parents of the bereaved. She also worked closely with artists and craftsperson's Nancy Falvey and Bernice Jones of Ballyphehane/Togher Arts + Craft Initiative. Also the project was replicated in Limerick and Waterford Hospitals. The artist time travelled in a way by working with families who experienced bereavement a long time ago and those quite recently within the past two years

The transversality of connections made extends beyond the group named above. It would be difficult to identify the very many other contributors to its success, but I draw attention to the way in which connections were made in order to address the projects own needs and desires, so for example the services of Coisceim Counselling Group were made available as a supporting partner in the event that any individual required its services. The art project enabled fluidity in making connections to shape itself according to its own needs and desires.²³⁷ *The Amulet* became the foil on which was balanced affirmative and joyful affects contra the politics embedded in site specificity. These map out the relational tensions worked out in modest local contexts as an instituent practice as part of and apart from the institution. Such an approach engenders the re-calibration of imagination to include institutions, technologies and personal encounters as experimental intensities of

²³⁷ The project spanned 2009 to 2013, consisting firstly of a two-year action research phase based at Cork University Maternity Hospital (CUMH), followed by an eighteen month production phase in collaboration with bereaved parents and a national community of interest in relation to pregnancy and infant loss spanning three hospital sites. The project culminated in three gallery exhibitions of artwork titled *Anamnesis* and a catalogue.



Figure 29 Marie Brett *Her Pink Shoe (Amulet Project)* 2009-2013

different speeds and slowness. This project has gone far beyond initial expectations. The fluidity in making connections to shape itself according to its own needs and desires is seen again in the national touring exhibition (2014-2015) extending to Galway, Limerick, Cork and Dublin. The Amulet project succeeded where many other projects failed. The transversal connections made through the project created the conditions of possibility for a dual zone of reference in healthcare institutions and culturally validated art institutions.

This section has attended to the transversal connections made possible by art in the relations established between objects that may seem incompatible. The next section addresses the way in which art can establish new territories and new relationships between territories.

9.3 CONSISTENCY

Uhlmann (2011) asserts that art can create the consistency necessary to understand interrelations that are 'real but difficult to conceive', in this regard I again turn to the unlikely conjunction of artist, researcher, healthcare professional, arts project participant, and health institution bearing in mind that a territory does not refer to a sedentary space with fixed borders, rather it is to be understood as a system of any kind; conceptual, linguistic, social, affective, etc. Following on from the last section in which we established transversality of practices, in this section I seek to establish the way in which art can construct territories and build networks of interrelations between territories.

The relation between the artist and the healthcare professional can be figured as the agonism of friendly enemies who share a common symbolic space whilst negotiating to organise it differently (Esche 2005). There is no doubt that these negotiations can be difficult as for example issues of consent and participation are teased out in terms of the contexts in which

they take place. This dissensus is key to the practice.²³⁸ It is an example of instituent practice as the artist works as part of and apart from the institution, working with the healthcare professional to imagine new forms of institutionality in modest ways. So for example, healthcare professionals primary concern expressed during research workshops (see Appendix 12.11) related to the care of individuals in their setting. They differed in their views regarding how that care could best be given, as some were fearful of outcomes and would seek to censure whilst others felt that a reaction (affect of an encounter) could not be anticipated. They felt vulnerable in relation to determining quality and anxiety in relation to the ad hoc nature of projects expressing a definite need for professional development training. Such expressions give rise to anticipation that healthcare professionals and artists can learn from each other's practices.

Returning to Fox's distinction between the vigil of care and the gift of care in which the vigil designates the exercise of power and the gift is figured as resistance to that discourse (see section 5.4.1), Fox proposes that the gift relation celebrates difference, otherness and diversity and is reciprocal affecting both care-giver and cared-for. It demands a radically different conception of human potential and of what constitutes the 'care', which engages with this potential. 'It is a process that offers promise, rather than fulfilling it, offers possibility in place of certainty, multiplicity in place of repetition, difference in place of identity' (Fox 1999, p.96). Each artist will have a particularity associated with their own practice, which sets them apart from defined roles in healthcare settings, as well as from other artists. The extent to which the artist can work within these settings and concurrently retain the dissenting and affirmative attitude so central to O'Sullivan's (2007) characterisation of an expanded arts practice, will be a determining factor in distinguishing the work as a creative service or an arts intervention. Such practices generate an object of encounter rather than an object of recognition, as a critique of the present and a call to the future (see section 3.1).

²³⁸ Dissensus, 'revolves around differing interpretations of a commonly understood "good"' (Charnley 2011, p.44).

The paradox of care then is an analytic that allows us to see the work of the artist as not necessarily being concomitant with the institutionally and disciplinary defined discourses of care. I have positioned myself at the intersection of individual and institutional concerns at a remarkable time for institutions as authority crumbles in crises of legitimacy. Consequently my specific interest lies in formulating healthcare institutions as heterotopic spaces.

In establishing the context for this research I have already referred (in section 2), to the Guidelines for Participatory Arts Practices in Healthcare Settings in which 'the term "practitioner" ... refers not exclusively to artists but rather to anyone who has a professional role in the preparation, delivery and evaluation of the work' accorded in recognition of the leverage required to negotiate arts projects into these settings (White 2009b). Yet when working with healthcare professionals who actually implement and commission arts projects, they had no knowledge of this new designation. At a subsequent thesis peer feedback meeting a health professional declared that having read a draft of this thesis, they could now envisage themselves as an arts and health practitioner whereas previously they would have been uncomfortable with this designation. And this works in both directions as the challenges of working with healthcare professionals led me to reconsider boundaries to participatory practice. Choosing to work with healthcare professionals, gives rise to the challenge of gaining access to a cohort of people who have busy work lives. This was an overriding factor in negotiating research practices throughout all the work of this research project and pre-empted reflection on the limits of collaboration.²³⁹ This shaped the way in which I thought about collaboration and collaborators as a durational relation based on an affinity supporting the project in diverse ways as it progressed through its various phases.²⁴⁰

²³⁹ I had access to fifteen days of healthcare professionals' time through their attendance at workshops, but after that I had to work around the exigencies of the workplace.

²⁴⁰ Tait (2009) makes the case for shifting from a generalised 'ideal' of participatory practice in favour of what he terms molecular collaboration. These are uniquely manifested through a particular set of relations, particular participants, and particular spaces whose parameters are fixed by the choice of setting.

There is a growing interest in the site of the institution as a site of practice. I referred already (in section 5.5.3) to the third phase of institutional critique, coined as an instituent practice by Raunig (2009). He is concerned with understanding what forms of institutions and instituting are needed in the context of a bankrupt politics. As traditional understandings of institutions no longer have currency, instituent practices flag sites of tension, not in opposition to the institution but fleeing institutionalization and imagining new forms of institutionality. Within this flux Esche formulates the idea of modest proposals in answer to the question, how can we learn solidarity anew, while retaining the notion of individuality? These modest proposals are at once speculative and concrete, 'the idea of concrete conditions ... was dealing with real stuff, and with the pragmatics of day-to-day life' (Esche 2005, p.25).

The *mac* project (Broderick 2011d) originated in such concrete conditions. Existing everyday objects, protocols and situations were manipulated into different performative configurations, as an outcome of collaborative workshops with healthcare professionals. This approach had a quietly spoken ambition to reconfigure the apparatus of the healthcare institution going beyond the opposition of panoptic biomedical processes and practices of resistance to consider multiple processes of ordering in everyday relations. The participants in *mac* had very different experiences of it. For some there was no connection and nothing changed. For others connections were made within the parameters of their habitual practices, treating it as a teaching aid. And for others connections were made in which it was evident that they were stepping outside their everyday selves becoming part of the *mac* assemblage and producing new capacities to affect and be affected. The interactivity of the installations was premised on providing an opportunity for participation of episodic duration in what might be figured as a molecular collaboration (Tait 2009). Working in this mode, collaboration shifts to creating the conditions of possibility for the work through institutional negotiation and alliances. These modest proposals dispense with conventional figurations of activist practices in favour of a practice that can operate a 'tactical quietism' distinct from

an art that operates through loud 'copycat gestures' that 'fetishise politics' (Adajania 2012) in the day-to-day negotiation of shared symbolic space between agonistic participants.



Figure 30 Sheelagh Broderick mac 2011

In summary then this research acts as a call to healthcare professionals, artists and researchers to re-imagine and reorient themselves to the possibilities for practices along three axes.

Firstly, in terms of healthcare professionals the institutional context is paramount. Arts practices in healthcare settings are extra gallery practices that are institutionally embedded. That is, they take place in institutional contexts with institutional support; without these institutional partnerships, to fund, and manage projects, it would not be possible to mediate and implement projects in these contexts. Indeed, the encounter between institutions in addition to that between artists and healthcare professionals can be configured as sites of practice themselves. Healthcare professionals deploying a sensibility of the paradox of care with the capacity to control and resist (see section 5.4.2), themselves can engage in instituent practices re-imagining the institution as a heterotopic space with the possibility for both order and transgression. The point here being: forces of liberation and coercion coexist and confront each other. 'An expanded practice in this sense is both, and at the same time, a critique of the present and a call to the future' (O'Sullivan 2005a, p.68). It opens up the possibility of healthcare professionals extending their practice to include all aspects of the healthcare context not solely the patients in their care.

Secondly, artists have been characterised as having singular practices, operating within a particular field of reference and logic (section 3.4). Working in healthcare settings gives them another layer of particularity. O'Sullivan has outlined one possibility for practice in a proliferation of parallel universes that are intended to be made inaccessible to power. He offers tools to think through four emblematic moments, in collaboration, ethics, politics and virtualities. How these might be manifested will differ in practice. Furthermore, he has offered a particular characterisation of an aesthetics of affect that resonates with the ethological approach to health, in the way that it registers an increase in the capacity of the body to affect and be affected - as acts of resistance. Consequently, different

sites become available for practice from micro subjectivities to macro discourses of power in for example, the healthcare system and pharmaceutical complex. These lay out a challenging territory, which will not appeal to all artists, but which will be of importance because it establishes an orientation to which artists can adopt a relation. I am reading the conjunction of these texts in the way that they relate to my own interests and practice. Nevertheless, rather than circumscription, the expression of this orientation for practices opens up new territories, as positions are adopted in relation to these different coordinates, establishing a mesh of interconnecting points. But how that might happen is not possible to know, as it is not possible to know in advance what a body can do.

Thirdly, arts and health researchers come under the lens as they largely have shaped research trajectories. This project has emphasised the way in which discourse operates to determine the kind of questions we can ask. Research practitioners can locate themselves and their research interests in relation to the concepts outlined here, perhaps giving rise to a different set of preoccupations. Continuously asking the same question will yield the same answer. Repeatedly in my research encounters, I would meet individuals who were involved in projects to prove a causal relationship between arts practices and health outcomes. I would like in future to meet researchers who will attempt to disprove such relationships, or researchers who find such characterisations irrelevant. Setting out a research agenda based on difference holds out the prospect of failure (however that might be understood), but also the possibility of creating something novel. This project has asserted artistic research as a practice within disciplinary contexts and seeks to develop its research ambit through linking with other disciplines in transdisciplinary contexts. In this way we do not privilege knowledge in one area, nor do we escape from being researched ourselves as we become answerable to other disciplines.

All the foregoing seeks to provide instances in which bodies are compounded by their reciprocal passage from one territory (health institutions) to another (art practices) in a consistency hitherto unanticipated. In so doing arts practices can create or mark the territory and mark emergent relations or shifts between territories, ultimately even to go outside that territory.²⁴¹ Arts practices that take place in healthcare settings can operate in any of these modes, but here I am calling attention to the 'degree to which they provoke reflection on the contingent systems that support the management of life' (2011, p.29). The possibility of making transversal connections between bodies is not so much a cure, but a means by which individuals and institutions can resingularise or reorganize themselves in a creative affirmative and self-organizing manner (O'Sullivan 2007, pp.27–28). The objective is not to reintegrate a 'cured' individual back into society, rather it is an encouragement to become involved, to participate, in one's own self creation and in the creation of new modes of instituting. O'Sullivan (2005c) suggests that this is an appealing framework for rethinking collaborative and collective art practices of today. Art practices might be seen as producing communities and subjectivities in precisely this sense. This field of expanded practice does not require spectators as such but participants - who are 'transformed' through their interaction with the practice (O'Sullivan 2005c). Furthermore, remarking on institutional engagement, Jackson speculates 'such an orientation proposes that an aesthetic intervention in civic and state processes might be its own act of estrangement or redirection, not perhaps institutional opposition but something more like infrastructural antagonism' (2011, p.72). In this way we can see the manner in which art can create the consistency necessary to understand interrelations that are 'real but difficult to conceive', opening up a vista for practices shared that includes human, non-human, animate, inanimate, organic and inorganic in its ambit of interest, and that is both situated and singular.

²⁴¹ Following the tri-fold instantiation of the refrain by Deleuze and Guattari (Deleuze & Guattari 2004b, p.343).

9.4 RECAPITULATION

This chapter attempts to open up lines of flight by articulating a minor literature of instituent practices distinct from polemical art critical discourses and appropriating health discourses. Rather than engage in such negative dialectic, this chapter turns away seeking to navigate to a position of affirmation, to a position where connections can be understood in the way they produce affects, defined by how they connect and transform, by what they do, rather than being a means to an end. Deploying concepts of affect, transversality and consistency I shift attention to the evolving relation between healthcare professional, institution, researcher and artist as a site for instituent practice in which collaboration creates the conditions of possibility for imagining new forms of instituting suggesting they are the people yet to come. Recall from Section 5.5.3 it is not just the moment of instituting that characterises an instituent practice, it is also 'the plurality of activities involved, the fragmentation of one clear goal and protocol into numerous registers of simultaneous activity ... which thereby refuse the possibility of being internally cohered and branded' (Rogoff 2010b, p.45). Hence in this chapter I have emphasised the unlikely rhizomic connections being made and attempted to articulate a view that is recognisable to those who experience it as a minor literature.

10 CONCLUSION

Open up a space of research, try it out and if it doesn't work, try it again somewhere else (Foucault 2002a, p.223)

This thesis connects two previously separate bodies of scholarship, health sociology and an art criticism of expanded arts practices. Each draws on the immanent ontology developed by Deleuze and Guattari to be applied in their distinct fields. By connecting these works, this inquiry offers a new conceptual language and orientation for arts and health practitioners distinct from the evidence-based practice model most prevalent in academic and professional discourses and consequently establishes a transdisciplinary trajectory for research practices. I foreground both the instituent capacities and, the material and affective flows that inhere within artistic practices. In doing so I realise that I am writing against the flow of common sense 'intuition'. Such work can be disorienting, as self-evident terms and the institutions and practices which they name are retired in the retooling of a lexicon of practices (Wright 2013).

My emphasis throughout has been to engage with arts practices in healthcare settings not as individual case studies, but as an already entangled assemblage of practices, materials and spaces. In doing so I have travelled a circuitous route to find a language and a practice with which to 'jostle the reins of the majority identity to investigate new possibilities new ways of becoming that are no longer bound to dominant molar lines' (May 2005, p.34). In this way the inquiry acquires the character of performance, rather than rehearsal in its challenge to unexamined habits of mind, that ranks representationalism and correspondence, rather than practices, doings and actions (Barad 2003). It operates within the highly regimented institutional frames of health, art and academia. Yet those bodies seep and leak under their own weight. Fleeing this excess are a dispersed people, myself included, who in their own particular field seek to construct a minor literature. 'A minor literature doesn't come from a minor language; it is rather that which a minority constructs within a

major language' (Deleuze & Guattari 1986, p.16). Such efforts are apparent, for example, in the struggle in this thesis to deterritorialise 'evidence' as an order word, or through the emphasis on a collaborative approach rather than individual achievement, and finally in the interlacing of different regimes of knowledge to produce new lines of experimentation, all are congruent with a minor literature.²⁴²

This inquiry has taken on the task of unsettling foundational claims for arts practices in healthcare settings to rethink the ambit of its practices from a transdisciplinary perspective. It is characterised by a reflexivity that can displace both reader and writer as researchers consider, 'Under what institutional and historical constraints is this speaking, writing taking place?' (Clifford, 1986 cited in, Game 1991, p.31). This question has troubled the research processes associated with this inquiry throughout. Consequent to the burgeoning weight of interest, both within and beyond academic circles, in applying narratives of evidence-based research to arts practices in healthcare settings, only few have come close to expressing the disconnect that exists between theory and practice. Parkinson expresses concern that the power of the artist to provoke is lost in such evidence based narratives (section 2.1); White turns to medical humanities as a philosophical space of creative enquiry (section 3.2); Raw et al. (2011) look to the micro processes deployed by artists in their practices to theoretically place them in relation to outcomes (section 2.1); and Fox (2012a) presents a claim that health and creativity are tautological (section 5.4.3). Of these, only Fox has succeeded in positioning practices within a broader theoretical framework, despite the institutional and historical constraints that weigh down on arts and health research. Yet it is not possible for one person to hold the truth of the collectivity, and this thesis seeks to connect with the work of Fox by foregrounding sensibilities associated with arts practices.

The legacy of art criticism informs the self-conscious work of artists, across diverse art forms and art contexts. This disciplinary self-awareness is

²⁴² Deleuze & Guattari ascribe three characteristics to a minor literature; deterritorialisation, collective enunciation and politics (Deleuze & Guattari 1986, pp.16–17)

cautionary in understanding the ways in which arts practices can be appropriated through discourses of creativity and critique (Sections 5.5.2 and 5.5.3). O'Sullivan has formulated what he calls an aesthetics of affect by bringing an intense focus on arts practices unconcerned with what an artwork means, but what this artwork can do. He lays out a programme for a political art practice that is not just about institutional or ideological critique, but also about the active production of our own subjectivity. This formulation opens up to a wide field of possibility, making connections with broader discourses of health, art and politics.

10.1 LIMITS TO AND TRAJECTORIES FOR RESEARCH

Such possibilities point to future research trajectories that might investigate for example, the affinities that exist between O'Sullivan and Fox in relation to the micro as a process of active, processual and unfolding embodied subjectivity. When situated in a healthcare context, such unfolding can paradoxically have the capacity to control - in the territorialisation of subjectivity but also operate as spaces where subjectivities are deterritorialised emerging in resistance to discourses of care. Such an avenue has already been opened up in the work of Braidotti (2011; 2012) who deploys the term 'endurance' in the formation of alternate subject positions and the construction of social hope in the future and finds resonance with durational arts projects that can span many years.

Research opportunities exist too in relation to macro contexts, it is here that one might redefine the institution through instituent practices, which, rather than fleeing the institution re-imagines them, working with what already is in place, what is happening, in order to expedite new and different circumstances, in a refusal of existing categories. This opens up the potential for artists to work with healthcare professionals as part of and apart from the institution in their common articulation of practice.

A change in the order of discourse does not presuppose 'new ideas', a little invention and creativity, a different mentality, but transformations in a practice, perhaps also in neighbouring

practices, and in their common articulation (Foucault 2002b, p.230).

The adjacency of arts and health discloses tensions between disciplines, between institutions and, between arts and health practitioners (and of course researchers too). Only in evolving local sensibilities through concrete practices can encounters become commitments and passing intimacies become indelible social marks through their common articulation in slow and modest measure - otherwise these practices may become systematised, rather than resistant. The point here being, that forces of liberation and coercion coexist and confront each other (O'Sullivan 2005a, p.68). This has a marked similarity in structure to the paradox of care as outlined by Fox in which both the exercise of power and resistance to that power are figured. This analytic then allows us to see the work of the artist as not necessarily being concomitant with the institutionally and disciplinary defined discourses of care, but may intersect with institutionally based caring and administrative practices through what Balkema has coined wormholes connecting worlds or in the transversal relations discussed in the previous chapter. Observing our ambivalent relation to institutions Jackson avers that 'navigating that ambivalence seems necessary to perform our connection to the future now of people whom we may never know' (2011, p.247). Such navigations are the starting points for research in macro contexts.

This inquiry seeks to establish a separate space for arts practices in healthcare settings distinct from therapeutic approaches, therefore I have found it necessary to distinguish between arts therapies, recreational arts practice and contemporary arts practice. Although I agree that none of these exist as distinct categories, it was necessary to do so in order to disclose the significance of the 'social turn' for artists who choose to work in a participatory mode. Even though practices might appear similar they differ in what they do. So for example an arts therapist will work as part of a clinical team with access to clinical notes to arrive at the desired clinical outcome. A recreational artist will be concerned with skill specific activities that provide diversionary entertainment. A participatory artist

may use skill specific activities as an initial part of the process of exploration, but will always have an experimental, non-clinical intention for the artwork. However that is not to say that unintended consequences might also arise. For example, not every participant might experience the artwork as the artist intended and as a consequence one could say that unintentional outcomes arising from an arts project can also be recreational or even therapeutic.

The phrase 'I am more than my diagnosis' is frequently heard in patient support groups. The artist works with the people they meet without access to clinical records working with the 'more' rather than the 'diagnosis'.²⁴³ They also work with the institution in its many configurations. There is a distinctly unpredictable character about participatory arts practices. It is impossible to know in advance what the assemblage of artist, healthcare professional, institution and patient/service user can do, as the circumstances of each encounter will differ in its affective capacities. For arts therapy and recreational arts activities, the intention is closely linked to expected outcomes. If instead a transdisciplinary approach is adopted, engaging with the amorphous terrain of contemporary art and the emerging domain of health ethology, a wider field of practice emerges with the possibility of unforeseeable consequences as improvisations rather than innovations.

More problematic is the distinction made with arts and disability as this is a boundary clearly drawn by disability advocates to delineate inclusionary measures for people with disability to participate in and experience arts activities and exclusionary measures which focus on developing specific artforms based on disability i.e. disability arts/ deaf arts (Naughton 2011). These measures stem from the social model of disability, a model informed by identity politics. However contemporary theorists draw attention to perceived limitations of a politics based on identity and the extent to which:

²⁴³ Although the diagnosis is not always evident to the artist.

identity categories might themselves conceal as much as they express. Individuals, for example, cannot but exceed the identity categories, which seek to contain them: most traverse multiple identities at once, and many find that no group represents their individual circumstances and interests (Hickey-Moody & Malins 2007, p.5).

Already, critical disability studies are moving away from identity based discourses to discourses based on resistance and difference (Gabel & Peters 2004; Shakespeare & Watson 2002). Rather they reconceptualise dependence as connectivity distinct from the modernist concept of the autonomous and bounded subject (Gibson 2006; Goodley 2007). Shakespeare and Watson assert that, '*we are all impaired*. Impairment is not the core component of disability ... it is the inherent nature of humanity (Shakespeare & Watson 2002, p.27, italics in orig.). Furthermore, they conjecture that hostility to disabled people lies in the denial of vulnerability, frailty and mortality by non-disabled people who can subsequently oppress exclude and ignore.²⁴⁴ Clearly, this is beyond the scope of this current project, but is being foregrounded here to emphasize the permeability of boundaries between practices and possible directions for future research.

10.2 A PEOPLE YET TO COME OR A LITERATURE YET TO EMERGE?

This project has been concerned with arts practices in healthcare settings constituted by what could be characterised as a new public. Walwin (2010) recognises this new public in extant practices of collaborating, participating and influencing. She suggests that we are looking for a way to speak about these practices that:

are as much a part of art as they are of the everyday. The only reason they [the public] have been traditionally separated from ... discussions of art practice to date is that ... we cannot focus on a theory of art which deals with the art of encounter, if

²⁴⁴ Shakespeare and Watson reminds us of the socially constructed nature of disability that precludes definitions when they refer to learning difficulties as a modern disability unknown in preliterate societies (Shakespeare & Watson 2002, p.28).

we are not at the same time rethinking social relations at large (Walwin 2010, p.14).

Without rethinking, we will continue to be blind to these everyday practices. Already we can see such an agenda in the 2014 – 2016 BAK programme of work entitled *Future Vocabularies*. This discursive space constituted in the world of art, knowledge and advocacy addresses the 'incapacity to articulate the contours of new prospective itineraries through the existing conceptual vocabulary' (BAK 2014 unpaginated). A repurposing of critique is envisaged as an affirmative proposition rather than a negative torpor tied to the rehearsal of the same again. Such an attitude leads to questions of what it might mean to institute ourselves.²⁴⁵

This inquiry took on the ambition to rethink the world away from logocentric narratives that dominated the way in which arts practices in healthcare settings were being understood through the exercise of evidence based practice. This necessitated a shift in research orientation in terms of reconfiguring the site of practice from the actual location to the discursive sites that constitute these subject arts practices as a field of knowledge, intellectual exchange, or cultural debate in the social conditions of its institutional frame. These encounters led to an understanding of discourse through participation in it and ultimately to a further re-orientation of the research. Hence the subsequent adoption of a speculative turn and the engagement with a literature that could imagine how these practices might be repurposed. These moves reflect the ongoing and dynamic nature of the work. As Ringrose and Renold observe; 'Rather than conceptualising analysis as something which occurs post-fieldwork, we foreground how meaning making emerges over time: before "research" begins, during live research encounters and afterwards' (2014, p.2). This approach eschews straight line before and after

²⁴⁵ BAK (Basis Voor Actuele Kunst) describes itself as 'a space of interlocution between *art*, *critical thinking*, and *advocacy*. Envisioned as a base, a modest yet animated, focused, and determined *understructure*, BAK seeks to offer itself to artists, thinkers, activists, and its wide-ranging publics as an experimental, improvisatory, and speculative site through which to explore the conceptual itineraries that might enable us to collectively imagine and think the world we share otherwise' for more information see <http://www.bak-utrecht.nl/en/About>

approaches and instead adopts the middle, revisiting, refiguring and refusing.

And now as I write, the site is once again shifting to the site of artistic research shaped by the institutional demands of a PhD. The tensions that exist between each of these sites are played out in this thesis as I struggle with my own place in the research and in the writing of this text. This thesis as part of the overall research project functions as a machine in the way it is intended to create relations of immanent possibility. What is written here comes from a set of relations and is intended for some unanticipated relation in the future. Moreover, these words are not possible without a whole network of other words written and spoken, and so cannot be said to originate with me, but rather emerge from a context, a time and a place. Now the site shifts once more, and this time to the reader's encounter with the text. The world is always more than the categories through which we can know it, yet by creating and articulating a problem as is intended in this thesis, fields of discussion can open up in which there are many possible solutions, each of which captures something, but not everything put before us by the problem. This is not anticipated to be an easy or straightforward project, as we cannot know in advance what this body of work might do in imagining 'how one can "institute" what remains "outside" the institutionalisable rules of sense?' (Rajchmann 2011, p.83).

This thesis is timely. It comes during a period when arts and health researchers are coalescing in a network of diverse interests (see section 2.4). The discussions at the inaugural arts and health researchers network seminar disclosed widespread dissatisfaction with evidence-based approaches, but were without direction in terms of detaching from the logic of logocentric practices.²⁴⁶ Their language and concepts can only specify disenchantment with post-enlightenment modern methods of knowing. The work as has been detailed here provides a way out of this impasse. This thesis then as part of the overall research project functions as a machine in the way it is intended to create relations of immanent

²⁴⁶ AHRC Arts Health and Wellbeing Research Network: *Existing Knowledge, Contested Approaches and Future Agenda*, Institute of Mental health, Nottingham University, March 7 2013.

possibility, it is intended as performative.²⁴⁷ It is intended to do something in the world in the way;

1. it questions narratives concerning arts practices in healthcare settings as cross-platform artforms situated in institutionally bounded spaces,
2. it apprehends the way in which discourse circumscribes explanatory frameworks in terms of evidence-based accounts of benefits accruing to these arts practices;
3. it abandons a logocentric position in favour of adopting a transdisciplinary orientation for practices, connecting discourses on art and health;
4. it struggles with itself as artistic research within a wider disciplinary conflict;
5. It develops my own practice and understanding of collaboration in institutional spaces.

What is written here comes from a set of relations and is intended for some unanticipated relation in the future;

1. as an address to healthcare professionals in their role as arts and health practitioners who can find new language with which to conceive of practices;
2. for artists and arts administrator who position their practice in these settings (also designated arts and health practitioners) who can find a different orientation for their work by positioning themselves in relation to the coordinates offered here;
3. for a curious and critical academic readership that will be interested in the claim being made for new knowledge asserted by this thesis;
4. for myself as a project that has pushed me beyond my own limits;
5. for the people who supported and collaborated in the work in diverse ways.

²⁴⁷ What distinguishes the map from the tracing is that it is entirely oriented toward an experimentation in contact with the real ... The map is open and connectible in all its dimensions; it is detachable, reversible, susceptible to constant modification ... It can be drawn on a wall, conceived as a work of art, constructed as a political action or as a meditation ... the map has to do with performance (Deleuze & Guattari 2004b, pp.13–14).

6. There are future audiences too, as this work reaches out in varying modes to an audience yet to come.

What has been presented throughout this thesis is intended as an emergent minor literature, in the conjunction of theoretical perspectives and in the way it foregrounds and connects actually existing artistic practices operating with reference to artistic intentions rather than clinical goals. Hence the struggle in this thesis, to deterritorialise 'evidence' as an order word, or the emphasis on a collaborative approach rather than individual achievement, and finally the interlacing of different regimes of knowledge to produce new lines of experimentation, congruent with a minor literature. Deleuze and Guattari note 'talent isn't abundant in a minor literature' (Deleuze & Guattari 1986, p.17). What is written here is not possible without a whole network of other words - written and spoken - and so cannot be said to originate with me, or indeed to conclude here. As the title of this thesis suggests perhaps more than all the subsequent text, this is an evolving project of affirmation and resistance - what else can an arts practice do?

11 GLOSSARY

- affect '*L 'affect (Spinoza's affectus) is an ability to affect and be affected. It is a prepersonal intensity corresponding to the passage from one experiential state of the body to another and implying an augmentation or diminution in that body's capacity to act. L'affection (Spinoza's affectio) is each such state considered as an encounter between the affected body and a second, affecting, body (with body taken in its broadest possible sense to include "mental" or ideal bodies)*' (Massumi 2004a, p.xvii).
- assemblage Derived from the French agencement and translated as arrangement, an assemblage refers not only to the outcomes of the interaction between all of a body's relations, but also the process of arranging. An assemblage has no final position rather it is shaped by the connections made.
- becoming Is the continual production of difference. It does not indicate a time of change between events, rather it indicates the continuous flow of changes analogous to Nietzsche's concept of the eternal return. Becoming displaces being and the idea of fixed immutable entities.
- BwO Originating with Antonin Artaud, the phrase denotes a process of becoming that does not exist prior to an organism, but rather proceeds adjacent to it in a disorganised desiring flow. As a surface of intensities, it is the locus of forces that dynamically inscribe the body in a struggle between territorialisation and affirmative will-to-power of the BwO.

desire	Distinguished from the psychoanalytic definition of desire as 'lack', desire is connection constituted as a process of experimentation having both positive and productive relations. It is constituted and constitutive. Desire is centrally implicated with the BwO in open-ended exploration.
difference	is typically understood as difference from the same as a relative measure of sameness, but for Deleuze, difference refers to a singularity of experience internal to itself. Although things may appear the same Deleuze privileges the inherent difference-in-itself, escaping the tyranny of identity and representation and instead attending to the uniqueness of this thing at this moment.
ethology	taken from the work of Spinoza, ethology refers to an ethics distinct from any morality. It is the study of compositions of relations or capacities to affect between different things. A thing is not defined by its form or function, rather it can be found in the relations of speed and slowness (longitude) and the set of affects as intensive capacities (latitude) that occupy it as it is constantly being composed and recomposed.
force	Any capacity, physical, psychological, artistic, philosophical, to produce a change. As such the world is a contingent and complex expression and consequence of interactions between forces.
instituent practice	Refers to a current third phase of institutional critique in which arts practices are concerned with practices of persistent pluralistic instituting events. Instead of becoming ossified in representational protocols

	<p>instituent practices fluidly make and unmake themselves as practices of self-organisation.</p>
lines of flight	<p>Refers to the possibility of any connection mutating into something else, in the actualisation of the virtual that brings about an augmentation in the power of acting.</p>
logocentrism	<p>The claim to authority to speak the 'truth' in for example science or religion.</p>
logos	<p>For Deleuze the logos can be understood as a "law" indicating everything in it's right place as a structured and ordered concept of existence and asserting a certain truth or knowledge of the world. It is opposed by the anarchic <i>nomos</i> by Deleuze.</p>
milieu	<p>'In French, <i>milieu</i> means "surroundings", "medium" (as in chemistry), and "middle". In the philosophy of Deleuze and Guattari, "milieu", should be read as a technical term combining all three meanings' (Massumi 2004a, p.xvii).</p>
minor/major	<p>The minor does not refer to a 'minority' in terms of numbers, rather it refers to the composition of groups and their relation to a standard. The major then refers to a fixed standard, so for example the 'ideal' human has long been the white, adult male. While the major operates to exclude those groups deemed not to meet the ideal standard, the minor does not refer to any grounding standard and so can transform ideas of what constitutes the standard. In a minor literature any standard of recognition or success is repudiated. A minor politics then appeals not to who we are but to</p>

what we might become.

molar	The molar order corresponds to signification that delimits objects, subjects, representations through their aggregating reference systems and governing apparatus.
molecular	Refers to flows, becomings, phase transitions and micro-intensities that destabilise perceptions of reality
nomadology	Releases thought from a fixed point of view or position of judgement, it allows thought to wander, to create new territories, produced through its distribution.
nomos	is distinguished from the <i>logos</i> as a distribution in space and an approximate form of knowledge or practice, following on intuition rather than reproducing in isolation.
relations	Deleuze insist that relations are external to terms. By this he means that there are no prior entities rather there are only potentialities that become actualised in their relation to other powers. The composition of relations then gives the world a particularity that can be only changed through the actualisation of different relations.
resingularisation	'the potentiality for, and practicalities of, reconfiguring our subjectivities' (O'Sullivan 2005c, p.276)
rhizome/ rhizomatics	Distinguished from arborescent forms of thought that follow lines of cause and effect, the rhizome can drift infinitely, establishing transversal, proliferating decentred connections which are open to entry at any point.

territorialisation
deterritorialisation
reterritorialisation

These three terms are centrally implicated with each other. Territory does not refer to a sedentary space with fixed borders, rather a territory can be a system of any kind: conceptual, linguistic, social, or affective. A territory can be deterritorialised, as a line of flight, in which fixed relations are released and exposed to new forms of organisation. It is a movement or process by which something escapes in a line of flight. Reterritorialization refers to the ways in which deterritorialised elements recombine and enter into new relations in the constitution of a new assemblage or the modification of the old.

12 APPENDICES

12.1 TWO VOICES

Marie Brett & John McHarg

Waterford Healing Arts Trust, March 22nd 2010

	Arts Practice – Marie Brett	Arts Therapy – John McHarg
1	An artist usually works freelance & solo, not as part of a team, often without support of other professionals. Tending to be short term in a centre, an artist can be on the fringes.	An art therapist is usually a member of staff in a centre and so would have a long term and continual relationship with the centre. The art therapist often works as part of a team and has the support of other professionals, and shares information on clients.
2	An artist may work in a healthcare setting to expand or develop his/her own practice. The artist must think carefully about how they may benefit from the experience.	The art therapist is in the healthcare setting in a serving role.
3	The artist has no access to information on a participant's history, state of health, or particular needs. Information may be given by staff if thought appropriate. The artist must consider does this help the artist / art making. Health and safety related information can be sought but responsibility must remain with the healthcare staff.	The art therapist has information on history of the client, i.e. state of health, medication etc.
4		









	Arts Practice – Marie Brett	Arts Therapy – John McHarg
	The artist starts with a blank slate working from scratch and builds up a relationship. It's unknown what's brought a person to the arts activity. What their expectations, hopes and reasons to do the activity are or what they may have done before creatively. Information given out by staff is very important in setting the scene.	A client very often comes to art therapy because of a specific issue or concern which is subsequently addressed in the session, using the art making as a tool to address the concern.
5	Artists and art therapists both use art making materials.	Artists and art therapists both use art making materials.
6	Artists work with participants.	Therapists work with clients
7	For the artist, the primary concern is the artwork. Some artists adopt a process led emphasis on creating work. The artist must make it clear that the experience, that is the project, serves the art.	For the art therapist the client comes first. The therapist works to develop and maintain a safe place for the client and the work; a therapeutic relationship between the client and the work.
8	An artist will comment on the work made, will make aesthetic judgements and influence the process / outcome. An artist will push bounds aiming for a balance between challenge and support; for participants to work at the edge of their creative potential.	The art therapist does not make judgements on the work produced by the client. The therapist only responds to a client's request to comment.
9		

	Arts Practice – Marie Brett	Arts Therapy – John McHarg
	An artist's role can shift between mentor, facilitator and artist and care must be taken about adopting a teaching role. Relationships are built during the activity.	The role of the art therapist is defined before a relationship is formed with the client.
10	An artist takes responsibility to prepare for and provide a set number of hours with materials, tools, resources, transport and storage. An artist will provide a safe space, physically and emotionally. They're not responsible for a participant's medical wellbeing.	The responsibility taken on by the art therapist incorporates safety, care, provision of the materials etc. Boundaries are set at the outset, e.g. the number of sessions, length of each session, etc. and these boundaries are adhered to.
11	The artist doesn't have the resource of personal supervision and rarely has access to emotional or creative support or review / evaluation services.	The art therapist has the resource of personal supervision.
12	An artist doesn't make artwork during the session unless collaborative.	The issue of making of art by the art therapist in the presence of, or with, a client is an issue that the art therapist needs to give great consideration to.
13	The person working with the artist is not a client but a participant.	The client is a client from the beginning of the relationship.
14	The artist serves the artwork as well as the participant; they are in an attending role to both.	The art therapist is in an attending role, is there to give of his/her time and attention to the client.

	Arts Practice – Marie Brett	Arts Therapy – John McHarg
15	For an artist, the artwork produced stands on its own merit. Artists adopting a process led emphasis on creating work must think carefully about this issue.	Both the art therapist and client use the work produced in a number of ways, interpretatively, symbolically, as a tool.
16	The artist needs support to maintain the integrity of the space.	The art therapist supports the integrity of the space.
17	<p>Marie Brett, freelance visual artist awarded a Masters Degree with distinction in Visual Arts from Goldsmith's College, London University in 2000 and 1st class BA in Visual Arts in 1987.</p> <p>A qualified teacher, trained in community development, she has studied group facilitation and has over 20 years experience in the field of participatory public art projects. Specialising in the area of arts & health and education, she was selected to exhibit in The Arts Council's 'Vital Signs' arts & health exhibition/conference 2009 and has received numerous awards for her work, namely from Culture Ireland, Create, several local authorities and The Arts Council. Her work is held in private and public collections having received commissions from the HSE, VEC and numerous Council</p>	<p>John McHarg Artist/Art Therapist attended Cork School of Art from 1971 - 1974, received Post Grad Diploma in Art Therapy from the Crawford College of Art & Design in 2005. He has over 20 years experience of working in the healthcare area, initially solely as an artist and since 2005 as an art therapist. As a result of his experiences while working as an artist in the healthcare area, both in a psychiatric day care centre and in the area of intellectual disability, John decided to study for a diploma in art therapy. At the same time he has continued to be a practising artist. The question and place of "The Art" in art therapy, how it is received and how it is dealt with, has always been an issue of the utmost importance to him.</p>

	Arts Practice – Marie Brett	Arts Therapy – John McHarg
	<p>departments. Through experience of working as an artist in a range of healthcare settings, including acute mental health hospitals, day care centres and the area of intellectual disability, she has developed a clear understanding of her role as an artist and established successful participatory methodology whilst actively pursuing her artistic interests, in some cases evidenced in the areas of cultural symbology and collective memory. The issue of how participatory practice influences an artist's work and how an artist deals with this, is of particular relevance and importance to her.</p>	

12.2 ARTS & HEALTH: TABLE OF CONTENTS

Editorial	
<p>Developing the field</p> <p>Raul M. Ceric, Stephen Culp & Norma Deskin page 3</p> <p>DOI: 10.1080/17533015.2012.639052 Version of record first published: 10 Jan 2012</p> <p>Citations: 0 Article Views: 25</p> <p>Further Information First Page Preview Related</p>	<p></p>
Research	
<p>Let's Keep Moving: A dance movement class for older women recently relocated to a continuing care retirement community (CCRC)</p> <p>Mary Ann Kluge, Ashley Tang, Linda Glick, Michelle LaCompte & Barbara Wild pages 4-12</p> <p>DOI: 10.1080/17533015.2010.551717 Version of record first published: 13 Jun 2011</p> <p>Citations: 0 Article Views: 42</p> <p>Further Information Abstract References Related</p>	<p></p>
<p>Nude drawing - a relevant tool in Health Professions Education? Developing skills in observation method for reflective physiotherapy practice</p> <p>Mari Fougner & Vikke Lund Korseth pages 16-25</p> <p>DOI: 10.1080/17533015.2011.591359 Version of record first published: 13 Jun 2011</p> <p>Citations: 0 Article Views: 24</p> <p>Further Information Abstract References Related</p>	<p></p>
<p>Determining the effects of therapeutic clowning on nurses in a children's rehabilitation hospital</p> <p>Stephanie Bush, Shauna Kinganorth, Lindsay Steinhilb & Patricia McKeever pages 26-30</p> <p>DOI: 10.1080/17533015.2011.591359 Version of record first published: 13 Jun 2011</p> <p>Citations: 0 Article Views: 44</p> <p>Further Information Abstract References Related</p>	<p></p>
<p>Dance program for physical rehabilitation and participation in children with cerebral palsy</p> <p>Orall Lipko-Ortiz, Kim Gladson, Laura Deoy, Jennifer Schmidt, Gay Gissanti & Deborah Galtman-Sorel pages 39-54</p> <p>DOI: 10.1080/17533015.2011.594199 Version of record first published: 13 Jun 2011</p> <p>Citations: 0 Article Views: 33</p> <p>Further Information Abstract References Related</p>	<p></p>
<p>Exploring the ability of a drawing by proxy intervention to improve quality of life for hospitalized children</p> <p>Judy Rollins, Joan Drescher & Mary Lou Kelleher pages 55-60</p> <p>DOI: 10.1080/17533015.2011.594194 Version of record first published: 13 Jun 2011</p> <p>Citations: 0 Article Views: 66</p> <p>Further Information Abstract References Related</p>	<p></p>
<p>The use of material objects in understanding the process of recovery from a first episode of schizophrenia</p> <p>Donna Romano, Elizabeth McKay & Katherine Boydell pages 73-82</p> <p>DOI: 10.1080/17533015.2011.594862 Version of record first published: 27 Jun 2011</p> <p>Citations: 0 Article Views: 45</p> <p>Further Information Abstract References Related</p>	<p></p>
<p>Can group singing provide effective speech therapy for people with Parkinson's disease?</p> <p>Caroline Evans, Michael Cartman, Christopher Foy, Roger Lingford & Ruth Proctor pages 83-95</p> <p>DOI: 10.1080/17533015.2011.594863 Version of record first published: 27 Jun 2011</p> <p>Citations: 1 Article Views: 46</p> <p>Further Information Abstract References Related</p>	<p></p>

12.3 VITAL SIGNS ARTWORKS

curated by Michelle Brown 2009

Project	Description
<i>Memory Dress</i> Charlotte Donovan & Marie Brett (2006/7)	Visual Art St Finbarrs Hospital/ Triskel Arts Centre
<i>Sub-Aquatic Dublin</i> Paul Gregg (2003)	Visual Art Our Lady's Hospital for Children, Crumlin
<i>Life Blood</i> Cathy Henderson (2009)	Visual Art St James's Hospital
<i>The Bedmaker</i> Helene Hugel (2008)	Performance Our Lady's Hospital for Children, Crumlin
<i>Hello – Hello</i> Danny McCarthy (2005)	Visual Art (sound installation) O'Connell Court, Sheltered Housing Unit, Cork
<i>Lived Lives: Visual Autopsy Manifestation</i> Seamus Mc Guinness (2006)	Visual Art Dept. of Psychiatry, St Vincents Hospital, Dublin
<i>Beyond Appearances</i> Paul Maye (2004)	Visual Art University Hospital Galway

<p><i>Auxiliary Hospital Equipment: Personal Effects</i> Jennie Moran (2009)</p>	<p>Visual Art Merlin Park Hospital Galway</p>
<p><i>Haiku Week</i> Mark Roper (2003)</p>	<p>Literature Waterford Regional Hospital</p>
<p><i>Mind-Matter</i> Dominic Thorpe (2007)</p>	<p>Visual Art Based on direct engagement with an individual suffering from the chronic pain disorder, neuropathic pain.</p>
<p><i>Sing Another Story</i> John Tunney (2009)</p>	<p>Music Sheltered Housing and Daycare Centre, Kilmaley</p>
<p><i>A Clinically Useful Artwork? Part 1 & 2</i> Dennis Roche (2006)</p>	<p>Visual Art St James Hospital</p>
<p><i>Ó Bhéal Guth Béal</i> Ger Wolfe (2007)</p>	<p>Music Daycare Centres, Gaeltacht Muscraí, Co. Cork</p>

12.4 ETHICS CONSENT FORM

Project Title: Interpreting Arts & Health**Researcher: Sheelagh Broderick**

Please read and sign the to indicate that;

1	Have you been fully informed/read the information sheet about this study?	YES/NO
2	Have you had an opportunity to ask questions and discuss this study?	YES/NO
3	Have you received satisfactory answers to all your questions?	YES/NO
4	Have you received enough information about this study and any associated health and safety implications if applicable?	YES/NO
5	Do you understand that you are free to withdraw from this study? <ul style="list-style-type: none"> • at any time • without giving a reason for withdrawing • without affecting your future relationship with the Institute 	YES/NO
6	Do you agree to take part in this study the results of which are likely to be published?	YES/NO
7	Have you been informed that this consent form shall be kept in the confidence of the researcher?	YES/NO

Name of Participant _____**Signature** _____ **Date** _____**INFORMATION SHEET**

The aim of the project

This project is intended for healthcare professionals and concerns their role and practice as arts and health practitioners as defined by the Guidelines for Participatory Arts Practices in Healthcare Settings. This project takes the form of an arts based inquiry, adopting archival and documentary methods to disclose and consolidate already existing knowledge and practices.

What will be required of the participants

To participate in two workshops on, 20/01/2011 & 24/03/2011 at the Government Buildings, Sullivans Quay, Cork and to participate in one to one interviews with Sheelagh Broderick

Confidentiality and security of information.

Sheelagh Broderick will keep information provided at interview confidential. These will not be shared. They will form part of the field notes and may be referenced anonymously so as to protect informant identities in published text. Any materials brought by participants to workshops must comply with institutional guidelines governing confidentiality. Only materials that are in the public domain under Freedom of Access to Information and Data Protection Legislation should be shared. Participants will be advised to only share information that does not break patient confidentiality. As much of the project is based on information sharing, participants are advised to only disclose information that does not reveal patient identities. The primary output from the research phase will be a an exhibition of work at the Jennings Gallery (College of Medicine UCC), a PhD thesis submitted to DIT, secondary outputs may lead to the publication of journal articles or other analytical formations. Participation in this project is completely voluntary; Participants are at liberty to withdraw at any time without prejudice or negative consequences

Risks/Benefits

There are no anticipated risks for participants.

Benefits will include a sharing of information, with the opportunity to formulate ideas concerning practice. It will create an opportunity for health professionals involved in arts and health practices to connect with peers involved in similar work and deepen understanding of context for work.

Contact details of the investigator:

Sheelagh Broderick, Church Strand, Baltimore , Co. Cork

Tel: 087 9005458

Email: sheelaghbroderick@eircom.net

Contact details of Supervisors

Dr Mick Wilson, Director, GradCAM, c/o NCAD 100 Thomas St. Dublin 8
mick.wilson@gradcam.ie

Professor Declan McGonagle, Director NCAD 100 Thomas St., Dublin 8,
mcgonagled@ncad.ie

Contact details of the DIT Research Ethics Committee should participants wish to make a complaint on ethical grounds:

Graduate	Research	School	Office
143-149	Rathmines		Road
Dublin 6			
t:	+353	1	402
e:	raffaella.salvante@dit.ie		7529

12.5 RESPONSE TO ETHICS COMMITTEE

Application for Ethical Approval ref 66/10

Sheelagh Broderick

Graduate School of Creative Arts & Media

School of Art, Design & Printing

Faculty of Applied Arts

RESPONSE TO ETHICS COMMITTEE

1 December 2010

Q. With regard to the sample selection, the applicant appears not to have clarified the process of how the Cork Arts & Health project will recruit a sample of healthcare professionals. The applicant outlines that she has asked "Cork Arts & Health Project to mediate with the healthcare professionals" but does not expand further.

A, This inquiry is characterised by its interdisciplinary and intersectoral nature. Create the national agency for collaborative arts and Cork Arts & Health Project (CAHP) are collaborators to the research. In this context, the role of the collaborator is to provide advice and support as well as providing a range of key contacts.

The HSE South Arts and Health Programme developed out of a partnership between the Health Services Executive South and Cork 2005: European Capital of Culture. The HSE South/Cork 2005 partnership enabled the delivery of 32 innovative arts projects in over 40 healthcare settings in Cork City and County in 2005. A DIT Research Institute for Culture & Heritage report concluded,

'Undoubtedly, the Culture and Health strand of the programme constitutes one of the undisputed successes of the Cork's European Capital of Culture Year..... The commitment and the expertise of the people involved were critical'.
(Quinn & O'Halloran 2006, p.56)

Cork Arts and Health Programme (CAHP) was established by the HSE South in 2006 in order to build on work undertaken in 2005 and to advance this work in a strategically. CAHP has worked across all

departments in the Health Service and with several organisations in the Community and Voluntary Sector to develop and deliver participative arts activities, environmental enhancement, health promotion, research, training and networking initiatives. CAHP no longer has a full time co-ordinator and it has been assigned to the portfolio of responsibility of HSE South, South Lee Community Work Department.

The role of CAHP in the selection of candidates is to provide the researcher with an introduction to potential participants. That is, let them know the research is taking place and that an opportunity to participate exists. No documentation has been provided to CAHP for circulation to healthcare professionals. If the healthcare professional is interested CAHP will give me the contact details. I will contact them and arrange to meet with them, introducing the context for the work and discussing their own experience of arts and health projects. At this stage, if they fit the profile of participant, it is up to the healthcare professional to decide if they wish to participate in workshops or not. They will be offered the consent form and invited to return it if they decide to participate.

Q.For example, will she provide Cork A&H Project with the project information sheet to give to health professionals to inform them about the project?

A. No, the role of CAHP is to introduce potential participants. It is the role of the researcher to meet them and inform them about the research project.

Q. Will she ask CAHP to get the consent of professionals?

A. No. Consent is secured after the healthcare professional has met with the researcher (who clarifies that they have experience in the commissioning and implementing arts projects), been informed of the research context/process and secured line manager approval to participate.

Q. What guidance will she give CAHP to ensure that there is no element of coercion to participate?

A. CAHP do not have a role in securing consent. The role of CAHP is to introduce healthcare professionals who have a track record in commissioning arts projects in their own healthcare setting.

It is more likely that instead of being coerced to participate that potential participants will be prohibited in participating. An overriding factor regarding participation concerns line manager support. Participants will have to be released from their workplace. This will undoubtedly affect who can participate in the research. In the current budgetary climate it is more likely that front-line staff will not be released and that only those in a management role will attend. As my interest is not specifically in relation to patient outcomes, rather it concerns modes of practice. I am equally interested in what front line staff and managers may have to say about arts practices. Managers secure budgets and approve projects therefore they are accountable for activities within their purview.

Q. Will these health professionals feel obliged to participate?

A. Anecdotally it has been very difficult to get healthcare professionals to attend arts & health conferences/seminars/ network meetings, unless they are themselves speaking. It is very unlikely that they will feel an obligation to attend these workshops, given this history. The research process has been designed to provide a supportive space at agreed intervals with opportunities for one to one discussions between workshops in order to encourage participation.

Q. What is the power relationship/dynamic between CAHP and the healthcare professionals?

A. CAHP acts as a resource for healthcare professionals, e.g. organizing conferences, circulating e-bulletins, making applications for funding. While there is no direct link organizationally between CAHP and these diverse healthcare settings, CAHP provides a moderate level of support, which generates good will toward CAHP. An introduction from CAHP to a healthcare professional, establishes the bone fides of the researcher and also the integrity of the healthcare professional. (In a large institution there are many who would seek credit for the efforts of a few – divining the difference between these two groups of people would be impossible from the outside).

Q. Will the sample group consist of staff and managers and is this likely to impact on the recruitment and level and extent of participation (staff may feel more obliged to participate if they perceive that it will be viewed unfavourably by management)

A. The composition of the group aims to draw on a geographical and disciplinary spread. Therefore it is not possible that a manager and staff member from the same setting would participate – it would be one or the other but not both.

Q. Additionally, staff may be more reluctant to divulge relevant information when managers are present combined these two issues create a) ethical (coercion) and b) methodological problem (data validity)

A (a) CAHP co-commissioned with Waterford Healing Arts Trust, *Participatory Arts Practice in Healthcare Contexts - Guidelines for Good Practice*, with the support of the Arts Council of Ireland. This document is a values based approach to practice. Adherence to these guidelines prohibits coercion. The success of this project is premised on the active participation of healthcare professionals – coercion to attend would provide a disincentive to participate and jeopardise the project on a substantive as well as on an ethical basis. Healthcare professionals

typically orient themselves to a set of values in practice that can be expressed under the following principles, justice, autonomy, beneficence and non-maleficence. They are attuned as part of their role to be aware of factors that may influence them adversely.

A(b) Reflection on practice through the arts is not new. A special edition of the journal *Reflective Practice, Engaging Reflection through the Arts in Health and Social Care* details a range of interventions. The overriding preoccupation is not concerned with data validity rather it is concerned with knowledge production. The journal editorial notes;

'These papers highlight dynamic conversations emerging at the nexus of various interdisciplinary fields around how reflection generally and reflection through the arts more particularly might transform the ways we engage with patients, educate students, foster the ongoing development of practitioners, deepen our practices, unearth subjugated knowledges, re-vision our work, foster social justice and cultivate morally committed practitioners in health and social care contexts' (Kinsella & Vanstone 2010, p.415)

The 'swamp in healthcare practice', necessitating such conversations has its origins in increasingly complex cases, at the boundaries of ethical concern, conflicts between economic and human interests, high professional attrition rates, increasing specialization of healthcare fields that lead to disciplinary silos and crises of professional knowledge that have themselves generated a new discipline of knowledge translation (Kinsella 2010). What is at issue here is less about validating data and more about elaborating understanding.

Q. The researcher mentions that the sample is not randomised - it is therefore all the more relevant that she reflects on the potential issues involved in choosing a select group as a sample group. There is no evidence of this in the current application. The applicant is advised to provides a detailed account of the process and issues related to sample selection in this context.

A. Arts practices in healthcare settings typically do not attract the attention of critical discourses in either the arts or health domains and so remain invisible. CAHP are in a key position to identify healthcare professionals who have a track record in commissioning and implementing arts projects. The researcher is not choosing specific individuals, rather as I have indicated these practices are prevalent, but hidden, so I am relying on knowledge residing within CAHP to identify potential participants. Other factors play a part in group composition, such as geographical location, staff career grade, healthcare setting and budgets.

The participants are not objects of enquiry rather they will constitute agents of enquiry, formulating ideas about practice, documenting and validating extant practices through peer reflection. The participant group is not intended to be a statistical sample, rather it is a group of research partners who are bringing personal experience and insight to bear in a hermeneutic discursive enquiry. The researcher is not intending to create a situation of ideal speech, rather in a Gadamerian tradition, I am setting in play a historically, socially and culturally situated conversation that will be mediated through artefacts and documentary materials. Participants will come to the conversation with a particular vantage point, prejudices, understandings and experience. The concern is not to win an argument or prove a point, rather it is to advance understanding in a process of reconciliation of prejudice and practice. The horizon of the present is continually formed in the to and fro of dialogue, when understandings of tradition (medical culture) from which participants operate is confronted by living practices.

2. The researcher has completed the risk assessment form 9 and partially completed form 13. She needs to, at a minimum, include N/A in the sections under 14.5 that are not applicable, the committee cannot be expected to guess that there is no physical or other risk involved in the study.

A. Appendix 9 amended and resubmitted

3a It is concerning that the researcher states that insurance is n/a in form 13. The researcher needs to check that her fieldwork is covered under the standard DIT insurance policy. She should be advised to check within her School as the committee will not know if there are particular issues involved that might exclude her from the policy.

A. Having checked with my supervisor, I can confirm that as a DIT student, I am covered by DIT insurance.

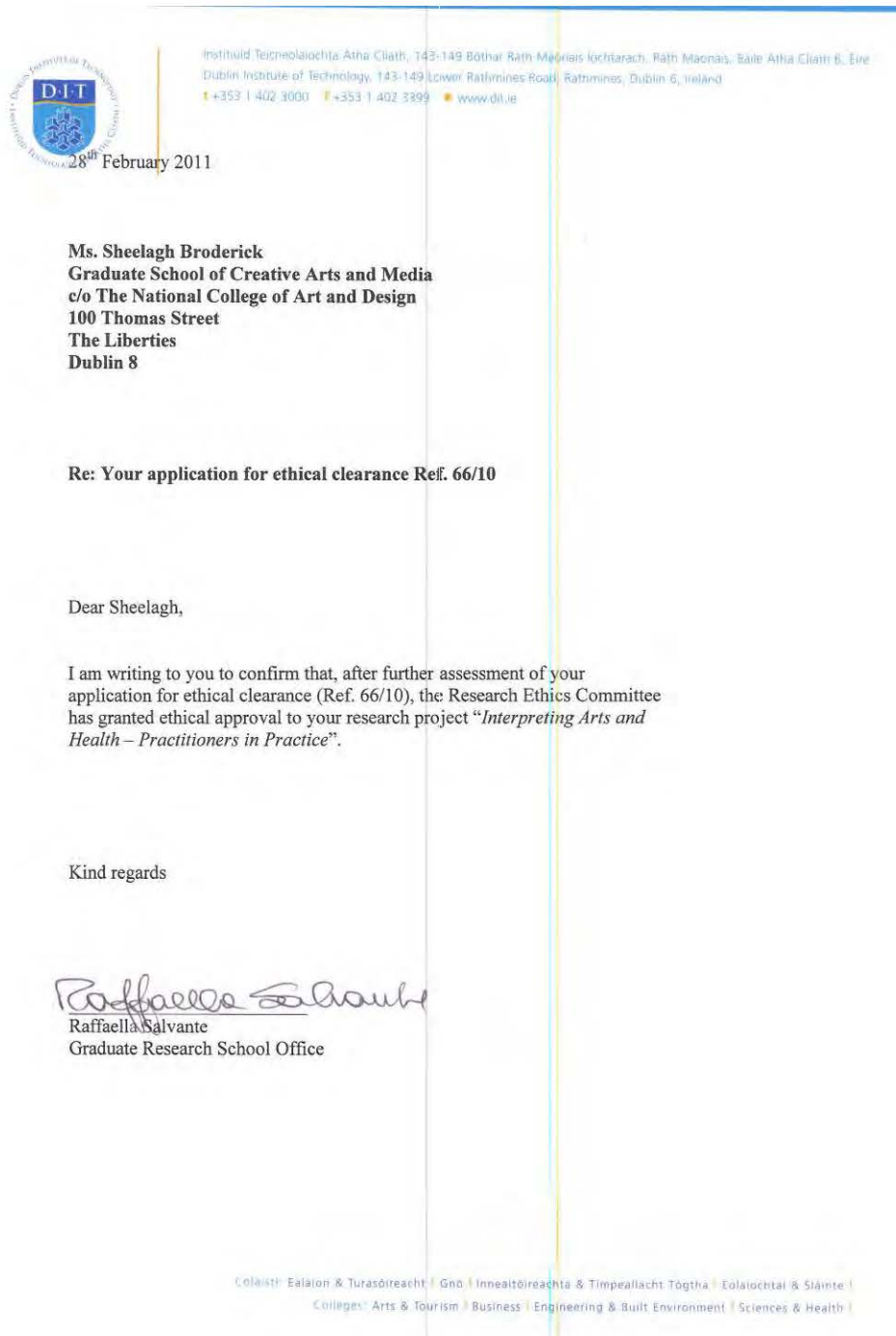
3 b Similarly, she suggests that arrangements for those with disability are n/a, again very surprising and unethical given that the sample is not yet chosen. At a minimum, she should ensure that the location is accessible to those with mobility and other potential issues.

A The National Sculpture Factory is a national resource agency for the arts. They are supporting the research project by providing a venue for the workshops free of charge. I chose to work with the NSF for a number of reasons.

1. To take healthcare professionals out of the healthcare setting physically seeks to alter their horizons. (In a previous arts project, Roche (2008) recognised the importance of removing the psychological architecture of healthcare provision by conducting meetings in an inflatable room within St James Hospital).
2. The NSF plays a role in commissioning public art projects and can be an invaluable resource to participants who no longer have the support of a dedicated staff member in CAHP.
3. To validate the inquiry within its own critical discourse through peer recognition.

Regrettably this room is only accessible by stairs. It is not ideal to host workshops in this venue and it will exclude any participant that has mobility issues. However the room is approved for public use, in a publicly funded building in which regular Arts Council funded activities take place. THE NSF does not have another workshop room.

12.6 ETHICAL APPROVAL



12.7 DATA PROTECTION

From: Data Protection <info@dataprotection.ie>
Subject: response
Date: 7 October 2011 15:41:19 GMT+01:00
To: sheelagh broderick <SHEELAGHBRODERICK@EIRCOM.NET>

Dear Ms. Broderick,

I refer to your recent email query to this Office.

The Data Protection Acts 1988 & 2003 state that "personal data" means data relating to a living individual who is or can be identified either from the data or from the data in conjunction with other information that is in, or is likely to come into, the possession of the data controller. On this basis an image of a person is considered "personal data" and would be subject to the provisions of the Acts. The capturing of a person's image via a webcam and the subsequent displaying of such images over the internet constitutes processing of personal data within the meaning of the Acts.

Individuals have a right to have their personal data processed in a manner which complies with the requirements of the Acts. Section 2(1) (a) of the Acts requires that personal data "shall have been obtained, and the data shall be processed, fairly." One of the key provisions with regard to the processing of personal data is that it should be done with the consent of the individuals concerned and we note that you have taken steps in this regard.

To ensure compliance with the Acts, it is necessary that those people whose images may be captured by a webcam are informed that a webcam system is in operation. This can be achieved by placing easily read and well-lit signs in prominent positions, in this case at the entrance to the art project. These signs should list the purpose for the recording of the images, contact details for the data controller, make clear that any images captured will be displayed on Youtube and provide the means by which a person can opt-out from such display.

I hope that this is helpful.

Regards

Siobhán Brown
Compliance Officer

Office of the Data Protection Commissioner
Cana House
Station Road
Portarlington
Co Laois
Ireland
telephone: 057 868 4800
fax: 057 868 4757
website: www.dataprotection.ie

12.8 CONFERENCES / SYMPOSIA ATTENDED

WHAT	WHERE	WHEN
AHRC Arts Health and Wellbeing Research Network: Existing Knowledge, Contested Approaches and Future Agenda	Institute of Mental Health, Nottingham University	7 March 2013
Former West: Beyond What was Contemporary Art Part 1 (BAK Utrecht)	Academy of Fine Arts Vienna	19 – 20 April 2012
Measuring the Public Value of Arts and Humanities Research: From theoretical challenges and practical problems towards a policy, public and university consensus (HERAValue)	Higher Education Policy Research Unit Dublin Institute of Technology	25 – 26 Oct 2012
If Music Be the Food of Life Play On, (Music Network) http://www.rte.ie/radio1/doconone/radio-documentary-podcast-if-music-be-the-food-of-life-play-on-music-network-healthcare.html	RTE Doc on One	20 Oct 2012
Association of Medical Humanities Annual Conference	University College Cork	9-11 July 2012
Sustainable Creativity in Healthcare, Arts Care NI 21st Anniversary Conference	Lyric Theatre, Belfast	17 -18 May 2012
Critical Response Process led by Liz Lerman (Theatre Training & Development Workshop)	Theatre Development Centre, Triskel Arts Centre, Cork	12 May 2012
Creating a New Old (Bealtaine)	Irish Museum of Modern Art, Dublin	8 - 10 May 2012
Narrative and Catharsis Richard Kearney (In-Discussion)	Dublin Institute of Technology	25 April 2012

WHAT	WHERE	WHEN
Medicine in Art: Illness as Creative Inquiry	Department of Art (Pori Unit), Aalto University School of Arts, Design and Architecture	22-23 Mar 2012
Dialogues Arts + Health National Exchange Day (Create/ WHAT / ALAAO / AHCI)	Rua Red Arts Centre	6 Dec 2011
<i>mac</i>	Jennings Gallery, School of Medicine, University College Cork	11 – 25 Nov 2011
Dialogues Arts + Health Regional Exchange	St Johns Church, Limerick	16 Nov 2011
Arduino Body Rhythm workshop with Benjamin Gaulon	The Lab, Foley St, Dublin	16 Nov 2011
Art and Civil Society Symposium (Create)	Triskel Arts Centre, Cork	20-21 Oct 2011
Dialogues Arts + Health Regional Exchange	St Johns Church, Limerick	13 Oct 2011
Social Pathologies of Contemporary Civilisation (School of Philosophy and Sociology)	University College Cork	15 – 16 Sept 2011
Dialogues Arts + Health Regional Exchange	St Johns Church, Limerick	15 Sept 2011
Making Sense of Health, Illness and Disease, 10 th Annual Conference (inter-disciplinary.net)	Mansfield College, Oxford	06 – 09 Sept 2011
International Summer Academy for Artist-researchers	Helsinki & Seili, Finland	22-31 Aug 2011
Keeping Up: Enthusiasm, Anxiety And The Culture Of Wellbeing	University of Waterloo, Toronto	23-26 June 2011

WHAT	WHERE	WHEN
Arts & Health: Perspectives on Mentoring, Public Interview with Sarah Tuck (Create / Common Ground)	Cork County Council	2 June 2011
Where does Arts and Health Research belong (in academic terms)? (WHAT)	Trinity College Dublin	11 May 2011
Arts & Health Exchange Day (South Tipperary Arts and Health Interest Group)	Clonmel	27 April 2011
Critical Perspectives in Public Health Module SS6017 Masters in Public Health	University College Cork Dr Orla O'Donovan	21 Jan – 18 Mar 2011
Professional Development workshop with Mark Storer (Helium)	Rua Red Arts Centre, Tallaght, Dublin	9 Dec 2010
For the Best: Seminar with Mark Storer and Dr Emma Curtis (Helium)	Science Gallery Dublin	8 Dec 2010
Arts & Health : Perspectives on Practice (HSE South/CIT)	River Lee Hotel, Cork	9 Nov 2010
The Question of Culture II / Autumn School in Practical Creative Research (GradCAM)	Irish Museum of Modern Art, Dublin	1- 5 Nov 2010
Who Cares? Actors Attendants & Agents: Speculations on the Cultural Organisation of Civility (SKOR)	Felix Meritis, Amsterdam	29 – 30 Oct 2010
'Faculty of Being Public' Jeanne van Heeswijk	GradCAM, Dublin	15 Oct 2010
Approaches to Collaborative Arts Practice: Chu Yuan in conversation with Mick Wilson	Wood Quay Venue, Dublin	30 Sept 2010
Public Interview with Katherine Atkinson	Axis Arts Centre, Ballymun	16 Sept 2010
Concepts of Health and Illness (AHRC)	Bristol, University of the West of England	1- 3 Sept 2010

APPENDICES

WHAT	WHERE	WHEN
Can Culture Make You Well? Symposium	Tate Modern	13 May 2010
Deschooling Society Conference	Serpentine & Hayward Gallery, London	29-30 April 2010
Art & the Social: Exhibitions of Contemporary Art in the 1990's Conference	Tate Britain	30 April 2010
Transplant (CPD)	Waterford Healing Arts Trust	27 - 28 April 2010
Doing Dissemination	maHKU Symposium, Utrecht	01 April 2010
Two Voices (CPD)	Waterford Healing Arts Trust	22 Mar 2010
The Art of Good Health and Wellbeing: International Arts & Health Conference	The Glasshouse, Port Macquarie, NSW, Australia	10 – 13 Nov 2009
Vital Signs conference & Exhibition (Arts Council Ireland / Create)	Dublin Castle / NCAD Gallery and Healthcare settings	15 Oct 2009
1 st International Visual Methods Conference (ESRC Researcher Development Initiative)	University of Newcastle	21-22 May 2009
Niet Normaal: Difference on Display	Beurs van Berlage, Amsterdam	28 Feb 2009
Arts Research Publics & Purposes (GradCAM)	Project Arts Centre, Dublin	15-19 Feb 2009

12.9 TEXT ABSTRACTS

The following texts follow the progressive attempts to formulate a theoretical frame for practices.

12.9.1 ILLUSTRATING GREY MATTERS : ARTS PRACTICES IN HEALTHCARE CONTEXTS

Presentation, Keeping Up: Enthusiasm, Anxiety And Wellbeing Toronto, Canada, June 24 2011 Discipline: Sociology

ABSTRACT: There has been an infiltration of health spaces in recent years by artists who seek to make artworks in these contexts. In a turn away from object oriented arts practices of the past, this work is often characterised in the artworld by its relational / dialogical aesthetic, but the dominant discourse of evidence-based medicine has typically resulted in these artworks being understood as a therapeutic intervention or recreational service. The enthusiasm for this orthodox adherence to evidence based narratives of knowledge validation and (re) production signals an anxiety with indeterminacy and a desire to establish a hierarchy of knowledge that seeks to eclipse all others. Efforts to formulate arts practices in this way have led to the proliferation of a grey literature of evaluation reports evidencing accruing positive health gains. In this presentation I distinguish between therapeutic / recreational and contemporary arts practices, referencing exemplars of contemporary arts practice from Canada, UK and Ireland. Through site and subject specific inquiry, arts practices represent descriptive, critical and analytical modes of inquiry that can add to our understandings of health, illness, and indeed healthcare systems themselves. The contingency of these arts practices places them at odds with the commercialised networks of knowledge distribution exemplified by peer reviewed publications that accelerate the accumulation of specific commodified knowledges. ²⁴⁸

²⁴⁸ I had the opportunity of visiting Baycrest Geriatric Centre, through connections made at the conference. Baycrest is a 400 bed residential care home as well as being leading research institute in

12.9.2 SENSE AND SENSIBILITY : ARTS PRACTICES AS MODES OF INQUIRY IN HEALTH, ILLNESS AND DISEASE

Presentation Making Sense Of Health Illness and Disease, Oxford, Sept 6 2011
Discipline: Medical Humanities

ABSTRACT: Arts and health is a new interdisciplinary field of inquiry that is defining its boundaries, distinguishing itself from art therapy and struggling to find appropriate methods of validation. Epistemological bias in healthcare has resulted in some arts projects being validated using the gold standard of a randomised control trial. However there is an expanding literature that considers that arts practices represent an alternate body of knowledge that can add to our understandings of health, illness, disease and indeed healthcare systems themselves. This presentation is based on my research *Interpreting Arts & Health*. It will demonstrate exemplars of contemporary arts practices in relation to experiences of health and chronic illness. *Liminality* (McMahon 2011) and *Transplant* (Wainwright & Wynne 2008) adopt different approaches to the issue of transplant. The former considers how the transplant reconfigures the subjectivity of patients, while the latter is more concerned with a phenomenological account of being in hospital waiting for a donor. *Cradle to Grave* (Pharmacopia, 2003) is an installation that considers how Western society responds to sickness and ill health. It consists of a lifetime supply of prescription drugs based on the fictional biographical life course of an average man and woman. Using these examples, I suggest that arts practices can operate in descriptive, critical and analytical modes in its address of health and illness, which are relevant for healthcare professionals and patients alike.

cognitive neuroscience. It has a huge private collection of modern art and a busy arts programme run by its Department of Culture, Arts & Innovation. Baycrest was unique among the healthcare spaces visited having a blend of many discourses run seamlessly together in its mission statement of, 'a holistic vision of health and wellbeing that embraces spirituality, innovation and the arts'. Remarkably too Baycrest has a philosopher in residence, whose reflections on knowledge transfer I found particularly instructive in which exposes the complex path from research to application. 'Research problems are understood in a theoretical frame (sometimes called a paradigm). At times, because the frame is undergoing change, or is incomplete or wrong-headed, it can lead researchers away from a viable solution. There can be plenty of evidence for a conclusion within a paradigm, but the conclusion can still be mistaken' (Glouberman 2009, p.556).

This paper was not included in the edited and selected conference presentation publication. An Arts & Healthcare special edition of the UK based gallery and education resource journal engage subsequently rejected a modified version of this paper. ²⁴⁹ Nevertheless this was an important conference presentation because despite the lack of interest in publishing the paper, I made a connection with a medical humanities scholar who related to my intention for the work. The conference convener Dr Maria Vaccarella subsequently extended an invitation for my work to be included in a funding bid for a medical humanities conference.

12.9.3 FROM AESTHETIC TO ANAESTHETIC : TRAJECTORIES FOR ARTS PRACTICES IN HEALTHCARE SETTINGS

Presentation: Social Pathologies Of Contemporary Civilization, University College Cork, 16 Sept 2011
Discipline: Sociology

Abstract: Cognitive capitalism seeks to turn all kinds of knowledge into commodities. Creating value through intellectual, communicative, relational and affective activities, whether they are artistic, philosophical, cultural, linguistic or scientific. This exploitation of human capabilities can be understood as a social pathology, as it internalizes processes of subjugation through internalised forms of conditioning and social control. This paper will briefly explore the parallel trajectories of biomedical research and artistic research practices in the context of cognitive

²⁴⁹ Submitted ABSTRACT Arts and Health (or is it Culture and Wellbeing?) finds its roots in a shift from gallery-based art, to context and participatory modes of practice. Debate can be said to polarize around and between two poles; a) cultural interventions that are instrumentalised for their anaesthetic, healing and educational powers and b) cultural interventions that are seen to operate as critique challenging the knowledge base and cultural practices of the healthcare system itself. These interdisciplinary practices point to a new formulation of cultural encounter that is amorphous and fluid. Stepping outside disciplinary silos brings with it the potential for epistemological conflict, but also opportunities for phenomenological, analytical and critical analysis through diverse modalities. This paper is based on my research *Interpreting Arts & Health*. It will discuss the arts projects *Liminality* (McMahon, Dublin, 2011) and *Transplant* (Wainwright & Wynne, London, 2008). The former considers how organ transplantation reconfigures the subjectivity of patients, while the latter is more concerned with a phenomenological account of transplant patients in hospital waiting for a donor. Both projects made the transition back from healthcare setting to gallery setting and were accompanied by online documentation blogs opening them up to a wider audience for critical discourse.

opportunity of presenting new work that aims at synthesis and will draw on video documentation of the *mac* installation.

This paper gave me an opportunity to try again to move away from a position of negation to a position of affirmation through the conjunction of the work of Fox and O'Sullivan. This was made possible by attempting to connecting the work of two writers, Simon O'Sullivan and Nick Fox for the first time.²⁵⁰

12.9.5 INTERPRETING ARTS & HEALTH:

HOW DO YOU DO?

Presentation; Sustainable Creativity in Healthcare, Arts Care NI, Belfast, May 16 2012

Discipline: Arts & Health

ABSTRACT: This paper will refer to the ongoing arts project *mac*, which has been installed at the Jennings Gallery, Faculty of Medicine, University College Cork in November 2011, documented at the website www.medicineasculture.com, and projects by other artists exemplifying phenomenological, analytical and critical approaches to practice. The matrix of health settings and disciplines combined with the diversity of artsforms and practices presents a field of activity that is vibrant, fluid and open. What might it mean to deploy embodied creativity as a defining characteristic of arts and health practice straddling individual bedside experiences and collective interest-based works. Can such a theoretical concept dynamically occupy a space between health oriented instrumentalised understandings of practice and critical arts discourses? What are the possibilities? What are the consequences?

My ambition for the paper was to move away from a perspective dominated by groupthink to a position of strangeness.

²⁵⁰ At the time of writing this paper – Fox had not yet published his contribution on Creativity and Health.

12.9.6 mac AN ARTS PROJECT FOR HEALTHCARE PROFESSIONALS?

Presentation: Medical Identities: Patients and Professionals, 2012
UK/Ireland Association for Medical Humanities Annual Conference,
University College Cork 9-11 July 2012 Discipline: Medical Humanities

ABSTRACT: This presentation is part of an ongoing arts project *mac*, which has been installed at the Jennings Gallery, Faculty of Medicine, University College Cork in November 2011, (<http://www.medicineasculture.com/gallery/>). *mac* differs from other arts projects in that it is targeted specifically at healthcare professionals. It adopts an iterative and reflexive approach to the manner in which healthcare professionals understand and implement arts projects in healthcare settings. In Spring 2011, workshops were facilitated with healthcare professionals who have had a role in commissioning or implementing arts projects in different healthcare settings across diverse care areas (acute hospital, maternity hospital, community mental health, community work, eldercare, disability and administration). The arts project *mac* emerged in response to the issues discussed. This paper will discuss the issues of concern to healthcare professionals, their responses to the installation and suggest analytical frames of reference for future work

12.10CHH FUNDING BID

Irish Eyes: Vision in Modern Irish Culture

ORGANISERS: Dr Keren Hammerschlag, Dr David Stone, Dr Maria Vaccarella

CHH STRANDS INVOLVED: “Case studies of medical portraiture” and “Illness narrative as life-writing”

PROJECT OVERVIEW

‘Irish Eyes’ will seek to examine the rich and varied depictions and descriptions of vision in modern Irish art and literature through academic investigation, art practice, and conversation with clinical practice. Representations of eyes and optics will be understood in the context of medical discourses around the history of eye conditions and ophthalmology during the period.

It will constitute the first in a series of research events focused on the cultural history of medicine in the British ‘white colonies’ of Ireland, Australia, and Canada during the modern period (please see ‘Outputs’ section). Apart from the Nursing and Identity research strand, other CHH strands have not actively engaged yet with colonial history. Irish medical humanities offers the ideal subject for a pilot event, firstly because of the contentious nature of the classification of Ireland as a British colony, and secondly because of Ireland’s significance in the history of medicine, art, and literature.

Our cross-disciplinary exploration of the topic of vision will ultimately offer a valuable contribution to the CHH research programme “The Boundaries of Illness”. Given its both physical and epistemological implications, vision is a privileged site of inquiry into crucial aspects that will help us set the boundaries of the cultural experience of illness, such as issues of literal and metaphorical distortion and misrepresentation, as well as the tension between authenticity and performativity in artistic depictions of medical conditions.

BACKGROUND

Modern Irish culture stands out as a fertile, yet underexplored, site for medical humanistic investigations. While Irish medical historiography has been flourishing over the past twenty years (two milestones are Jones and Malcolm 1999 and Cox and Luddy 2010), cultural representations of medicine and medical issues in Ireland have not attracted adequate critical interest yet. Drawing on the organizers’ wide-ranging expertise in visual arts, Irish cultural studies, and clinical medicine, this project is based on the premise that critical and creative reflections on modern Irish art and literature would constructively supplement historic surveys of Irish medicine and greatly expand their scope.

Nineteenth-century Dublin was a thriving centre of high-quality medicine and medical education (one eminent alumnus was King’s College Hospital’s founder, Robert Bentley Todd). The development of medicine in colonial Ireland was however affected by three main socio-cultural factors: Catholicism, imperial politics, and traditional healing practices. Sir William Wilde’s researches on Celtic cures, William Orpen’s emphasis on the teaching of anatomy to artists, and James Joyce’s fascination with medicine as a scientific counterpoint to religion are all instances of cultural responses to this typically Irish interplay of knowledge.

FORMAT

This proposal is for a grant to support: a visit to the museum in the joint library of Moorfields and the Institute of Ophthalmology to view and discuss their large and varied collection of ophthalmological instruments, antiquarian books, and old water colour paintings of the eye; a one-day inter-disciplinary workshop on the theme of vision in modern Irish culture, including a keynote address by a leading scholar in the history of Irish medicine; and an installation by Irish artist Sheelagh Broderick, who has special interest and expertise in medical issues [<http://www.sheelaghmag.net/index.html>].

Hence the relationship between 'Irishness,' vision and medicine will be approached from different angles and in an interactive and dynamic way. It will traverse different disciplines—the history of medicine, the history of art, and Anglophone literature—and different spaces where vision is prioritised and problematised—the Museum and the Anatomy Theatre.

PROVISIONAL PROGRAMME

Date: early December 2012

Day 1:

- Evening presentation by Richard Keeler (Honorary Curator at The Royal College of Ophthalmologists / Honorary Archivist for the Moorfields Eye Hospital Alumni Association) at the newly installed museum in the joint library of Moorfields and the Institute of Ophthalmology.
- Drinks reception at Moorfields Museum.

Day 2:

- Keynote address by a scholar in the history of Irish medicine and culture (possibilities: Professor Elizabeth Malcolm, University of Melbourne; Professor Catherine Cox, University College Dublin).
- Roundtable discussion of scholars from the Centre for the Humanities and Health working in the Irish medical humanities:
 - Dr Maria Vaccarella: 'Sir William Wilde, Ophthalmologist and Ethnographer'
 - Dr David Stone: 'Irish Eyes / Jewish Eyes'
 - Dr Keren Hammerschlag: 'William Orpen's Nostalgic Look at Ireland'
- Irish artist Sheelagh Broderick's introductory talk and unveiling of her installation on the themes of the conference in the King's College London Anatomy Theatre (to stay on display at King's for a week)
- Dinner

OUTPUTS

- 1 co-authored report for an academic journal
- 1 co-authored shorter report to be published on the Wellcome Trust blog and linked to on the CHH blog
- 1 co-authored research article for a peer-reviewed journal

- The workshop will be the first event in a larger project on cultural representations of medicine and medical issues in the British 'white' colonies, to be developed in collaboration with King's College London's Menzies Centre for Australian Studies, the Centre for the History of Medicine in Ireland at University College Dublin, and Gorsebrook Research Institute for Atlantic Canada Studies at St. Mary's University, Halifax, Nova Scotia, Canada. On the model of 'Irish Eyes', a pivotal medical theme for each nation will be identified and explored through a triangulation of academic investigation, art practice, and conversation with clinical practice.

WORKS CITED

- Greta Jones and Elizabeth Malcolm (eds.), *Medicine, disease and the state in Ireland, 1650-1940*. Cork, Ireland: Cork University Press, 1999.
- Catherine Cox and Maria Luddy (eds.), *Cultures of Care in Irish Medical History, 1750– 1970*. Basingstoke: Palgrave, 2010.

BUDGET

Staff costs (KH, DS, MV): 10% for 3 months	£ 3,600*
Travel and accommodation (1 speaker: 2 nights – 1 artist: 5 nights):	
- travel: £150 x 2 = £300	
- accommodation: £140 x 7 nights = £980	£ 1,280
Installation costs	£ 1,000
KCL venue hire for installation exhibition (5 days)	£ 2,500
Conference packs (30-40 people):	
- printing: £250	
- personalised folders: £250	£ 500
Food and refreshments (30-40 people):	
- 1 st day off-site drinks reception: £500	
- 2 nd day morning tea and coffee, lunch and afternoon coffee break: £900	£ 1,400
Restaurant dinner (10 people):	£ 300
Total	£ 10,580

N.B.: delegates' registration fees (£10 each) will help cover refreshments and conference pack costs
* to be confirmed by Research Grants and Contracts

12.11 WORKSHOPS: PRACTITIONERS IN PRACTICE

COLLABORATIVE WORKSHOPS WITH HEALTHCARE PROFESSIONALS,
20 JAN 2011 AND 24 MARCH 2011, CRAWFORD COLLEGE OF ART, CORK.

While the articles discussed in the previous section were published in Summer/Autumn 2011, there was a considerable delay between writing and publication. The preparation for these articles overlapped with workshops planned with healthcare professionals. According to the *Guidelines for Good Practice of Participatory Arts in Healthcare Contexts*, healthcare professionals are viewed as arts and health practitioners if they have a professional role in the preparation, delivery and evaluation of work (White 2009b, pp.5–6).²⁵¹

My research at this stage was concerned with how arts practices were perceived within the institutions of health service delivery by healthcare professionals, being confined to the specific, materials, knowledges and territories of healthcare professionals in healthcare settings. My intention was to question the contradictions, which made possible the application of evidence-based research to arts practices through collaborative workshops.²⁵² Given that these health professionals worked within a regime of evidence based practice, how could they as individual champions, congruently go beyond their assigned clinical roles to commission and implement arts projects?²⁵³ And how could I engage with them in this process?

²⁵¹ It could be said that the increasing prevalence of arts practices in clinical settings meant that healthcare professionals take on the role of cultural producers as they commission, implement and mediate arts projects in diverse healthcare settings.

²⁵² The delivery of healthcare is mediated through institutions populated by individuals trained in particular specialties to a specific clinical governance regime of evidence-based medicine.

²⁵³ Constantly being asked throughout, why is this worth knowing? I would reply: Arts and health practices are characterised by their invisibility. They serve specific populations in specific contexts, far from the mainstream of arts activity and often bound by issues of confidentiality. A naming of actually existing practices will specifically identify healthcare settings as a site of arts practice opening up a new field of artistic endeavour for artists, health services clients and health services staff. Exploration of issues in relation to practice will yield insights, for professional artist training and practice (Moss & O'Neil 2009), and the role of healthcare services in supporting projects. It will open up new avenues of discussion that will be useful for all stakeholders. Motivations to provide arts projects in the healthcare domain differ, but typically are characterised as being 'good for you'. Arts and health practices operate in the epistemic domain of health. How can arts practices engage in these constructions of health and wellbeing leaving aside these normative claims? Artists engaged in social practice maintain an awareness of the exigencies of working with curators, galleries and museums informed by

12.11.1 PLANNING

My intention at the time was to put in play questions addressing the way in which arts practices in healthcare settings were being understood, through collaborative workshops with healthcare professionals. In order to do this a significant period of time was spent in obtaining permissions. In the form of ethical approval from DIT Graduate Studies, but also negotiating access to these individuals and institutions as follows:

- I visited healthcare sites before and during the process, planned and facilitated workshops, sourced resource and reference materials.
- CA+HP who have been at the forefront of developing arts and health projects were committed to supporting implementation by mediating with healthcare professionals and providing financial support.
- A cohort of 9 healthcare professionals from 8 different healthcare settings participated in the project (Acute Hospital - Cardiology & ER, Community Hospital, Maternity Hospital, Administration, Disability, Mental Health & Community Work).
- With the assistance of Arts Council Ireland Connect Mentoring Programme Artist Marie Brett who provided mentoring support.²⁵⁴
- The Cork Institute of Technology, Crawford College of Art provided workshop space free of charge at their city campus.
- The Jennings Gallery Faculty of Medicine, University College Cork who agreed to host subsequent planned intervention.

institutional critique (Alberro & Graw 2006). Similarly artists working in healthcare settings need to develop an awareness of the structures, politics and culture of healthcare institutions.

²⁵⁴ Managed by the arts organisations Create and Common Ground.

Following correspondence with the DIT Ethics Committee I relocated workshops to a new venue at the Cork Institute of Technology, Crawford Art College, City Campus (see section 11.5 and 11.6). It was important to have the workshops in an officially sanctioned art venue as a knowledge sharing gesture. The impact of the delay in securing ethical approval meant that instead of having three workshops in a six-month period, I was only able to facilitate two workshops in four months

The CA+HP assisted in identifying healthcare professionals who had a role in mediating or implementing an arts and health project. This participant profile was selected as the healthcare professionals needed to have had professional practical experience of having been involved in arts project delivery. The support of CA+HP was invaluable, as many projects do not have a public profile and it would have been very difficult to find these healthcare professionals otherwise. I contacted eleven healthcare professionals and arranged to meet them at their place of work to explain what the project was about and to give them a consent form (see section 11.4).²⁵⁵

One of the prospective participants took early retirement prior to workshop commencement; another prospective participant decided not to participate because it would require travelling a long distance. Nine healthcare professionals agreed to participate in two daylong workshops. Their professional roles were as follows: Nurse Practice Development Facilitator, Hospital Arts Coordinator, Community Worker, Senior Executive Officer, Community Mental Health Nurse, Nurse Planner, Art Therapist and two Acting Directors of Nursing. They came from diverse healthcare backgrounds: eldercare, mental health, maternity hospital, disability, community work, acute hospital and administration.

²⁵⁵ Meeting the participants in advance of the workshops gave me access to the healthcare setting in which they worked and provided me with an opportunity to learn about arts practices in those settings. These host sites are a huge resource as repositories of practice and knowledge.

In preparing for the workshops I made the space as familiar as possible, in terms of materials and knowledges of healthcare professionals relying on office-based materials and modalities in formatting the workshop, yet situating them within an art institution.²⁵⁶

The aim of the workshops was to facilitate collaboration and knowledge exchange between practitioners working in a range of locations and disciplinary contexts, bringing together people who might not ordinarily have had the opportunity to work together. The over-arching objective was to tease out understandings of the problems and possibilities of arts practices in healthcare settings, within the context of evidence based practice. The participants were introduced not only to each other and each other's diverse healthcare practices, but also to the idea that they themselves had been designated arts and health practitioners as defined by the Guidelines.²⁵⁷ This was news to many, as although the Guidelines had been launched in 2009, they had not permeated into all areas of practice.

Participants were informed that there would be a range of project outcomes, in a variety of formats. As well as writing about the workshops, I intended to take the discussions and ideas emanating from the workshop as source material for an installation at the Faculty of Medicine, University College Cork. In short I hoped to generate question and discussion through a shared language in an inter-sectoral dialogue based on parity of esteem.

12.11.2 WORKSHOP 1

²⁵⁶ For example one of the group exercises was to ask participants a series of questions concerning how they would describe their character if they were a font, punctuation mark, mathematical expression, text style, text abbreviation etc. This fed into the text culture within which they worked and was an area where they could demonstrate their individual and diverse preferences in a very simple and effective way.

²⁵⁷ 'The practice of arts and health is not a single professional role but a skills partnership of people who come together in their distinctive roles to engage the public in creative activities that aim to improve health and wellbeing. The term 'practitioner', as used throughout this document, refers not exclusively to artists but rather to anyone who has a professional role in the preparation, delivery and evaluation of the work. The term 'participant' refers to patients, clients, service users, staff members, carers, or indeed any person in a community taking part in an arts and health project' (White 2009b, pp.4-5).

A period of time was set aside for introductions. Each healthcare professional had the opportunity of exchanging in pairs their experience of implementing arts and health projects, so that all had met each other individually by the time the round robin ended. The overwhelming sense of feedback following these introductions was one of astonishment that so much arts activity could be happening in one organisation and that each of the healthcare professionals had been operating in their own settings without knowledge of any of the others. Other comments offered as individual opinion, such as: that 'an umbrella organisation was required to link different health services'; 'healthcare workers need exposure to open minds to the potential of arts and this was an opportunity to build identity as arts and health practitioners creating their own network'; 'the potential to bring art into work had not been explored before, possibly because of lack of training / courses' and 'a lot of information is available e.g. music is used to soothe and reduce blood pressure'. A view was expressed that the 'arts have been used predominantly in care of the elderly services, but that other services need to look at the potential'; that it was 'not necessarily an expensive activity but resources were needed to improve the experience'; that there was 'artistic potential in different health experiences'.

The diversity of comments expressed encapsulates the diversity of views regarding practices. Very definitely some of those present associated arts practice with improved health outcomes for example by referring to reduced blood pressure. Others were more exploratory in their views open to diverse understandings. But all of them felt that the support of colleagues would be of benefit to them in their role as an arts and health practitioner.

I had set out two framing documents for the participants to consider:

1. The Arts Council Arts & Health Policy and Strategy (Arts Council of Ireland 2010)
2. The HSE South Participatory Guidelines (White 2009b)

Conversation was unstructured, but it is possible to draw out thematic strands:

1. The overarching concern related to the care of the individuals in their health setting. Concern was expressed about the potential for negative impacts. A view was expressed that art is subjective and artists need to grasp the reality of healthcare settings. 'Dark depressing and gory images are to be avoided', and healthcare professionals do not have time/energy to react to 'negativity around art'; they especially don't want to add to the burden of people.

This sparked off a whole chain of conversation. The concern and anxiety expressed about how people react to art was countered with an argument that no-one really knows how someone will subjectively react: 'art can also create a discourse and dialogue and is about process rather than product', 'the interaction with artwork is not just with patient but with everyone who sees it, healthcare worker, visitors, family'. The subject of censorship remained an open and unresolved issue.

2. Concern was expressed that the Arts Council of Ireland Strategy & Policy document was unreferenced: that it didn't aspire to be research based (Arts Council of Ireland 2010).²⁵⁸ Participants wanted to know, 'who said this, who is the reference?' Some of them felt that the text was contradictory. For some the exclusion of arts therapy in the Arts Council document caused disagreement. Although the primary purpose of therapy is ascribed to therapeutic outcome, this is not an accurate reflection of reality. What does clinical mean in any case? This was countered by other participants saying that arts therapy was available only on referral, whereas arts projects were available to all in the healthcare setting, based on service user choice.

²⁵⁸ This concern illustrates the emphasis healthcare professionals place in their own practice where policy documents are always referenced and linked to evidence-based literature.

3. Vulnerability was expressed in relation to determining quality. Participants wanted information about making decisions concerning art commissioning, on standards and appropriateness in order to get value for taxpayers money, 'the artwork needs to be sustainable with a lasting impact'. This was a concern from different points of view, firstly, there were legacy issues associated with high value artworks that healthcare services were unable to deal with, and secondly there were issues in relation to ownership. Who actually owns the artworks? Can they be sold? Can the artist sell the idea to other venues/owners? And thirdly in relation to commissioning of work, uncertainty was expressed about whether they are doing it in the best way or the most efficient way.

4. The ad hoc nature of projects caused anxiety as, 'each is having to make it up as they go along and shouldn't have to', being 'reliant on the interest of one individual'. There is a 'need to know what resources are there' and a 'need to structure', to 'share information in a practical way e.g. health and safety concerns', 'how to choose and how to maintain artworks'. Information sharing might 'improve confidence in choices e.g. music vs. visual arts'. There was a view that that there is strength in numbers e.g. 'the arts in mental health working group share information on best practice'.

5. Professional development was raised as an area of potential as the opinion was expressed that; 'Arts can be about you as a practitioner too'. But a contrary argument asserted that if 'professional training is systematised, it is hard to work in a way that the arts need' (process oriented, rather than procedural).

6. Participants expressed a need for 'leadership development to advocate for practices', 'invest money in building capacity amongst people in healthcare so that it can continue on'. The need for leadership and strategy at a national level was expressed, otherwise 'it falls through a gap'. Art should be 'visible in health policy - or else there will be no evidence of benefit'. 'Health cuts will lead to art falling down the list of

priorities'. 'We are in the early stages of arts & health in Ireland – a blue print won't work'. 'Time to define where we stand on arts and health'.

In terms of specific understandings of practices:

- Wellbeing is the root of the big picture
- Art is part of our work 'the art of nursing' and needs to be seen as such
- Practices should not be polarised in smaller disciplines or marginalised to a concept of working with particular client groups e.g. mental health / eldercare
- Part of the holistic care of service users – the health and wellbeing for all users of health services
- Conceive of arts and health as an evolving web rather than as a structured programme
- Overload, confusion, lack of support structure, too much systematisation could kill creative root of arts and health work
- Dealing with artists infighting / self-employed
- The current requirement of linking resources to defined objective outcomes
- The assumption that nurses could add this to their current workload without resources – providing - existing level of service with less money
- Identity and difference among arts and health practitioners
- Creativity energises opens up new ways of thinking and seeing life and situations and understanding health and illness and wellbeing
- Allow arts and health to flow, be mobile and evolving

At the end of the day participants were asked to evaluate the workshop in terms of a) knowledge exchange, b) Extending understandings of problems and possibilities of arts and health practice from healthcare professional perspective. Responses were diverse and are detailed in full in section 11.11, but a selection below indicates the openness to, and appreciation of practices

- Better sense of the limitations and partiality of my own perspective and approach
- Greater appreciation of the work that other healthcare practitioners are doing and greater understanding of the challenges that others face
- Multiple approaches and perspectives: All are valuable
- No-one has all the answers
- Diversity in services and possibility of future connections
- Would like us as such a diverse group who had just met to continue this pathway
- Mind opened to new ideas for acute sector

Overall, coming away from this workshop I was impressed with the curatorial concerns for practices expressed during the day and the way in which healthcare professionals had taken on these roles bravely.²⁵⁹

12.11.3 WORKSHOP 2

It had been agreed that we would look at the question of evidence at this workshop. The format for this workshop was quite different from the previous one moving through a lot of material at quite a pace. I had contacted Local Authority Arts Officers and Arts and Health Coordinators, to source documentary evidence of projects that had been supported by them (see section 11.12). A considerable amount of material was returned that constituted a large mass. These documents were presented as a *corpus*, a body of evidence concerning arts practices in healthcare settings (see section 11.13). The healthcare professionals were invited to examine the body, laid out on the floor, to determine its health status and to create a clinical profile for the status of this corpus of evidence. The

²⁵⁹ It is provocative to position healthcare professionals as curators, but nonetheless through dialogue it became clear that at least some of them had responsibility for some of the following roles: commissioning, implementing, programming, mediating, installing and evaluating art projects. Note the etymology of the word finds its origin in *curare* - to take care of.

energy in this second workshop was much more fluid. Individuals had got to know each other a little better and were more forthcoming.²⁶⁰

The story that emerged from their examination described the body of evidence for arts practices in healthcare settings as requiring, supportive care. This is a technical term that is used in triage to describe admissions. Supportive care refers to interventions that help the patient achieve comfort but do not affect the course of a disease and is congruent with palliative care. In their words, the body was non-responsive, requiring intubation. Complex issues were presenting as there was multi-organ failure. The body would become a placement issue and as a consequence, a funding issue too. The body was homeless, not dead, but not responsive either. The challenges of working in a healthcare setting are disclosed in this close reading of text. The healthcare professionals could read the body of evidence and position it in their terms. They unveiled the institutional frame governing practices while considering what they could do with this body. Assigning a category of care to the body would determine its care path. However for some presentations there is no category and the body becomes stuck - as we did in our conversation at this point.

Sitting around, looking from the body to the wall sheets on which our analysis had been recorded it seemed that was that. No further action was possible. We sat in a quiet air of dejection. But then one individual called out: vital signs are ok, there's a slow pulse. Despite the interjection of another and the fact that the body was disjointed with no connection between parts, they decided that the body was young and resuscitable. It would need a coordinated response (even though one was not currently available). A long-term care plan would have to be put in place ultimately looking for the body to become self-caring with some supportive role for the HSE. Thinking hard about these new circumstances the suggestion was made that a different model was viable with multiple personalities including care, health gain and arts projects. The injunction

²⁶⁰ One individual opted out of this exercise as they felt the use of clinical language objectified the body.

came that we must pull out all the different strands through the HSE and Arts Council working together. There followed unresolved discussion on how the lead on these issues should be made. Should it be the preserve of an outside agency, HIQA for example, or should it reside within the HSE or the Arts Council, or some other agency?

The issue of placement is of great consequence. Does the support for practices reside within health institutions, arts institutions or some other external agency? A coordinated response is necessary to move the body on through the system, to ultimately become a self-organising entity that can have many different manifestations. Although there is support at a practice level, a lead needs to be taken on it. They could see the multiple presentations involved in these practices; that they were not uniform. The tension between healthcare, health gain and arts practices was expressed and will continue to be a preoccupation. The existence of these practices has led to a bottom up approach, as there appears to be little consciousness of them at a corporate level.

The urgency with which the healthcare professionals engaged in this imagined drama was truly staggering. As they sat around the body, they worked on sheets on the wall to chart the clinical status and care plan. The issues that arose were so relevant and so resonant with issues I had encountered elsewhere in my research, but were succinctly expressed here because they were practice based.

Overall during the two days the primary issues raised related to:

- A sense of isolation from colleagues involved in similar projects
- The inadequacy of ad hoc projects
- The unresolved question of evidence
- Whether censorship is appropriate
- Distinction between art therapy and arts and health practice
- Ownership
- Placement

While the foregoing narrative reads much like a report, the actuality of the experience was very different. In Workshop 2, the participants worked with greater freedom and autonomy than previously, performing voluntarily assigned and shifting roles related to the corpus of evidence and later in the afternoon, literally taking over the session in a spontaneous and frenetic action. I stood back while they designed, decorated and made a large box object with a tail which they then threw out of the window of the 2nd floor concrete building in an attitude of delightful, unrestrained and uncontrolled abandonment, probably taking no more than 30 minutes in all and in which each played some role. The fluidity of that day is hard to capture in words. I like to think of it as an uprising where participants cast off responsibilities, transgressing their roles to assert temporarily a nomadic subjectivity.

12.11.4 OUTCOMES

These workshops were devised prior to formulating the current theoretical framework. They were an attempt to understand the underlying assumptions that drive the impulse to implement participatory arts practices in healthcare settings from a service provider perspective.²⁶¹ The healthcare professionals articulated a series of issues across the two workshops, which they felt were important to address. In doing so they themselves emerge as caring, professional, systematised, cautious, vulnerable and enthusiastic.²⁶² In hindsight, I can see how this profile can be understood using Fox's (1993; 1999) formulation of the paradox of care, but at the time did not have the benefit of this analytic.

²⁶¹ My approach was emergent rather than fixed. This process of evolving research design is a characteristic qualitative inquiry: 'Rather than start with a research question or a hypothesis that precedes any data collection, the researcher is encouraged not to separate the stages of design, data collection and analysis, but to go backwards and forwards between the raw data and the process of conceptualisation, thereby making sense of the data throughout the period' (Mays & Pope 1995, p.8). The project proceeded on the basis of an encounter with healthcare professionals who have been commissioning and implementing arts projects in healthcare settings for a number of years using a qualitative approach in which the goal is to 'understand, not erase, differing perspectives' (Kuper et al. 2008, p.408).

²⁶² I am grateful to the healthcare professionals who committed and engaged, because of their interest in these practices. They opened a door to the possibility of rethinking these practices with energy and enthusiasm.

Thinking through each of the affinities for my own practice, previously foregrounded (in section 4.3), in terms of my intentions for the work, this intervention was only partially successful. The collaboration did not correspond with any ideal of practice, rather it shifted throughout.²⁶³ The first workshop was more participatory than collaborative a situation reversed in the second workshop. Yet the episodic nature of these encounters - happening over one day, each after an interval of two months and with no prospect of continuing - meant that it didn't go anywhere in terms of the contradictions I wished to address.²⁶⁴ In terms of ethics, while the workshops were constitutive of difference, it is not possible to say that they in themselves subsequently increased the productive capacities of participants to affect and be affected, nor is it possible to know in advance what this body of work can do, yet. I am confident in saying that the work did operate politically, connecting art to the wider social milieu and in particular prompting reflection on what art might mean for the healthcare professionals themselves rather than as a practice for 'other' people. As described above the healthcare professionals in workshop 2 moved beyond their familiar roles in a self-overcoming in which they performed roles and manifested actions outside their typical inclination. Still the most difficult issue in terms of working with healthcare professionals had been established as their accessibility and this would remain a feature that would impact on the tactics with which I would proceed. My next steps were to carry forward the substance of the issues identified and to be reconfigured for a wider healthcare professional engagement at the Faculty of Medicine in UCC.

²⁶³ Tait (2009) makes the case for shifting from a generalised 'ideal' of participatory practice in favour of what he terms molecular collaboration, which he characterises as being uniquely manifested through a particular set of relations, particular participants, and particular spaces whose parameters are fixed by the choice of setting.

²⁶⁴ Healthcare professionals attended these workshops as part of their professional role during work time.

12.12 WORKSHOP FEEDBACK

Meaning and value exists in the negotiation between what is accepted as art and what is 'not art', the relational field where the non-artist is acknowledged as a participant or co-producer and where the artist, the curator, the critic/writer enter that field on the same terms but with different intentions and baggage (McGonagle 2010, p.54)

January 20th CIT, Sullivans Quay, Cork

Group Contract

What I Need	What I will give
Participate in a different experience Research in action Networking opportunity Sharing information Clarity on the format/context for the day Direction / Pull Back Acceptance of limitations Openness Interested in artist perspective Clear communication Participation Risk	Time energy & enthusiasm Open to group with honesty Fun Companionship Give/take network Share experience and opinions honestly Openness to ideas of others Share knowledge of working in different areas Experience of arts and health Support Information Respect for differing opinions Listening Timekeeping

Round Robin Feedback

Didn't know wealth of practice happening

Artistic potential of different health experiences

Need to look at availability of resources (CDs / Audio Books)

Not necessarily expensive but resources are need to improve experience

Amazed that different practices exist in same organisation

No umbrella organisation to feed into

Change split between acute and community care results in no local interaction

Potential to bring art into work not explored before

Possibly because of lack of training / courses

A lot of information is available e.g. music is used to soothe & reduce blood pressure

Arts have been mostly used for the elderly

But there is a need to interact with other sectors

Acute services need to look at potential

Healthcare workers need exposure to opens minds to potential of arts

Opportunity to build identity as arts & health practitioners creating own network

Group I - Arts Council Strategy

Distinction made between arts & health and other sectors

Arts & health more of a journey – we don't need a 3rd anchor for arts & health – it can interact by itself – it doesn't need to produce

Art therapy differs in that there is a 3rd person involved in the process, whereas an artwork can have a direct impact

Concern was expressed about potential for negative impacts

Art is subjective / artists need to grasp reality of healthcare setting. Dark depressing and gory images are to be avoided

Who really knows how someone will subjectively react

Concern/ anxiety expressed about how people will react to art

Art can also create a discourse and dialogue – but that needs to be the aim of the project (too much reaction)

Is censorship an issue?

Healthcare professionals do not have time/energy to react to negativity around art – don't want to add to burden of people.

Arts & health can include work on whole family which impacts on patient.

Funding streams could be merged more

Contradictions in text

Emphasis on visual arts

Environmental enhancement is subjective

Interaction with artwork is not just with patient but with everyone who sees it

What is a good goal/good outcome?

- Process rather than product

- Censorship

- Health in broader context outside hospitals

- Arts can be about self as a practitioner too

Crossover could be allowed between arts and disabilities

Exclusion of arts therapy is seen as unnecessary the primary goal as therapeutic is not an accurate reflection of reality – what does clinical mean? Improve health / keep dignity

Arts & health does not require a referral whereas art therapy does.

Group II GUIDELINES FOR PARTICIPATORY ARTISTS / Values & Governance

Ownership of work – who owns it – can the artist sell the idea to other venues/owners?

Leadership development is needed , to advocate and push and lead

Policy document is unreferenced, we need to see evidence – who said this? Who is the reference?

The document doesn't aspire to be research based – this is a value that is missing from the document.

What is high quality art – who knows?

Information is needed for people who make decisions about art on standards and appropriateness in order to get value for tax payers money

The artwork need to be sustainable with a lasting impact

Information sharing might improve confidence in choices e.g. music vs visual arts.

Invest money in building capacity amongst people in healthcare so that it can continue on

Possible need for dedicated room for artwork in hospital – moving things is time consuming – projects could be based in this room

Helpful to have a focus – even if much art is brought to the bedside thru art carts etc

Need to know what resources are there

Need structure, to share info in a practical way, health & safety concerns, how to choose & how to maintain artworks

Each is having to make it up as they go along and shouldn't have to

Healthcuts will lead to art falling down the list of priorities

Art should be visible in health policy- or else there will be no evidence of benefit (like health promotion)

Need leadership and strategy nationally – it falls through a gap

Can art be sold afterwards if we need the money?

Don't know if we are doing it in the best way or the most efficient way.

Reliant on the interest of the individual

(National Arts Coordinators in Hospitals group)

Arts & health should span hospital and community

Time to define where we stand on arts and health

The Cork Arts & Health Project is trying to improve the flow of information, building up a picture of what going on

Model shows there is strength in numbers e.g. arts in mental health working group share information on best practice

We are in the early stages of arts & health in Ireland – a blue print won't work

If your professional training is systematised – it is hard to work in a way that arts need (process oriented rather than procedural)

THINKING ABOUT PRACTICES

The Big Picture

Emerging benefit for health

Development of understanding of arts and health and of training as a support

Need for integrated policy between Arts Council and HSE

National and local support frameworks

Wellbeing is the root of the big picture

Art is part of our work "the art of nursing" & needs to be seen as such

Should link all health sectors & not be polarised to smaller disciplines or marginalised to a concept of working with particular client groups e.g. mental health / eldercare

Part of the holistic care of service users & still in its infancy

Health and wellbeing for all users of health services

No national champion

Facts & Information

Limited

Facts are available but need to be disseminated through media, peers, other disciplines, modules at university

How can we coordinate & disseminate information flow to the wide range of arts and health practitioners. What media of information will work best?

Ebulletin / Arts Council Newsletter, / Arts Council website / new Irish arts & health website commissioned by arts council– lots of arts & health work in the UK is documented on web

Whose facts are they , who do they serve?

Inclusion of arts & health at the very outset of employment into the health sector at induction would be good

Perception

New Ideas

Strategy (National)

Funding (National)

Leadership (National)

Conceive of arts & health as an evolving web rather than as a structured programme

Allow arts & health to flow, be mobile and evolving

Avoid over systematisation

Promote the research that underpins arts & health – needs greater visibility

Local networking

Arts sharing

Integrate the arts into care pathways

Motivation & Leadership

Feelings & Emotions

Caution

Connectedness

Positive – see benefits for all involved in health journey

Sometimes elation / demoralisation

Enthusiastic

Excitement / animation / fear / frustration/

Fighting

Hoping

Defensive

The art makes me smile / happy/sad

Being Cautious

Little support from peers/supervisors

Health & safety

Vulnerable people

Confidentiality

Overload , confusion, lack of support structure, too much systematisation
could kill creative root of arts & health work

Ethics

Artist involvement

Economic climate Art priority decreases & workload increases

Dealing with artists infighting / self-employed

Cautious of own knowledge – knowing what is good/appropriate/value
for meoney

Understanding

Perception of other staff/patients

Public money

The current requirement of definite linking resources to defined objective
outcomes

The assumption that nurses could add this to their current workload
without resources – providing - existing level of service with less money

Overextending yourself or the project at the expense of a good outcome

Blurring of limitations

Exaggeration of outcomes

Sustainability of projects

In current service planning cancer and reconfiguring of services are
prioritised for resources.

Not getting the support you need for its implementation

Being Positive

There is strength in numbers

Huge benefits to participants
 Social inclusiveness
 Breaking down barriers
 Educating the public
 Empowerment of service users
 Promotes connectedness and positive engagement
 That we actually do have art in hospitals/healthcare settings
 Growing recognition of the potential contribution of the arts as the exiting
 arts (potentials & Growth)
 Building solidarity
 Identity & difference among Arts & health practitioners
 Creativity energises opens up
 New ways of thinking & seeing life & situations & understanding health &
 illness & wellbeing
 Legacy / contribution (I did that!)
 Inviting pleasantness / enjoyment to healthcare
 Some funding and support is available in the HSE

Evaluation in terms of the following objectives;

- Facilitate knowledge exchange
- Extend understandings of problems and possibilities of arts and health practice from healthcare professional perspective

What I have received/ learned	Needs not Met
<p> Wide variety of projects There are other people who work in arts & health that I didn't know about Knowledge of this is already happening in the health sector, but not all areas There are a good few projects that have been </p>	<p> I came today with an open mind. I have learned a lot out of the day. I hope I can be involved in this setting up in my area. </p>

<p>made known to me.</p> <p>Better sense of the limitations and partiality of my own perspective and approach</p> <p>Creative workshop really interesting questions / exercises / ways of recording</p> <p>Greater appreciation of the work that other healthcare practitioners are doing and greater understanding of the challenges that others face</p> <p>Pleasant social occasion</p> <p>How much we don't know about each other re possibilities that exist and willingness of those with interest</p> <p>Its OK to be involved in arts project</p> <p>Multiple approaches and perspectives: All are valuable</p> <p>Good to be asked to participate in a research project</p> <p>No-one has all the answers</p> <p>Diversity in services & possibility of future connections</p> <p>Would like us as such a diverse group who had just met to continue this pathway.</p> <p>There was great sharing and shared experiences here today</p> <p>Useful networking and exchange of ideas</p> <p>Mind opened to new ideas for acute sector</p>	<p>More information on the wide range of projects currently happening in the health service</p> <p>I did not have identified needs beforehand</p> <p>More time to get to know the work of the others in the group</p> <p>I came with no need to be met, I didn't seek policy information like other study days. Today I felt was about me simply and honestly giving my opinions and experiences</p>
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The way forward

Let the HSE South form strong collaboration links between all hospitals/ PCCC/ Integrated Services to introduce arts & health (the HSE south

being us!)

For Cork Arts & Health Project to provide greater support , solidarity , networking, information exchange and critical thinking through e bulletins, organizing seminars, events etc

Integration of all arts in to the medical/ ??? area

National support umbrella

More money please!

Collaboration and promotion of links between different disciplines please

Registrations

Name	Role	Service	Present
	a/Director Nursing		Y
	Practice Development Facilitator		Y
	Arts Coordinator		Cancelled
	Art Therapist / Arts and health coordinator		Y
	Community Worker		Y
	Senior Executive Officer		Y
	Community Mental Health Nurse		Y
	a/Director Nursing		Y
	Nurse Planner		Y

8 attendees / 1 cancellation

WORKSHOP 2**March 24th 2011 CIT , Sullivans Quay****Group Contract**

What I Need	What I will give
Participate in a different experience Research in action Networking opportunity Sharing information Clarity on the format/context for the day Direction / Pull Back Acceptance of limitations Openness Interested in artist perspective Clear communication Participation Risk	Time energy & enthusiasm Open to group with honesty Fun Companionship Give/take network Share experience and opinions honestly Openness to ideas of others Share knowledge of working in different areas Experience of arts and health Support Information Respect for differing opinions Listening Timekeeping

Reviewed documentation from previous workshop

I had already discussed the written feedback individually with participants prior to their coming into the workshop. I clarified that all had had the opportunity to read and discuss document individually and whether there was any issue arising for further discussion. There was not.

I showed video footage of photodocumentation from last workshop. I showed them the 'true' images and an x-ray modification which preserves participant anonymity. They were very pleased with this and found it quite entertaining and approved the use of footage beyond the confines of the workshop. I pointed out cameras currently in position.

Discussion of evidence / presence

Rayograph exercise

TYPES OF EVIDENCE

Scientific	Testimonial	Anecdotal	Intuition	Personal Experience
Research based fact	Controversial	Hearsay / Infleuntial	Intuitive care (health)	Old
Reputable		What other people say	Based on experience	Lived
Verifiable	Not always accurate	Opposite of scientific	Green/yellow/orange	Exposure to Events
Wealthy	Shade of darker side of life	Very Interesting	Light/depends /can be a response	Repeated Experience + Continuous exposure -> knowledge
International (probably not Irish)	Related to Skulduggery	Easier to understand/identify with	Unnerves you	Everything in Life is Personal Experience
Male/It(Androgenous)		Easier language	Unwelcome – copuld cause harm	
Heavy	Subjective	Light – not threatening	Maybe a risk attached to it	Mauve -> Purple
Blue/Black/Dark	Wealthy/costly	Multi-layered entertaining	Full self-respoonsibility	Colour depends on character of the experience because
Red Alert	Endless black hole	True to the experience of someone	Tipping Point / Edgy	not all are good
Black & White	There is another person	Subjective	Learning to Listen to yourself	Painful -> Good
Refutable	Male dominated	Truthful?	Entrepeunarial	Interviews
Can be misleading e.g. Food labelling	hierarchy topheavy	Conversational Dangerous	Expressive	Signifiacnt experience

<p>Antiaging creams Iatrogenic illness Depends on context Right/wrong provides an answer to a question Becomes part of who you are</p>	<p>Green – justice Lady Justice V. intrusive into private life Make public Chance to be heard Moral impact Give witness to Reference for someone</p>	<p>Unsubstantiated Safe Interpretive Flowing Telling a story Observational</p>	<p>Artistic Listen Differently Thinking outside the box High IQ</p>	<p>can be one off Integrate into life Rich Unique – shadows of your fingerprint V. Important Attuning /acknowledging personal experience Space to express experience so it becomes real If experience can't be understood it can become a blockage with potential negative consequences</p>
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Body of Evidence

Supportive Care

Time of arrival 9:32

Non-responsive

Airway non-obstructed 100% O₂ -> GCS 6 -> Intubation

IV access

Catheter

Skin Integrity

Social Hx (homeless)

At this point one of the participants expressed concern about the clinical approach to the body in the manner described above.

I set with her and tried to work through whether the facilitation or the exercise was at issue. – must clarify still

Complex issues presenting

Multi-organ failure

A compartmentalised system => Placement issue

Funding issue

Not dead but not responsive

Vital signs OK – pulse slow

Disjointed no connection between parts

Hard to distinguish part - > difficulty in placing him

But resuscitable – young and flexible

Requires a HSE coordinated response

That is not available

Individual Programs with same aims

Long term care plan – where does he fit in?

Ultimately self-caring but HSE has a role

Different model is viable

Multiple personalities – care/healthgain vs arts projects in healthcare settings

Pull out all the different strands

HSE & Arts Council work together

Happens from bottom up no governance

But need lead to pull together

Independent outside body – no stake

HIQA

Registrations

Name	Role	Service	Present
	a/Director Nursing		Y
	Practice Development Facilitator		Y
	Staff Nurse		Y
	Art Therapist / Arts & Health Coordinator		Y
	Community Worker		Y
	Senior Executive Officer		Y
	Community Mental Health Nurse		Cancelled
	a/Director Nursing		Cancelled
	Nurse Planner		Cancelled

6 attendees / 3 cancellation

12.13 SOURCES OF EVIDENCE

Edelle Nolan	arts & health documentation	6 February 2011
margaret@galwayartscentre.ie	arts & health documentation	6 February 2011
info@bluedrum.ie	documentation	6 February 2011
smacconghail@monaghancoco.ie	arts & health documentation	6 February 2011
kkennell@kerrycoco.ie	arts & health documentation	6 February 2011
mscott@northtippcoco.ie	arts & health documentation	6 February 2011
mnichona@laiscoco.ie	arts & health documentation	6 February 2011
oscannell@dublincoco.ie	Arts & health documentation	6 February 2011
morgan@waterfordcoco.ie	arts & health documentation	6 February 2011
brian.harten@louthcoco.ie	arts & health documentation	6 February 2011
jsherwin@wicklowcoco.ie	arts & health documentation	6 February 2011
krredmond@dlrcoco.ie	arts & health documentation	6 February 2011
sdeegan@limerickcity.ie	arts & health documentation	6 February 2011
jharrold@galwaycity.ie	arts & health documentation	6 February 2011
sinead.redmond@wexfordcoco.ie	arts & health documentation	6 February 2011
connornolan@waterfordcity.ie	arts & health documentation	6 February 2011
sally.oleary@southtippcoco.ie	arts & health documentation	6 February 2011
artsoffice@roscommoncoco.ie	arts & health documentation	6 February 2011
gbailey@meathcoco.ie	arts & health documentation	6 February 2011
amccarthy@mayococo.ie	arts & health documentation	6 February 2011
arts@limerickcoco.ie	arts & health documentation	6 February 2011
lodowd@leirimcoco.ie	arts & health documentation	6 February 2011
mary.butler@kilkennycoco.ie	arts & health documentation	6 February 2011
lrussell@kildarecoco.ie	arts & health documentation	6 February 2011
mgaughan@galwaycoco.ie	arts & health documentation	6 February 2011
rory.obryne@fingalcoco.ie	arts & health documentation	6 February 2011
sinead.connolly@dublincity.ie	arts & health documentation	6 February 2011
siobhan.mulcahy@clarelibrary.ie	arts & health documentation	6 February 2011
ian.mcdonagh@corkcoco.ie	arts & health documentation	6 February 2011
mmcauliffe@sligococo.ie	Arts & health documentation	6 February 2011
soreilly@offalycoco.ie	arts & health documentation	6 February 2011
Dara Carroll	arts & health documentation	6 February 2011
monica.mcgill@hse.ie	Arts Collection Scheme databank	6 February 2011
Maeve Dineen	arts & health spring clean!	6 February 2011

12.14 CORPUS OF EVIDENCE

These are the documents referred to in workshop 2

DOCUMENT	YEAR	AUTHOR / ARTIST / FUNDER
<i>Beag Early Years Arts Team: Report of a Pilot Project for Cork</i>	2011	Cork City Council HSE South Cork County Council
<i>Arts and Health Phizzfest Documentation</i>	2011	
<i>Evaluation Notes from 6 week trial music and health sessions in Bandon Alzheimers Day Centre</i>	2011	HSE South CA+HP Music Alive
<i>Beag Intermim Project Report</i>	2011	
<i>The Musical Playground, Paediatric Unit Cork University Hospital Documentation</i>	2011	Helium HSE South
<i>The Write Stuff: An Arts and Minds Project Documentation</i>	2011	Mahon Family Resource Centre
<i>Bandon Alzheimer Arts and Health Initiative Documentation</i>	2011	CA+HP West Cork Arts Centre Bandon Alzheimers Day Centre
<i>What's The Story? Documentation</i>	2011	Johnny Hanrahan Meridien Theatre Company St Finbarrs Hospital HSE CA+HP
<i>Music Sessions (Perrott House and Saol Nua) DVD Documentation</i>	2010	West Cork Mental health Services Music Alive
<i>Arts for Health: Conversations in Colour Evaluation</i>	2010	West Cork Arts Centre HSE South Cork County Council Cork Adult Education Services
<i>Hide & Seek II: An artists response to migraine Documentation</i>	2010	Waterford Healing Arts Trust
<i>Report and Findings: On the Edge of My Sky</i>	2010	Marie Brett
<i>Community Arts Clay Project Documentation</i>	2010	Glen and District Neighbourhood Youth Project
<i>Project Brief – Public Art – Per Cent for Art Scheme Cardiac / Renal Centre Cork University Hospital</i>	2010	HSE South
<i>Project Brief – Public Art – Per Cent for Art Scheme Tralee Community Nursing Unit</i>	2010	HSE South
<i>Evaluation: One of Our Ain</i>	2010	Dr Mary E Mulcahy HSE South CA+HP Social Inclusion Unit Cork City Council

DOCUMENT	YEAR	AUTHOR / ARTIST / FUNDER
		Arts Office Cork County Council
<i>Transition – Visual Arts Project , Final Report</i>	2010	Waterford Healing Arts Trust Grangemore Rehabilitation & Recovery Services Arts Council of Ireland HSE South
<i>Arts in Health Exchange Day</i>	2010	Kildare County Council Riverbank Arts Centre Arts Council of Ireland HSE
<i>The Post Room Project Documentation</i>	2010	Emily Robyn Archer Waterford Healing Arts Centre
<i>The Haiku Project Documentation</i>	2010	Denise Hall An Arts and Mental Health Initiative HSE South
<i>Final Report: Who Do You Think You Are? A participatory arts and health project for young people in Waterford</i>	2009 - 2010	Arts Council of Ireland Waterford Healing Arts Trust Waterford City Arts Centre HSE South Squashy Couch
<i>Report on a month residency with the Healing Arts Trust in Waterford Regional Hospital</i>	2009	Laura Fitzgerald
<i>Report for SOLAS: An exhibition of artworks selected by the members of staff at Naas General Hospital from the Kildare County Council Municipal Art Collection</i>	2009	Kildare County Council
<i>Who Do You Think You Are? Weekly Art Workshops Squashy Couch Youth Café Documentation</i>	2009	Arts Council of Ireland Waterford Healing Arts Trust Waterford City Arts Centre HSE South Squashy Couch
<i>Waterford Healing Arts Trust & Respond! Housing Association Community Arts Programme Evaluation</i>	2009	Arts Council of Ireland Waterford Healing Arts Trust Respond! Waterford County Council HSE South FAS
<i>Infant Imaginings: Music, Play and puppets for parents and babies (under 2 years) Documentation</i>	2009	Sligo County Council Social Entrepreneurs Ireland Helium Sligo RAPID
<i>Documentation of Open Studio Workshop March 2009 – June 2010</i>	2009 - 2010	Waterford Healing Arts Trust

DOCUMENT	YEAR	AUTHOR / ARTIST / FUNDER
<i>A Review of a Per Cent for Art Commission: HSE Pearse Street Primary Care Centre</i>	2009	Ruairi O'Cuiv HSE
<i>Life Force: Final Evaluation</i>	2009	Patricia Hunt Blue Drum Crooked House Theatre Dormant Accounts Fund Pobal
<i>What Training do artists need to work in healthcare settings?</i>	2009	Medical Humanities Vol 35 H Moss D O'Neill
<i>Project Brief – Public Art – Per Cent for Art Scheme Chamber House Healthcare Centre, Tallaght</i>	2009	HSE
<i>The Seen and the Unseen</i>	2009	Cork University Hospital
<i>An evaluation of the Forum Theatre production: Milk it! Much Ado About Nothing?</i>	2009	Barbara Whelan & Dr John Kearney HSE Dublin Mid-Leinster And the Area Breastfeeding Steering Committee in association with DIT
<i>Evaluation of Good Vibrations Creative Arts in Mental Health</i>	2009	HSE South Cork City Council Friends of GF Ward CUH National Lottery
<i>A Review of the per cent for Art Commission HSE Irishtown Primary Care Centre</i>	2009	Ruairi O'Cuiv HSE
<i>Once upon a time exhibition of artworks Waterford Regional Hospital Documentation</i>	2009	Waterford Healing Arts Trust
<i>Captured Time exhibition Dialysis unit Waterford Regional Hospital Documentation</i>	2009	Waterford Healing Arts Trust
<i>Arts and Health DRAMA initiative Tobacco (Health Service Standards) Proposal</i>	2009	Blue Drum HSE Irish Health promoting Hospitals Network Pfizer healthcare Asthma Society
<i>Arts and Health projects in Cork City and County Documentation</i>	2009	HSE South CA+HP
<i>NICHE Community Health project Outline of Arts Projects Documentation</i>	2009	
<i>Music in Healthcare Settings</i>	2009	Irish Times 31 March 2009

DOCUMENT	YEAR	AUTHOR / ARTIST / FUNDER
<i>Training programme</i>		
<i>WHAT's Art Newsletter</i> Jan – Mar 2008 Apr-Jun 2008 July – Sept 2008 Feb - May 2009 June – Sept 2009	2008/ 2009	Waterford Healing Arts Trust
<i>Punchestown Kidney Research Fund and the Hospital Arts Office Renal Dialysis Art Programme</i>	2008 / 2009	Lucia Barnes Adelaide and Meath Hospital incorporating the National Childrens Hospital
<i>Afternoons with Johnny DVD Documentation</i>	2008	Maximilian Le Cain
<i>The Rambling House: A Selection of photographs, poetry, prose and reflections from Court Writers Group Documentation</i>	2008	O'Connell Court Sheltered Housing HSE South CA+HP
<i>The per cent for arts scheme</i>	2008	HSE Staff Magasine The Pulse / Monica McGill
<i>Cork Arts + Health Programme Update</i>	April – Aug 2008	HSE South CA+HP
<i>Jenny Moran interviews Jenny Moran about Personal Effects</i>	2008	Create HSE West Galway City Council Galway County Council Galway University Hospital Arts Trust Galway University Hospital
<i>Time to Create: case Studies Celebrating the Creative Contribution of older People</i>	2008	Voluntary Arts Ireland Arts Council of Northern Ireland
<i>Ceol le Cheile Music Together Music in Mental Health Project Evaluation</i>	2008	Mike White, Durham University CA=HP Cork North Lee Mental Health Services Cork South Lee Mental Health Services Health Services National Partnership Forum North Cork Mental Health Services Psychiatric Nurses Association
<i>Poems in the Waiting Room Documentation</i>	2008	Kildare County Council
<i>Report on Poems in the Waiting Room</i>	2008	Kate Dempsey Kildare County Council
<i>A report on the Kildare County</i>	2008	Hilary Moss

DOCUMENT	YEAR	AUTHOR / ARTIST / FUNDER
<i>Council Arts and Health Steering Group</i>		
<i>The Green Room Project Catalogue with an essay by Prof Timothy Emlyn Jones</i>	2008	Rotunda Hospital ISANDS Kildare County Council Art Service
<i>Blood, Sweat and Tears an exhibition of artworks in response to the hospital context</i>	2008	KCAT Studio Artists Waterford Healing Arts Trust
<i>Passengers: A group exhibition on the theme of journey curated by a multi-disciplinary team from Waterford Regional Hospital</i>		Waterford Healing Arts Trust
<i>HE+ART: A Participatory Arts & Health Strategy for Sligo</i>	2007-2012	Sligo County Council
<i>A Cure for the Soul? The benefit of Live Music in the General Hospital</i>	2007	Irish Medical Journal Vol 100 no10 H Moss E Nolan D O'Neill
<i>Arts Office Annual Report</i>	2007 2009 2010	Adelaide and Meath Hospital incorporating the National Childrens Hospital
<i>Skibbereen Daycare Centre Arts Programme Evaluation and Recommendations</i>	2007	Kearney Consultants West Cork Arts Centre HSE South Cork County Council Cork Adult Education Services
<i>The Benefit of Creative Writing for Patients in a Cardiac Rehabilitation Department</i>	2007	Hilary Moss Adelaide and Meath Hospital incorporating the National Childrens Hospital
<i>Mapping Arts, Health, Older People Programming</i>	2007	West Cork Arts Centre
<i>A Cure for the Soul? An independent evaluation of the benefit of live music for patients in an acute hospital</i>	2006	Edel Nolan The Meath Foundation The Adelaide Society The National Childrens Hospital Appeal Fund South Dublin County Council Adelaide and Meath Hospital incorporating the National Childrens Hospital Irish Chamber Orchestra
<i>Conversations in Colour: Evaluation of an Arts for health</i>	2005/ 2006	West Cork Arts Centre HSE South

DOCUMENT	YEAR	AUTHOR / ARTIST / FUNDER
<i>Partnership Programme</i>		Cork County Council West Cork Adult Education Services
<i>Reflecting through Art</i>	2006	Cork Mental Health Association
<i>Mr Evil Loses Out</i> (A Raeoin Abbey production) DVD	2005	HSE South St Raphaels Colaiste Eoin South Abbey NS
<i>Puppetry Project Report</i>	2005	Adelaide and Meath Hospital incorporating the National Childrens Hospital
<i>Music in Healthcare / Mental Health: An evaluation of the participative music programme designed by Music Network</i>	2005	Orla Moloney Ste Stephens Hospital Carrigmore Centre Cork 2005 Culture + Health
<i>Billboard Exhibition Documentation</i>	2005	Mayo County Council Age and Opportunity HSE West
<i>Therapeutic Art Group for Patients: An Evaluation Report of a six-month pilot project</i>	Oct 2003 – Mar 2004	Hilary Moss Adelaide and Meath Hospital incorporating the National Childrens Hospital
<i>Arts & Health: Directory of Groups/Activities</i>	2001	Dublin Healthy Cities Project
<i>Mapping the Arts in Healthcare Contexts in the Republic of Ireland</i>	2001	Ruairi O'Cuiv Arts Council of Ireland Leargas Consulting
<i>Proceedings of a Arts & Health Conference: Creating a Healthier Future</i>	2000	Dublin Healthy Cities Project City Arts Centre Dublin South Dublin County Council Dublin Corporation Soilse/ Eastern Regional Health Authority Arts Council of Ireland Dun Laoghaire/ Rathdown Co Council National Health Promoting Hospitals
<i>An Evaluation Study of the Waterford Healing Arts Trust</i>	1999	Ruairi O'Cuiv Waterford Healing Arts Trust
<i>The Maugherow Project: Unwrapping Creativity an intergenerational approach pilot phase Resource Handbook</i>	1998-2001	Sligo County Council North Western Health Board St Paticks National School The Arts Council of Ireland
<i>W.H.A.T's art?: A study of an arts and health initiative at Waterford Regional Hospital</i>	1990-2000	Waterford Healing Arts Trust Arts Council of Ireland

DOCUMENT	YEAR	AUTHOR / ARTIST / FUNDER
<i>Doing The Rounds: An Exhibition of Extracts from the Art Collection of the Waterford Healing Arts Trust Documentation</i>		Arts Council of Ireland HSE Waterford Healing Arts Trust Galway Hospital Arts Trust Mater Campus Hospital Development St James Hospital
<i>Between Colours: Mayo County Council Artists Mentoring and Networking Programme</i>		Mayo County Council Arts Council of Ireland HSE West Age & Opportunity
<i>Culture + Health Strand: A Study of 32 projects in diverse healthcare settings</i>		Cork 2005 Europa Capital of Culture HSE South
<i>Burning Bright Documentation</i>		Galway County Council Age Action West
<i>Creative Reverie: Meeting the Person as Artist Documentation</i>		Arts Council of Ireland Mayo County Council
<i>Moving Further: An evaluation of a dance and a creative movement programme for people in the Southern Health Board Region</i>		Southern Health Board Institute for Contemporary Dance
<i>From The Hill Of Wild Berries: Readings from K.T.A.C Writers Enniscorthy edited by Sylvia Cullen CD</i>		Arts Council of Ireland HSE Wexford County Council National Lottery Shine
<i>A Great Start To The Week Monday Morning Group DVD Documentation</i>		Mountain Man Media
<i>I'm Not Much Of A Singer But ... Documentation</i>		Music Alive
<i>Let the Music Keep Your Spirits High CD Documentation</i>		Mountain Man Media
<i>Talking Lips Carnival Created and performed by Melissa Baker Documentation</i>		Arts Council of Ireland West Cork Arts Centre
<i>Tea Dance 2009 CD (Documentation only)</i>		Dun Laoghaire Rathdown Co Council
<i>Lifeforce: A devised theatre piece that explores issues of wellbeing and suicide prevention</i>		Blue Drum Crooked House Theatre Dormant Accounts Fund Pobal
<i>Crossing the Line: An Evaluation of a Music in</i>		Kevin O'Shanahan PNA Journal

DOCUMENT	YEAR	AUTHOR / ARTIST / FUNDER
<i>healthcare programme in Mental health Settings, Waterford City</i>		
<i>The Value of Art</i>		Waterford Healing Arts Trust
<i>WHAT Comparative Record of Participation in Participatory Programmes Jan-Jun 2008 / Jul-Dec 2008 / Jan-Jun 2009</i>		Waterford Healing Arts Trust
<i>A Menu of Poems Documentation</i>		Waterford Healing Arts Trust Galway University Hospital Arts Trust St Patricks University Hospital Waterford County Council The Adelaide and Meath Hospital Dublin St Lukes Hospital Kilkenny
<i>The Bedmaker: Documentation</i>		Monkeyshine Theatre Tallaght Community Arts Adelaide and Meath Hospital incorporating the National Childrens Hospital Irish Chamber Orchestra
<i>Report on the Bedmaker</i>		Monkeyshine Theatre Tallaght Community Arts Catherine Garland Adelaide and Meath Hospital incorporating the National Childrens Hospital Irish Chamber Orchestra
<i>Arts and Health: Some Ideas for Course Module</i>		Create Arts Council of Ireland
<i>Music in Healthcare proposal for CUH Paediatric Unit</i>		
<i>Moving Memories Report</i>		Kildare Co Council Rathangan, Allenwood & Carbury Day Care Centres
<i>Cork Arts + Health Project e-bulletin no 1 & 2</i>		HSE South CA+HP
<i>Creative Therapy and the Ulysses Pain Programme</i>		Hilary Moss Adelaide and Meath Hospital incorporating the National Childrens Hospital
<i>Postgraduate Certificate in Arts in Healthcare Settings Course Information</i>		NUI Maynooth (Kilkenny Campus)

12.15 CRITICAL SOCIAL SCIENCE PERSPECTIVES ON PUBLIC HEALTH COURSE OUTLINE

Orla O'Donovan, School of Applied Social Studies, University College Cork.

Overview of module, SS6017 / SS6028

This module introduces students to critical social science perspectives and demonstrates how they can be a resource for the analysis of interventions made in the name of public health. In the words of the influential social theorist Erich Fromm (1970), these perspectives "can be characterised by the motto: *de omnibus dubitandum*; everything must be doubted, particularly the ideological concepts which are virtually shared by everybody and have consequently assumed the role of indubitable commonsensical axioms." This does not entail radical questioning of ideas and how things are done for its own sake; instead it aims to open up space in which to think how things might be done differently. Common sense and taken-for-granted ideas in the field of public health therefore provide the key focus for our discussions. In the course of the module a series of radical critiques of public health are reviewed, and students are encouraged to reflect on and respond to them. For example, we consider the argument that public health measures focused on promoting "risk management" lifestyle choices are dividing practices that separate out "responsible citizens" from those who are unable to or fail to accept the new moral responsibilities of citizenship. So too is the assertion that "empowerment" in the field of public health has become a matter of "experts" coaxing their "clients" to conduct themselves in accordance with professionally ratified techniques for self-management. Specific Irish and international public health interventions are used as illustrative examples throughout the module. Our discussions will consider not so much what these interventions do, but their cultural effects, what they say about social inequalities, public and individual responsibilities, democracy, expertise, science, power, progress, health, and other issues of central importance to public health.

LECTURE TOPICS

What is a critical social science perspective?
 Taken-for-granted ideas about "consumer empowerment"
 Taken-for-granted ideas about "evidence-based healthcare"
 Taken-for-granted ideas about "development"
 Taken-for-granted ideas about "expertise" and "professionalism"
 Taken-for-granted ideas about contemporary "epidemics" (obesity)
 Taken-for-granted ideas about contemporary "epidemics" (Alzheimer's disease and dementia)
 Responding to radical critiques of public health

READINGS

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13 PUBLICATIONS

13.1 UNREASONABLE DOUBT

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POLICY

Arts practices in unreasonable doubt? Reflections on understandings of arts practices in healthcare contexts

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This article suggests that the discourse on arts and health encompass contemporary arts practices as an active and engaged analytical activity. Distinctions between arts therapy and arts practice are made to suggest that clinical evidence-based evaluation, while appropriate for arts therapy, is not appropriate for arts practice and in effect cast them in unreasonable doubt. Themes in current discourse on “arts” and “health” are broadly sketched to provide a context for discussion of arts practices. Approaches to knowledge validation in relation to each domain are discussed. These discourses are applied to the Irish healthcare context, offering a reading of three different art projects; it suggests a multiplicity of analyses beyond causal positive health gains. It is suggested that the social turn in medicine and the social turn in arts practices share some similar pre-occupations that warrant further attention.

Keywords: arts; health; evaluation; aesthetics; public health

Introduction

In the spirit of interdisciplinarity, which is espoused as a founding principle of this journal, this article seeks to claim a space for arts practices within the discourse on arts and health. To date, analyses of practice have largely relied on using approaches that employ methodologies originating in evidence-based medicine (EBM) to establish positive health gains; while this may be an appropriate methodology with which to validate arts therapy, it is not congruent with contemporary arts practices.

This article is necessarily a summary, as much ground needs to be covered to establish key concepts. To understand arts practices in healthcare settings, it is necessary to have an understanding of the reformulation of what is meant by health and the institutions and practice of healthcare in tandem with a nuanced awareness of the concerns of artists/art theorists and art institutions regarding arts practices in the social realm. The specific subject domains of “arts” and “health” do not exist as concrete entities, but are shifting, amorphous and contested, subject to competing knowledge claims within their own disciplines. I am adopting an approach that specifically addresses arts practices in health care settings, “not exclusively as an artistic genre but as a ‘problem idea’” (Kwon, 2002), that warrants greater attention than advocacy, cooption and assimilation. I am not concerned with establishing whether there is a causal relationship between arts practices and health outcomes; rather, my focus is on how these practices can be understood.

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In the first section, a distinction is drawn between arts therapy and arts practices based on policy, academic comment and practice-based observation. The aim is to distinguish between what on the surface appear to be similar activities, but are in effect quite different in their purposes, processes and outcomes. As intentions for arts projects differ, so too do expected outcomes; it is not a matter of privileging one approach over the other, rather it is a question of parity of esteem between disciplines (McGonagle, 2007). I suggest that a claim for a research agenda that foregrounds arts therapy and clinical evidence-based practice does not adequately reflect all the interests of this diverse field and specifically places arts practices in a position of unreasonable doubt.

In the second section, I discuss different approaches to understanding what is meant by the concept of “health”, the changing role of health services, the emergence of a social model of care in distinction from the traditional medical model and the influence of the meta narrative of the knowledge economy as it is operationalised through EBM. The *Open Window* arts project (St James Hospital, Dublin, Ireland) is discussed in light of the imperative to evaluate arts projects using the analytical framework of EBM.

In the third section, critical discourses relating to participatory arts practices are discussed in relation to two arts projects, *The Lost Children* (St Finbar’s Hospital, Cork, Ireland), and *Training to be a Service User* (RehabCare, Cork, Ireland).¹ One of the primary challenges for practice is validation. As a general case, I draw on literature synthesising analyses of the social impact of the arts, followed by the particular case of subdomain analyses of the impact of arts practices on health.

Arts Practice and Arts Therapy

Putland (2008) identifies the risk of an “eclipse of art” as a consequence of different knowledge systems competing to dominate discussion of practices. The possibility of diminishing arts practices to a subservient role can be reduced if these knowledge systems and their fields of operation are recognised. As a step toward this end, a distinction is made between arts practices and arts therapy. The Arts Council of Ireland makes this distinction by indicating that arts therapies are a therapeutic intervention informed by the practice of psychology, psychotherapy and psychiatry. Arts therapists work alongside other clinical grades in the planning and delivery of patient care plans. The Arts Council of Ireland (2003, p. 113) further clarifies:

From the perspective of a therapist, the intention is primarily therapeutic in that art is used as a means of communication and expression. Positive enjoyment of art is a bonus added to the value of their work. For artists, on the other hand, the primary intention is artistic and any therapeutic effect is seen as a bonus.

This analysis of the divergent roles of arts therapy and arts practice is shared by leading commentators in the field. Dileo and Bradt note that “arts therapies are inherently different in nature from arts in healthcare practices, therefore, each field and discipline needs to create and embrace its own body of literature” (2009, p. 177). White (2009) suggests that the confusion of arts therapy with arts practice has its origin in early hospital-based projects. He suggests that this confusion led to a burden being placed on the arts to demonstrate that they have a viable role in treatment that would require evidence of these benefits.

How these differences are made manifest in practice became the subject of attention in a collaboration between artist Marie Brett and arts therapist John McHarg, who worked together on a project over an 18-month period (at Bawnard Day Unit, St Raphael’s Hospital, Youghal, Ireland, 2008/2009). One of the outcomes of this collaboration was an analysis of the role of the artist and the arts therapist (Brett & McHarg, 2010). To the

outsider their work may seem similar, but for themselves and their professional practice they adopt entirely different approaches.

Their analysis highlights important factors such as work practices, duty of care, supervision and support, and aesthetic vs. therapeutic concerns as follows. The work practices of the artist and the arts therapist differ in that an artist usually works freelance as an individual on short-term contracts, whereas the arts therapist is typically a staff member working as part of a professional team. Supervision and support differ in that artists typically work in isolation, often without collegial professional support, while the arts therapist is professionally supervised. Artists do not bear a clinical duty of care, the artist–participant relationship begins without prior knowledge, the artist has no access to confidential medical information and their relationship develops over the course of the project. An arts therapist–client relationship is defined in advance; the arts therapist is focused on the client in a “serving role”. A client comes to arts therapy because of a specific concern; the arts therapist can access medical records and uses art making as a tool for recovery. For the artist, the primary concern is the artwork and the development of their own arts practice, an artist will comment on the artwork being made, making aesthetic judgements and influencing the process/outcome. An artist will push boundaries aiming for a balance between challenge and support for participants to work at the edge of their creative potential. For an artist, the artwork produced stands on its own merit. The arts therapist, on the other hand, aims to develop a therapeutic relationship and maintain a safe place for the client and the artwork. The arts therapist does not make judgements on the artwork produced by the client. Both the arts therapist and client use the artwork produced in a number of ways, interpretatively and symbolically, as a tool.

The foregoing summary of the analysis of Brett and McHarg (2010) clearly demonstrates practical differences in the art-making approaches of an artist and arts therapist. These characteristics, in conjunction with the policy frame outlined by the Arts Council of Ireland and the academic analyses previously referenced, establish a case for distinguishing arts practices and arts therapy. The clinical evaluation of arts therapy outcomes is appropriate as they have a clinical purpose. Arts practices, however, cannot be evaluated in the same way as they are concerned with different motivating forces.

How then might these arts practices be formulated? There are many possibilities, but, for example, thematically, arts practices could address disciplinary perspectives on health by opening a discursive space that can comment and critique the evolving relationship between medicine and society. These can operate at both the level of the individual and of collective experience. An individual narrative of illness is exemplified by the work of UK artist Jo Spence, who documented her experience of terminal cancer through photography, bringing her body to research “in an immediate and shocking way” (Bell, 2002, p. 23). An analytic of collective experience can be seen in the work *Cradle to Grave* at the British Museum (Pharmacopoeia, 2003).² The installation consists of a lifetime supply of prescription drugs based on the fictional biographical life course of a man and a woman. Over 28,000 pills are woven into fabric and displayed in a glass case 13 m in length (Mordhorst, 2009). Neither of these two artworks had the intention of seeking a therapeutic health gain, yet they can contribute to critical discourse on health and healthcare. Clearly, arts therapy and arts practice are very different in substance, yet each can undoubtedly play a different role in the context of health and healthcare.

Approaches to Health, Healthcare and Evidence-based Medicine

How we understand health is a central problem in the philosophy of medicine and the sociology of health and illness. Definitions exist on a continuum from a scientific naturalist

approach to a normative understanding with many hybrid definitions in between. The naturalist approach is exemplified in the biostatistical theory of health in which health is defined as a statistically normal function of species design, and “health” and “disease” are characterised as empirical, objective and value-free concepts (Boorse, 1997). A normative approach to the concept of health is illustrated by Nordenfelt (2001) when he argues that a healthy person is one who can satisfy “vital goals”, which are necessary and sufficient for minimal happiness. Interpretations offered under the rubric of the social construction of health offer socially and culturally embedded analyses of how we understand health at a given point in time and in a given place (Berger & Luckmann, 1967), e.g. masturbation, homosexuality, drapetomania and sluggish schizophrenia were all classified as disorders at one time, but now the first two examples are understood as expressions of sexuality and the second two as expressions of a desire for freedom.³ The above characterisations are only briefly cited as an indication of diverse approaches and understandings of what is meant by health and are the first point of entry to a discussion on arts practices in healthcare settings.

Secondly, the role of healthcare institutions has changed rapidly consequent to the demographic transition which has led to a change in the pattern of disease characterised as the epidemiological transition⁴ (Jamison, Creese & Prentice, 1999). Health services are no longer predominantly providing interventions to acute episodes and infectious diseases; rather, they concern the provision of services for people with chronic and degenerative illnesses. Prolonged longevity as a result of improved medical interventions and increased affluence has changed the balance of service delivery. As chronic and degenerative diseases have replaced infectious disease, life expectancy has increased and a greater emphasis is being placed on prolonging active life expectancy. From a health services perspective this is about maintaining individual independence, for the individual it is more about autonomy, especially because as one ages, health gains are likely to be proportionately greater from improvements in quality of life rather than length of survival (Evans, 1993).

The changing character of healthcare services has had a consequent change on the model of healthcare provided. Emergent themes in healthcare research point toward a social model of medicine in distinction to the interventions of the medical model (Blaxter, 2010). The medical model of health focused on the eradication of illness through diagnosis and effective treatment. Its origins are found in germ theory, which gave rise to the doctrine of specific aetiology: for every disease there is a single and observable cause that can be isolated. In contrast, the social model emphasises multiple and interrelated factors that influence health and points to changes that can be made in society to make a population healthier. Public health advocates have established a body of literature which emphasises the lifelong importance of the social determinants of health on health outcomes.⁵ One of the key determinants of health is equality: the more equal a society is, the better are its health outcomes; the more unequal a society is, the poorer health outcomes will be for all citizens independent of individual affluence (Wilkinson & Pickett, 2009). The benefits of investment into particular pathologies have been shown to be less effective than investment in improving the determinants of health, thus health has become less a corporeal concern, and more a social issue.

Thirdly, the hegemony of the knowledge economy has had a particular inflection on the domain of healthcare. In addressing the context for arts practices in healthcare settings, consider what are the accepted modes of acquiring and arranging knowledge within the medical domain? These can be characterised by the umbrella term evidence-based medicine (EBM), which describes the explicit process of applying research evidence to medical practice in an attempt to standardise practices and manage uncertainty (Timmermans & Angell, 2001). Research practices that generate income skew the

knowledge base and the application of that knowledge through practices and products. This approach to the practice of medicine can be seen in contrast to experiential approaches where decision-making is based on the experience of the practitioner relative to the particular patient and pathology. EBM has become the dominant frame in which medicine is researched, discussed and practiced and has a significant role to play in understanding how arts practices in health care settings have been interpreted.

Although EBM is the dominant form of knowledge validation, it is not without its critics even within the medical domain itself. According to Cohen in an analysis of criticisms of EBM, five critical themes emerge: (1) it has a poor philosophic basis for medicine; (2) the definition of evidence is too narrow; (3) it does not meet its own empirical tests for efficacy; (4) its utility in individual cases is limited; and (5) it threatens the autonomy of the doctor–patient relationship (Cohen, 2004, p. 37). A social movement perspective is offered by Pope (2003), who analyses the rise of EBM disclosing power struggles between different factions within the medical profession and beyond. She suggests that resistance to the EBM movement was related to how evidence was specified as rational/technical rather than contingent/experiential. Denny (1999) provides a different reading of the rise of EBM. He suggests that EBM operates as a discourse responding to specific contemporary challenges to medical authority. It can be understood as an attempt to re-establish medical dominance in relation to patients, other health professions and practitioners of complementary therapies as well as maintaining status of privilege and authority in society at large.

Medical humanities has emerged as a countermovement to the dominance of EBM by advocates of patient-centred practice, “to encourage curiosity about the human condition and healthy skepticism about the nature of medical ‘truth’ and to model acceptable moral behaviour” (Kidd & Connor, 2008, p. 51). Other commentators suggest that medical humanities can be formulated as additive or integrative. Additive refers to the practice of medical humanities where the objective is to produce more empathetic doctors, whereas integrative suggests encounters with the knowledge base of medicine itself (Greaves & Evans, 2000).

I cite these critical perspectives of knowledge claims within the sphere of medicine, as an insight to the internal discourses that take place within the domain of “health”. When understood as a practice of power, it is easy to understand why EBM gives rise to a tension in the articulation of arts practices in healthcare settings. This tension is discussed in relation to arts practices in community healthcare settings by Putland (2008), who highlights the pre-occupation by health advocates with establishing evidence based research and arts advocates that are concerned with the encroachment of reductive measures and narrowly defined objectives for arts practice.

The radicant⁶ advance of arts practices to healthcare settings presents a challenge to prevailing clinical orthodoxy. In order to remedy this situation, the discourse on arts and health is required to conform to that of the medical establishment, with the compliance of artists and arts institutions, to embrace the vocabulary of evidence-based clinical practice. This positivistic approach to activities that take place within clinical settings places an obligation on arts and health practices to conform to a clinical standard of evaluation. Thus we find, when reflecting on arts and health practices, the discourse is dominated by claims for positive clinical outcomes for patients.

For example, the arts project, *Open Window* (Roche, Napier, Maguire & McCann, 2008) at the National Bone Marrow Transplant Unit in St. James Hospital, Dublin brought together members of the National College of Art and Design, Trinity College Dublin and St James Hospital, to create arts-centred research to help patients deal with being in protective isolation. The *Open Window* project was subject to a randomised control trial

whose central research question was to assess whether the artworks had an impact on the recovery of patients, even though the original specification for the commission did not include this element. Randomised control trials are the basis for validating medical knowledge and rank highly in the hierarchy of evidence based medicine.

The artist noted that when creating an artwork that was accountable concurrently within the medical and artistic community, not only did he have to contend with the functional physical architecture of the hospital building, but also a second architecture composed of staff protocols and management structures. However, Roche was able to make a conceit on this idea of architecture when he created an inflatable sculpture, which doubled as a meeting room, in which the review committee discussed submitted artworks. Roche's purpose for the sculpture was to provide a space that could suspend the influence of the prevailing physical and psychological architectures in the application of normative criteria to the process of selection of artworks. Pressure to present positive evidence-based clinical outcomes is critical to sustain funding and to legitimate arts and health projects. In order to normalise this encroachment into the medical domain, projects are given legitimacy through clinical discourse. The key question asked of this artwork was whether it was clinically useful and indeed during the Vital Signs 2009 conference exhibition, a core element of the project was exhibited as *A Clinically Useful Artwork? Part 1 & 2*.⁷ This succinctly illustrates how biomedical discourse becomes the dominant mode of understanding arts practices in healthcare settings.

The discussion in this section broadly introduces themes from philosophy and sociology that indicate that the domain of health is an arena of complex contested claims to knowledge, regarding concepts of health, models of health care and validation of practices. I have offered a reading of an artwork that suggests that arts practices are subject to clinical knowledge claims through EBM, as a practice of power. My intent in this article is to divert attention from this dominant approach to claims for individual health gains, to an approach that can address the complexity of health and healthcare on the basis of an aesthetic.

The Social Turn in Contemporary Arts Practices

This section considers contemporary participatory arts practices in the social realm in general and in healthcare settings in particular in light of critical discourse on these practices. I am foregrounding these practices over and above other practices because the Arts Council of Ireland has singled out participatory arts practices as the predominant artform adopted in healthcare settings (Arts Council of Ireland, 2003). The discussion highlights the highly contested nature of the field. Validation of these arts practices has presented both a philosophical and methodological challenge that remains unresolved, particularly when value is deemed to be analogous with economic value.

The prevalence of participatory arts practices is not a phenomenon peculiar to healthcare settings, it is indicative of a widespread shift in artistic practice in general. These changes, in becoming increasingly participatory, have given artistic practices a new identity and character and represent a notable change from the artistic practices of previous decades in which the artist was studio based and audience engagement was mediated solely through the artwork itself. This shift in arts practices has been conceptualised in a number of different ways. Nicholas Bourriaud, Grant Kester and Claire Bishop are leading theorists in this field.

Bourriaud (2002), reflecting on the changing arts practices of the 1990s proposes that artworks are judged based upon the inter-human relations that they represent, produce

or prompt. Bishop (2004), reflecting on these ideas challenges the significance of the relations formed in the process, while Kester (2004) proposes a dialogical aesthetic, a performative, process-based approach in which artists become context providers not content providers.

In describing his conceptualisation of relational aesthetics, Bourriaud contextualises arts practices in a historical context. He eschews conceptions of artistic activity as an “immutable essence”; rather, he views it as “a game whose forms, patterns and functions develop according to periods and social contexts” (Bourriaud, 2002, p. 11). Relational art reflects the concerns unique to this period in time and may be described as a set of artistic practices, which theoretically and practically originate in human relations and their social context. Bishop suggests that aesthetics can offer the ability to think contradiction and negotiate the social constructs of our time (Bishop, 2006), but nonetheless retains a sceptical outlook. She decodes the conviviality of socially engaged practices as the imposed consensus of an authoritarian order, sheathed beneath recurring ethical themes in critical discourse. Bishop describes these as “well intentioned homilies espousing Christian ideals of self-sacrifice and ‘good souls’, in contrast to the contradictions that naturally arise from the artist’s intentions” (Roche, 2006).

The Lost Children by Marie Brett (Figure 1)

The Lost Children (Brett, 2007) took place with artist Charlotte Donovan, patients, staff and visitors at St Finbar’s Hospital, Cork. Participation was not predicated on an easy and relaxed subject matter. The artwork was a response to an embedded social memory. It uncompromisingly addressed the terrible legacy of Magdalene Laundries. Sculptural



Figure 1. *The Lost Children*.

artworks composed of plaster of paris moulds of children's dresses were created in response to the memory of unmarried pregnant girls, abandoned by their shamed families, their babies taken at birth to be sold or given away. This was at a time in Irish history when the authority of the Catholic Church was beginning to crumble under the weight of its hidden history of institutional abuse. The artwork proposed a medium of expression for those who had been shunned and forgotten and contributed to a new narrative that challenged institutional authority, enfranchising the disenfranchised. This project, although convivial in nature, did not suffer the "imposed consensus of authoritarian order" as Bishop feared; rather, it revealed an uncomfortable truth.

Bishop (2010) offers a reading of the social turn in contemporary art practices, describing how "the project" became the descriptor for the kind of artistic practices that engage with the social after the 1990s. It is an umbrella term for describing arts practice in relation to society through various modes, through elective practice, self-organised activities, documentaries, transdisciplinary research practices and participatory and socially engaged art. She notes that the paradox of participatory art in general is that the more participatory the artwork, the more it forecloses spectatorship and the less open it is to future audiences. This is a particular challenge for arts practices that take place in healthcare settings, as in addition to the process-oriented nature of practice, projects usually take place in contexts far from public gaze.

Training to be a Service User by *Colette Lewis* (Figure 2)

In July 2001, the management of a number of sheltered workshops for people with disabilities moved from a model of supported work practices to a model with a developmental and therapeutic focus. At the initial stage of this transition, people in the



Figure 2. *Training to be a Service User.*

workshops were concerned about what the changes in management would bring. In *Training to be a Service User* (Lewis, 2004), dialogue was recorded based around the changeover relating to identity and work. Ambiguities about the terms “trainee” and “service user” were teased out. Using the hand as a symbol of the relationship between physical ability and work, each participant explored their hands on video in terms of the shape, form, mobility, improvised movement and stories remembered about their hands. Using a camera connected to a TV monitor, participants could interact with their own image-making process. The outcome of the project claims as much for the process as the final artwork.

Training to be a Service User provided a safe space in which questions could be asked and criticisms made, that would not have been possible in another context; but clearly a collaborative encounter or conversation does not necessarily constitute an artwork or art practice. Kester (2004) proposes a dialogical aesthetic by declaring that it is not the dialogue but the degree to which emancipatory insights can be catalysed through dialogue that distinguishes a project as a work of art. His starting point lies in the assumption that aesthetic experience can challenge conventional perceptions and systems of knowledge. Artistic practices incorporate provocative assumptions about the relationship between art and the broader social and political world and about the kind of knowledge that aesthetic experience is capable of producing. The artist’s role in catalysing emancipatory insights is critical in this process. Contemporary artists and art collectives can be “context providers” rather than “content providers” located outside the institutional confines of the gallery or museum and separate from a tradition of object making, to carve out a new role in the facilitation of dialogue among diverse communities.

Beech (2008) is critical of the participatory project claiming that it is doomed by virtue of the inherent contradiction of participation. The price of participation is the neutralisation of difference and the diminution of the power of subversion; he further maintains that although Bourriaud’s conceptualisation of relational aesthetics includes a critique of the commodified art object, the practice of relational art is in fact extending the commodification of art by incorporating social events and exchanges into the field of art’s commodities. In a similar vein, Fraser (as cited in McIntyre, 2007, p. 38) notes the increasing tendency of arts practices to incorporate some aspect of service provision. These criticisms are cautionary for artists working in healthcare settings.

McGonagle (2009) reflects on the social turn in arts practice, in an analysis of the work of Canadian artists, Condé and Beveridge,⁸ whose work is an exemplar of the reconfiguration of arts practices, being both participatory and collaborative, reconnecting aesthetic values and ethical responsibilities to lived experience, “These are artists who engage in social processes and see no contradiction in their practice being validated as art” (2009, p. 35). This social turn requires a reconsideration of arts practices in relation to a repositioned understanding of art and its functions in the human project over the longer term. It differs radically from conventional understandings of arts practices in which the validation of artworks is mediated through the market, the academy or peer recognition. Much of this work is process led with a lesser emphasis on specific material outputs. As a result, they are not easily validated in an environment where merit is primarily accorded to artworks that have commercial value. Condé and Beveridge have succeeded in securing validation for their work by positioning it within the distribution zone where validation is conferred and using dissemination strategies beyond that of the exhibition. McGonagle proposes “A New Deal” for models of art and institutional practice that “foreground participation, engagement and commonality” (McGonagle, 2007). Nevertheless, participatory arts practices are not universally met with enthusiasm. Antagonisms emerge regarding conceptualisations of practices as socially useful rather than emancipatory in intent (Meade & Shaw, 2007).

These antagonisms can be seen in the literature on the social impact of the arts. The advent of New Labour in the UK inaugurated a period of commissioning policy reports that sought to validate investment in the arts on the basis of desired social outcomes (Landry, 1993; Matarasso, 1997). Much research attempted to address the impact of social arts practices and debates surrounding appropriate and rigorous methodologies abounded. Many journal articles synthesise and review this research (Merli, 2002; Mirza, 2006; Reeves, 2002; White & Rentschler, 2005). White and Hede (2008) suggest that research has been reoriented over the past 30 years, from an empirical emphasis on positive economic impacts during the 1980s, followed in the 1990s by trends in more socially oriented government policy leading to evaluation of positive social impacts which was subsequently replaced by a current pre-occupation with establishing *a posteriori* knowledge of the relationship between the individual's definition, experience, and impact of art.

Rather than focusing on methodological issues, Belfiore and Bennett (2008) have addressed the social impact of the arts in an intellectual history of claims regarding debates about the value, function and impact of the arts and by examining the many different ways in which the social impact of the arts have been articulated. They conclude that this is a dialectic that has existed as long as Western civilisation. From Aristotle and Plato through to contemporary censorship boards, the "good" and "evil" influence of the arts has been a source of debate in society. They suggest that an approach informed by advocacy is futile; rather, an active and sustained engagement with the history of ideas is necessary to gain any real understanding of the value of the arts.

Much of the early literature in relation to arts and health practices was similarly concerned with establishing an evidential base to state the health benefits of arts practices (Clift, 2005; Macnaughton, White & Stacy, 2005; White, 2006a, 2006b). In a guest editorial of the Journal *Health Education*, Clift (2005, p. 330) expresses sentiments widely held regarding the issue of evidence, but frames it within the context of individual health benefits:

Everyone with an interest in arts and health is exercised by the issue of "evidence" and the need both to demonstrate the effectiveness of arts-based interventions for health and to understand the processes by which engagement in the arts and creative activity can be beneficial for health.

Typically, research was framed to prove the health benefits of arts activity with the aim of becoming part of health service delivery (Eades & Ager, 2008). Attention focused significantly on methodological issues of measurement with a wide variety of scales used. The World Health Organisation Quality of Life Index (WHOQOL) was suggested as an international reference to establish common ground between projects across borders (White, 2006b). Mental health services in particular are singled out as key beneficiaries of the potent power of the arts as they provide an antidote to increasing alienation in the workplace and in the community (Camic, 2008), and can contribute to social inclusion measures (Hacking, 2006).

Dileo and Bradt (2009), writing on the nascent steps to establish a discipline and profession in the field of arts and health, claim that when providing evidence for health professionals, evidence-based practice should be adopted. Particular attention is accorded to Cochrane meta-analyses and randomised control trials as formulations for evidence-based practice. They argue that for arts practices in healthcare settings to be taken seriously within the medical domain, evidence must be provided in ways acceptable to the medical establishment.

Similarly, in an attempt to provide an evidential base for arts and health practices, Arts Council England commissioned a review of medical literature published between 1990 and 2004 demonstrating the impact that the arts can have on health (Staricoff, 2004).

The review explored the relationship of arts and humanities with healthcare, and the influence and effects of the arts on health. In total, 385 papers were reviewed. The findings highlighted the importance of the arts and humanities on: clinical outcomes, mental healthcare, practitioners and staff morale and job satisfaction.

Mirza (2006) adopts a critical perspective, caustically characterising arts and health practices as an anaesthetic instrumental intervention. She challenges the notion that social problems can be dealt with through therapeutic arts projects which in effect medicalise social issues. Her analysis would bracket claims for medical benefit within a health agency research agenda and replace the array of impact reports with a discussion about the “value” of the arts and why they should be subsidised.

O’Carroll (2009) suggests that seeking to validate arts practices and impacts using the dominant evidence-based model is futile. He suggests that artists who choose to seek integration within the boundaries of the medico-scientific discourse face a difficult challenge, because within the domain of health, the medical profession are the “arbiters of truth”. The impulse to establish a link between arts practices and health is based on two false assumptions: firstly that research can “prove” that arts are good, and secondly as a consequence more funding will accrue. Neither of these assumptions is likely to hold true. “The notion of evidence based art is as absurd as an impressionist school of science” (Baum, 2001, p. 306), but relinquishing the holy grail of clinical evidence-based outcomes (Hamilton, Hinks & Petticrew, 2003) does not necessarily infer that evaluation of arts practice should fall into the dominion of anecdote and opinion.

Mike White is a leading exponent for and researcher of arts and health practices. Despite, or perhaps as result of, having spent many years grappling with the methodological challenges of evaluation, he has changed his position on “proving the practice” in his most recent book (White, 2009). He historicises the emergence of arts and health practices in hospital programmes, which consequently left a legacy of confusion regarding art therapies and a burden of proof regarding evidence-based benefit. According to White, research has been limited by a focus on the individual rather than on the social and by poorly developed research methods. He suggests that a shift to social medicine is prompting a new research agenda. He suggests arts and health and its ally medical humanities can contribute to the dialogue in medicine concerning the complexity of extra physiological factors, by negotiating a philosophical space of creative inquiry rather than clinical evidence-based benefit. He suggests that these practices might be best understood using an anthropological approach informed by medical humanities. Putland (2008) asks what we want from evidence. She claims that we are looking for evidence that will not surprise us, to confirm what we already know, and suggests an alternate philosophical and interdisciplinary approach that can reconceptualise questions to create new knowledge.

In this section I have described critical discourses concerning participatory arts practices, discussing arts projects and artists in light of the social turn in contemporary arts practices. I have addressed the literature on the social impact of the arts in general and the sub domain of arts and health in particular. Dissatisfaction with the current approach of EBM has led to a rethinking of what is wanted from evidence prompting a new philosophical research agenda.

Conclusion

In this article, I have distinguished between arts practice and arts therapy, to create a space for considering how arts practices might be understood within the domain of health.

A brief introduction to some of the contested knowledge claims within this domain shows that there is considerable divergence of opinion on how health might be defined, how the practice of healthcare has changed from a medical model to a social model of care and how social factors influence knowledge validation. Health as a construct is not fixed, measurable or contained; rather, it is a nebulous complex. I suggest that although the dominant theme in arts and health discourse concerning validation has been characterised by clinical evidence-based practice, this mode of analysis is not congruent with contemporary arts practice, nor indeed universally accepted within the domain of health. The *Open Window* project provided a practical example of how clinical discourse can colonise an arts project by subjecting it to a randomised control trial. Theoretical concepts concerning the social turn in contemporary arts practice were introduced providing analytical reference points for discussion of *The Lost Dress* and *Training to be a Service User* arts projects. Literature evaluating the social impacts and health impacts of the arts were discussed, which in their separate disciplinary fields have moved to a position considering philosophy as an appropriate mode of inquiry.

From this discussion, it is evident that when the arts sector and health sector meet, there remains a considerable level of ambiguity about what arts practices might mean for the artist, patient and healthcare professional; indeed, each may have very different interpretations. The artist may be seeking an aesthetic objective, the service user an opportunity for conviviality and the healthcare professional may seek evidence-based positive clinical outcomes. While this ambiguity may have been tolerable, even useful, during the establishment of arts practices in healthcare settings, it is necessary now to reflect on whether any or all of these expectations are achievable or desirable.

Contemporary analyses in public health discourse claim that, in developed societies, post-epidemiological transition, what matters is the social environment. Improving the quality of social relations can lead to improvements in the quality of our lives. Such an approach encompasses the revolutionary ideals of liberty, equality and fraternity that suggest self-determination and risk (Wilkinson, 2005). Arts practices that offer dynamic engagement offer neither a solution nor a panacea to our ills, but can offer sustained critical reflection. It is at this point that the analyses of the social model of medicine meet the social turn in arts practice, sharing a critical engagement with structures that maintain and reproduce systems of inequality in local, regional and global contexts. Understanding arts practices in health care contexts in this way might lead to a more engaged deliberation on global health inequalities as was called for in a previous editorial of this journal (Clift, Camic & Daykin, 2010).

It is important that the ineffable character of arts and health projects is not lost in clinical service provision. Further research on arts and health as a field of practice is necessary to provide a conceptual frame as an alternative to the hegemony of the clinic. Equally research into pedagogies of practice, support and mentoring of artist practitioners would clarify the divergence between arts practices and arts therapy. All research should be informed by an analysis of the specific normative culture of healthcare settings and conceptualisations of arts practices from an interdisciplinary perspective and supported by an inter-sectoral dialogue based on parity of esteem.

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Notes

1. Both arts projects were funded by the Arts Council of Ireland through the Artist in the Community scheme managed by Create.
2. Susie Freeman, Liz Lee and David Critchley are the collaborators in Pharmacopoeia artworks. A detailed representation of the artwork can be found on-line, www.cradletogrove.org.
3. Both drapetomania and sluggish schizophrenia were supposed mental illnesses that led slaves to flee captivity in search of freedom and dissidents to “pathologically” deploy freedom of thought to question the social order of repressive regimes.
4. Epidemiological transition refers to the phenomenon in developed countries whereby increasing affluence and advances in healthcare reduce the mortality rate due to infectious and communicable diseases giving way to degenerative diseases such as heart disease and cancer (Wilkinson, 2005).
5. Social determinants of health include factors such as poverty, working conditions, unemployment, social support, good food and transport policy. The WHO Commission on the Social Determinants of Health includes a commitment to tackle inequitable distribution of power, money and resources (CSDH, 2008).
6. Radicant here refers to Bourriaud’s (2009) characterisation of arts practices, using a metaphor from botany of a creeping surface root, to describe the way in which arts practices insinuate themselves in social and cultural contexts.
7. See www.vitalsigns.artscouncil.ie for the programme of arts and health events.
8. Condé and Beveridge artworks: *Not a Care: A Short History of Healthcare 1999–2000*, *Theatre of Operations* 2000, *Ill Wind* 2001.

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13.2 HALE & ARTY

The Visual Artists' News Sheet

July – August 2011

17

ISSUES

Jennie Moran *Infection Control* 2010. Hospital regulation pillow case, embroidery thread.

Liminality installation shot. Photo: Marcel Vidal.

Hale and Arty

SHEELAGH BRODERICK, A PHD ARTIST RESEARCHER AT GRADCAM, DUBLIN, DISCUSSES CONTEMPORARY ARTS ENGAGEMENT WITH THE HEALTHCARE SECTOR AND CONSIDERS SOME CRITICAL FRAMEWORKS FOR VARIOUS 'ARTS AND HEALTH' PRACTICES.

CONTEMPORARY arts engagement with healthcare issues – and indeed the healthcare sector – in Ireland has increased dramatically over the past 20 years. Such 'arts and health' practices are now a significant field of pursuit for artists, with projects taking place across country. Despite this, there is a dearth of critical comment on this particular form of interdisciplinary and socially engaged practice.

This struggle to gain critical traction, is in part hampered by poor visibility of projects, but also by what can be understood as 'hegemonic knowledge' claims – in other words, rather fixed and limited ideas of what the fields of art and healthcare comprise of and can pertain to.

In fact the subject domains of 'arts' and 'health' do not exist as concrete entities, but are shifting, amorphous and contested, subject to competing knowledge claims within their own disciplines. In my PhD research at GradCAM, I have adopted an approach that specifically does not accept arts practices in health care settings, as simply a new artistic genre; but instead explores the complexities and problematics of a practice that can be or both art and health related.

Within the philosophy of medicine and the sociology of health and illness the concept of 'health' actually generates lively debate. What exactly might be a natural or healthy state is open to debate. Conditions that formerly were pathologised or regarded as 'illnesses', are now accepted within the normal range of human behaviour, such as homosexuality, while other conditions and syndromes are now medicalised, such as obesity.

Equally the role of healthcare institutions is not fixed. It has changed rapidly consequent to increasing affluence in 'developed' countries. Health services are no longer predominantly providing interventions to acute episodes and infectious diseases, rather they now concern the provision of services for people with chronic and degenerative illnesses. Emergent themes in healthcare research point toward a social model of medicine in distinction to the interventions of the medical model, which was based on the belief that for every disease there is a single and observable cause that can be isolated. In contrast, the social model emphasises multiple and interrelated factors that influence health and points to changes that can be made in society to make a population healthier.

Public health advocates have established a body of literature, which emphasizes the lifelong importance of the social determinants of health on health outcomes¹. One of the key determinants of health is equality, the more equal a society is, the better are its health outcomes, the more unequal a society is, the poorer health outcomes will be for all citizens independent of individual affluence. Investment into particular pathologies, illnesses and conditions has been shown to be less effective than investment in improving the determinants of health, thus health has become less a corporeal concern, and more a social issue.

This recognition of the social determinants of health, has been one of the key incentives for health services to engage with artists, while at the same time new trajectories for arts practices, in terms of social engagement and interdisciplinarity, have led artists to situate themselves in these contexts.

The Arts Council's *Arts and Health Handbook* (2003) pointedly makes a distinction between arts therapy – whose primary goal is therapeutic; and arts practice – whose primary goal is the experience of art or the production of art. How these differences are made manifest in practice was the subject of a collaboration between artist Marie Brett and arts therapist John McHarg. One of the outcomes of Brett and

McHarg's collaboration was an analysis of the role of the artist and the arts therapist. To outsiders their work might have seemed quite similar, but for themselves and their professional practice they adopt entirely different approaches. Their analysis highlights important differences such as work practices, duty of care, supervision and support, and aesthetic vs. therapeutic concerns².

Situating arts practices outside the gallery or studio contexts presents many different challenges for artists and audiences, foremost among them is a tendency to crudely instrumentalise practices in terms of social or health gain. This approach led in the late 1980s and 1990s to what could be characterised as the 'method wars', in which different methodologies were offered to measure outcomes, social impacts etc. These encounters have been carried over into the domain of arts and health in an even more extreme fashion. Evidence based medicine (EBM) applies research evidence to medical practice in an attempt to standardise practices and manage uncertainty. It is the hegemonic mode of producing and validating knowledge within bio-medical disciplines. Randomised control trials are the basis for validating medical knowledge and rank highly in the hierarchy of evidence-based medicine. When arts practices infiltrate these contexts attempts are often made to apply the same analytical frames.

In late 2010, the Behring Institute for medical research invited submissions of placebos for art in a 'double-blind' study to investigate the healing power of art on public health. A placebo is a simulated medical intervention that can produce a (perceived or actual) improvement on health, called a placebo effect. The placebo for art therefore had to simulate art: it had to look, sound, feel, or in any other way manifest itself as art, but not actually be art. The research strategy involved giving a target group extra 'real' art in their houses and in their jobs, while a control group got the same amount of extra's but in the form of placebos. Are the alarm bells ringing yet?

In fact, *Placebos for Art* was an artwork by Martijn Engelbregt, commissioned by the Dutch foundation SKOR, driven virally through internet blogs and arts resource agency websites³. It was so successful in its call for submissions, over 200 were received that a report of proposed placebos was compiled and published on its website. Placebos for Art functions best as an artwork, not as a clinical trial, for all kinds of reasons, not least of which is that Engelbregt has ramped up the stakes for critical arts practices in healthcare contexts by formulating an entry point for institutional critique in the sphere of arts and health.

Arts practices in healthcare contexts exist in a 'grey zone', because they are not amenable to techniques of methodological verification (nor are intended to be so), making other sources of validation through peer recognition and critical discourse an essential factor in developing practices. Critical discourses in contemporary arts practices share concerns with critical discourses in health that challenge conventions of knowledge and authority, offering rich opportunities for interdisciplinary exploration. Health as one of the emblematic referents of everyday life provides a context that has resonance for many artists, some of whom who will make their careers particularly within this zone and others who will add it as part of their overall portfolio of practices.

Irish artist Jennie Moran recognises this potential⁴. When asked in an interview, what do you think a hospital can bring to an arts practice? She responds that hospitals, "provide a new context, create new audiences...a place where artists can set up a very intense dialogue".

These comments flow from an interview Jennie Moran conducts with herself subsequent to completing *Auxiliary Hospital Equipment: Personal Effects* (2009), at Merlin Park Hospital Galway in which patient narratives prompted Moran to subvert ward apparatus. A hospital bed is reimagined as a playground slide and then embroidered on a pillowcase to subtly reconfigure the hospital landscape. The project had a number of beginnings and endings eloquently documented on the artists website which allows a view of the work that is uncommon in arts and health projects.

This intense dialogue is played out in private and in public in the recent work of Ciara McMahon⁵. *The Leaky Self* (2010) was a multi-platform collaborative art project by the community based Living Gift Transplant Support Group⁶ and McMahon that reflected on themes of subjectivity and embodiment. This project led iteratively to a number of outcomes concluding with performance installation and accompanying series of seminars at the NCAD Gallery.

A specific aspect of this project, entitled *Liminality* deployed the experience of waiting for a transplant and shifted it to the gallery environment, to explore the creative tension between a waiting subject – dependent on others to release them from a form of confinement – and that of the seeking subject, actively looking for answers through theory. McMahon spent a week in a hospital bed in the NCAD gallery. An open invitation was extended to gallery goers to inhabit the role of (hospital) visitor and/or to conditionally donate their physical presence, their self, to the project by substituting their body for that of McMahon, meanwhile, in the same gallery space and only separated by a screen, parallel discursive seminars explored theoretical analyses related to the work.

With *Liminality* McMahon stretched the possibilities initiated through the *Leaky Self* project, by critically engaging with emergent themes and unusually for an arts and health project crossing over into mainstream art spaces. She succeeds in positioning the project on the edge of many territories extending the ambit of the project to the spaces in between theory and practice, between conventions of what is inside and outside. The visibility of the project and the associated blog, which documents the process from *Leaky Self* to *Liminality*, also sets this project apart from many others, which either by virtue of the context of project locations, subject matter or participants, remain invisible.

Claire Bishop has remarked that the paradox of participatory art is that the more participatory an artwork is the more it forecloses spectatorship and the less open it is to future audiences, (Exhibitions of Contemporary Art in the 1990s, *Art and the Social*, TATE Britain 30th April 2010). This is a crucial challenge for artists, who in finding strategies to document their work publicly can stake a claim for alternate knowledge practices.

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Sheelagh is a PhD artist researcher with GradCAM. Her exhibition 'MAC' will open at the Jennings Gallery, College of Medicine and Health, University College Cork on 22 September 2011.

Notes

1. Social determinants of health include factors such as poverty, working conditions, unemployment, social support, good food and transport policy.
2. McHarg et al (2011) *Working on the Edge*. Journal of the Irish Association of Creative Therapists.
3. See www.ehg.nl for information on the artist and www.behringinstitute.com to download the report.
4. www.jennie Moran.com/personaleffects/ / vitalsignsartsCouncil.ie/exhibition
5. Both Moran and McMahon were supported by the Arts Council through the Artist in the Community Scheme managed by Create.
6. livinggift.ie/leaky-self/

13.3 WITNESS WRITER



Witness Writer

Sheelagh Broderick

One Artist's account of the
Regional *Dialogue Sessions*

Text developed for the
National | *Dialogue Arts + Health*

RUA RED, Tallaght, Dublin
Tuesday 6th December 2011

Nothing is as powerful as an idea whose time has come.

Victor Hugo

The opportunity to be a part of a big idea is something special. To become part of a big idea you have to recognize it and engage with it – look for its structure and coherence, play with it, find its aesthetic, know it.

The emergence of arts and health as an area of practice is a big idea. It knits together two disciplines that had been separated in modern times. As a big idea it warrants attention. Grappling with it, turning it over to see the underside, looking within to see the inside and, from that position, looking out to see the outside. Holding a mirror to see yourself within it, meeting with others to locate yourself in relation to them and their position. Moving around within it to find points of ease and discomfort, finding edges, seams, creases, tripping and slipping, holding, letting go, sinking to the bottom, floating up, floundering, grasping a thread and following it.

This is my witness account of the three *Dialogue Sessions* held in Limerick during Autumn 2011. They were nine hours of carefully structured encounters that allowed me to wallow in the company of my peers. We were all artists, curious about the big idea, bringing with us our own experience and understanding of our practice. We were a diverse bunch with practices that encompassed music, dance, sculpture, ceramics, storytelling, visual art, gardening, yoga, performance; travelling to Limerick from far flung places, like Tipperary, Clare, Cork and Kilkenny to talk about arts and health. To just talk in confidence with no expectations and no pressure lifted veils and uncloaked convention. A lot of listening happened too – the airy acoustics of Church space¹ demanded effort in speaking to be heard and listening attentively to hear, in literal and figurative senses, and there was such a lot to say and hear.

Marie Brett began by *Unraveling Arts and Health Practice*, picking out policy, projects, practices, places – there is so much happening so many things to consider, how could this idea be so prevalent and yet invisible – my mind is full. Throughout Marie maintains a strong position returning to her own visual arts practice to orient herself within the healthcare context and provides a text which is a really useful reference for subsequent discussions. Later Sean O'Laoghaire, a puppeteer, storyteller and practicing community artist of twenty-two years standing (half his lifetime he says) demonstrates his way of working with elder care groups. He provides us artists the opportunity to talk and to make. With *Conversation Pieces* he provides topics of conversation, clay and tinfoil as materials – we get stuck in. Some conversation is fluid and easy, others more stilted, but our hands keep working. We show and tell – everyone has something to say. Then its time to think about our next session and the challenges of Pecha Kucha before we all disperse to mull over the provocations of the day.

I like that I have a month to carry the conversations in my head before we meet again in October. Recalling snippets of conversation over coffee, contacts made, plans put in place – all the richness of getting a group of people together resonates without settling into any pre-formed shape. Visual artist Jennie Moran leads out *Dialogue Session # 2* with a facilitated workshop *Mind That Art Practice*. Over twenty of us huddle round tables under the arches and struggle with thinking. In relation to our individual arts practices we are asked: 'Why are you doing it?', 'Why are you doing it?', 'What's the difference?'. Communicating a real urgency that these are important questions for us Jennie brings us to a 'terrifyingly wide open' territory in which an arts practice needs protection and celebration. Topics related to context, engagement, magic, emerge and we become embroiled in intense discussion. This intensity is repeated with the Pecha Kucha presentations. Twenty slides and twenty seconds per slide concentrate the mind. It seems like a big ask, but the participating artists really take it on and give coherent presentations illuminating their practice. This is the heart of *Dialogue Arts + Health*; individual artists giving expression to their arts practice, contributing their piece of the jigsaw. Eight artists present work, some of them have been working in healthcare contexts for many years, others are newer. Combined they establish a significant professional identity for artists working in healthcare contexts. They present in practice much of what had been discussed earlier that day. Health contexts are exciting places to work. They are tedious too. Confidence and excitement grow in the room. We are stronger together. This is a critical point in the *Dialogues*. We had originally come as curious individuals, but through structured and unstructured discussion we had become a collective. Supporting each other. Leading to a final session in which three artists would present their own work for Peer Critique. Gulp.

Funny enough its warmer in November than it was two months previously at the first session in the Church space. There is no chill in the conversation as we arrive either. Small groups meet and exchange greetings, updates, observations, anticipations. We are busy with ourselves. Curator and *Dialogue Arts + Health* Artist Liaison Annette Moloney and visual artist Lucia Barnes facilitate the Peer Critiques establishing a safe and open space for discussion. Three very different presentations follow. All relate to current work in progress but each has reached a significant stage in the process. Discussion revolves around the reading of an artwork and related ethics, the intimacy of the body and its potential to provoke strong reactions and the challenges in developing a project that addresses social issues without actually becoming implicated in being a solution for these issues. Everybody without exception contributes. Time is pressing, but everyone has something to say. The feedback is taken in two parts. First we give an initial immediate response then, having had a chance to think, we suggest trajectories prefaced by the statement 'I wonder if...'. There is a lot of wondering before we are skillfully returned to final presentations. Mary Grehan, Waterford Healing Arts Trust presents the new online resource artsandhealth.ie²

and Katherine Atkinson, Create introduces the Artist in the Community Scheme as a possible support for future arts and health projects³. She is also the *Dialogue Arts + Health* evaluator.

And then it is over. I am hanging onto the bitter end, still tossing ideas around, but feeling part of a great maelstrom of intellectual activity. It's hard to let go. I went to Limerick three times this Autumn and I got lost every time. Signs pointing to Galway, Dublin made me realize my misdirection. I will miss that lost feeling, and intend to make a commitment to getting lost more regularly. I don't have all the answers to the big idea of arts and health, I do have lots of questions and now I have lots of people with whom I can talk about these questions. Roll on the National | *Dialogue Arts + Health*.

About the Writer

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About the Event

National | *Dialogue Arts + Health* was a one-day event which aimed to explore shared outlooks for arts and health practice in Ireland. The event was the culmination of twelve regional professional development events for artists, which took place in Cavan, Offaly, Galway and Limerick between September and November 2011. *Dialogue Arts + Health* was developed by the Arts + Health Coordinators Ireland (AHCI) in partnership with the Association of Local Authority Arts Officers (ALA:AO). It was funded by the Arts Council of Ireland and supported by numerous regional partners.

For more information about the overall *Dialogue Arts + Health* project please see <http://dialogueartsandhealth.wordpress.com/>

¹ The Limerick *Dialogue Sessions* took place in the former Daghda Dance Company Building, a converted church space in St. John's Square, Limerick.

² See www.artsandhealth.ie

³ see www.create-ireland.ie

13.4 TO EVIDENCE OR NOT TO EVIDENCE?

To evidence or not to evidence? | Arts & Health

<http://www.artsandhealth.ie/perspectives/to-evidence-or-not-t...>

To evidence or not to evidence?

'The notion of evidence-based art is as absurd as an impressionist school of science' (1)

Evidence is a concept that can fall into many categories; judicial evidence to establish a burden of proof, experimental evidence to verify or falsify hypotheses and statistical evidence to establish patterns.(2) It exists in relation to questions originating from a particular context and which are as a consequence already guided by inference.

In the domain of healthcare, the specific context is largely one of cure or care. Therefore it is unsurprising that the questions originating within this specific domain concern cure or care and in the case of arts practices are often formulated to consider 'the healing power of the arts'. As a consequence of the dominance of evidence-based approaches to medicine (EBM) and in tandem with a misunderstanding of the differences between arts therapies, arts recreation services and contemporary arts practices, the question of evidence has become a pressing one in relation to arts practices in healthcare settings.

The deployment of EBM in relation to arts practices in healthcare settings is challenged in this essay from two different points of view. Firstly I refer briefly to both internal and external critics of EBM and secondly, I point to an internal logical incoherence when such approaches are applied to arts practices.

The purpose of Evidence Based Medicine (EBM) is to identify safe, replicable and cost-effective interventions that can provide positive clinical outcomes to a target population. Policy makers and practitioners often see EBM as a 'gift horse' in the way that it combines science and managerial practices.(3) EBM purports to offer a transparent evaluative process. It offers the promise of objective measures to distinguish between effective interventions on the basis of resource allocation. It is easily deployed by decision makers who act on the basis of its 'independent' advice. It has become the dominant mode of validating knowledge in healthcare, providing a ranking schema for deciding which studies warrant greater recognition by deploying a hierarchy of evidence. Systematic reviews and randomised control trials rank highest while expert opinion is ranked lowest.

But EBM has also been seen as a 'Trojan horse' as it obscures the subjective elements that inescapably enter all forms of human inquiry.(4) The seemingly self-evident common sense of EBM occurs because it is assumed that contaminating factors such as social context have been statistically removed. The pervasive view that evidence-based practices stand or fall in the light of 'evidence' is based on outdated understanding of evidence as 'facts', through the scientific elimination of culture, contexts, and the subjects of knowledge production. Even advocates for EBM have expressed concern that a critical appraisal of studies can reveal a lack of rigour and tendency to bias.(5) This blind belief in a method 'permits the use of evidence as a political instrument where 'power interests can be obscured by seemingly neutral technical resolve'.(6)

Taking a satirical view, De Vries and Lemmens record their frustration with EBM in their article, 'Parachute use to prevent death and major trauma related to gravitational challenge: systematic review of randomized controlled trials.' With tongues firmly planted in cheeks, the authors review the medical evidence on the value of parachute use and conclude: (a) no RCTs of parachute use have been done, and (b) the basis for parachute use is 'purely observational', and could potentially be explained by a 'healthy cohort' effect. They conclude: 'individuals who insist that all interventions need to be validated by a randomized clinical trial need to come down to earth with a bump'.(7)

Notwithstanding these critiques, the question whether arts interventions should be subjected to clinical trials depends largely on what kind of arts intervention is at stake. The clinical evaluation of arts therapies is logically consistent as they are conceived of as clinical interventions, but clinical evaluation of contemporary arts practices is to misunderstand them. Expectations of positive clinical outcomes, places an unreasonable burden on artists who are not clinically trained and imposes an unreasonable doubt on contemporary arts practices.(8) These arts practices are concerned with issues such as power and knowledge, spectatorship and participation, institutional and public spaces, technology and embodiment, through diverse artforms including digital media, sculpture, performance and painting. They are not intended as clinical interventions and present clinical researchers with substantive and ethical impediments in research design.

Substantive issues relate to the necessity for trials to be replicable and to be constructed so that findings can be generalised to a given population. Arts practices are not replicable. An artist working with a specific cohort of people will not come up with the same outcomes or outputs when working with other groups. Similarly two artists working with the same group will not generate the same outcomes or outputs. Nor will an installation in one setting amount to the same thing when transported to another. Neither do arts practices give rise to generalisable outcomes. Sample sizes are too small to make generalisable claims that will stand up to subsequent scrutiny. In order to generate a statistically reliable outcome, a large sample is required as research findings are less likely to be true when the studies conducted in a field are

smaller. Finally ethical issues arise in relation to the imposition of a clinical frame on an arts practice that is not concerned with clinical outcomes.

The artist is concerned with an aesthetic that stands apart from clinical practices. When artists infiltrate healthcare spaces, their practices enter what Gadamer has coined 'the grey zone' - 'those areas which are not fully amenable to techniques of methodological verification'.⁽⁹⁾ Blum has also noted this indeterminacy when he writes of the zone of ambiguity that haunts modern medicine with unspoken assumptions, understandings and equivocations that cannot be completely mastered and made explicit.⁽¹⁰⁾ The field of art itself operates in this 'grey zone' of indeterminacy refusing to offer a definitive answer to the question 'What is art?', although Aranda et al concede that art at its best does not provide answers and solutions; it creates problems, troubling accepted narratives.⁽¹¹⁾

That is not to say that such arts practices should pass without ethical oversight or critical reflection. The artsandhealth.ie website is an important step in creating such a critical platform. It must be populated by examples of practice that can document prevalence, and also act as a locus for an interdisciplinary critical discourse that includes discussion of validation practices.

'We like to pretend that our experiments define the truth for us. But that's often not the case. Just because an idea is true doesn't mean it can be proved. And just because an idea can be proved doesn't mean it's true. When the experiments are done, we still have to choose what to believe.' ⁽¹²⁾

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(1) M. Baum, "Evidence-based art?," *Journal of the Royal Society of Medicine* 94, no. 6 (2001): 306.

(2) Thomas J.Csoradas, "Evidence of and for what?," *Anthropological Theory* 4, no. 4 (December 1, 2004): 474.

(3) Helen Lambert, Elisa J. Gordon, and Elizabeth A. Bogdan-Lovis, "Introduction: Gift horse or Trojan horse? Social science perspectives on evidence-based health care," *Social Science & Medicine* 62, no. 11 (June 2006): 2613-2620.

(4) Maya J. Goldenberg, "On evidence and evidence-based medicine: Lessons from the philosophy of science," *Social Science & Medicine* 62, no. 11 (June 2006): 2621-2632.

(5) K. L. Florczak, "Rigor: Lost in the Quest for Evidence-Based Practice," *Nursing Science Quarterly* 24, no. 3 (July 2011): 202-205; John P. A. Ioannidis, "Why Most Published Research Findings Are False," *PLoS Med* 2, no. 8 (2005): e124.

(6) Goldenberg, "On evidence and evidence-based medicine," 2622.

(7) Smith & Pell. 2003, p. 1460 cited in Raymond De Vries and Trudo Lemmens, "The social and cultural shaping of medical evidence: Case studies from pharmaceutical research and obstetric science," *Social Science & Medicine* 62, no. 11 (June 2006): 2694-2706.

(8) Sheelagh Broderick, "Arts practices in unreasonable doubt? Reflections on understandings of arts practices in healthcare contexts," *Arts & Health: An International Journal for Research, Policy and Practice* (June 2011): 1-15.

(9) HansGeorg Gadamer, *The Enigma of Health: The Art of Healing in a Scientific Age* (Polity Press, 1996). 106.

(10) Alan Blum, *The Grey Zone in Health and Illness* (Intellect, 2010).

(11) "Editorial - 'Artistic Thinking'," *e-flux*, no. 26 (2011), <http://e-flux.com/journal/view/242>.

(12) Jonah Lehrer, "The Truth Wears Off: Is there something wrong with the scientific method?," *The New Yorker*, December 13, 2010. http://www.newyorker.com/reporting/2010/12/13/101213fa_fact_lehrer.

13.6 SOMETHING HAPPENS

Text written for the catalogue of *e.gress* (2013) by Marie Brett and Kevin O'Shanahan

The *e.gress* project like other arts projects in healthcare settings is characterised by the involvement of health professionals in its commissioning and implementation. To a lesser extent families are involved too as consent to participate in *e.gress* was sought from them on behalf of their loved one. *E.gress* thus spreads itself wide in terms of its reach prior even to project commencement. The conjunction of arts project participant, artist, health professional and family is a curious relation, borne of different expectations in an encounter that makes the artwork possible. In this essay I draw on conversations with a family member and health professional in order to unravel some of these intentions and to position them in relation to the artistic claims discussed elsewhere in the catalogue.

Recognising personhood, identity and value is at the heart of care practices in Midleton and Bandon. This care prioritises choice and autonomy for service users. Having a suite of different activities is a primary concern in best practice care that recognises that the service user 'can still do things and still has a future', especially in rural environments where access to other services is limited. The focus is clearly on the whole person, on their abilities and not their losses, with the strongly held belief that people with dementia can live fulfilling lives.

Health professionals work with the dual challenge presented by the social model and medical model of care – requiring a change of organisational and individual attitudes to displace top down structures with flexible approaches to care and decision-making. These changes make interesting and meaningful work possible. *E.gress* was carried out on a 1:1 basis consistent with the ethos of person centred care. Initially this relation was brokered through the health professional who identified service users

to participate in the project and then later supported the artist and the service user to establish a relation and a connection that made it possible for them to work together – ‘reaching into the subjective reality of the person who remains behind the disease’.

E.gress follows on from a previous project *Converging Lives: Portrait of a Moment* (shortlisted for International Dementia Excellence Awards in 2012). From a health professional perspective, the previous experience of the artists made it easier to establish working relations - in the moment. The particular experience of participants varied with their ability to concentrate and also varied in terms of responses. Some were evidently proud of their work, while in another case work was cut short due to agitation on the part of the participant. The artwork respected the personhood of the participant through recognition that people are social beings, existing in relationships with other people and in a context through which their personhood is articulated as husband.. mother.. child. For the health professional immersed in an arts project alongside the very many other demands on time and attention, the artwork exists in the moment shared between artist and participant as a private shared reflection. The outcomes are not immediately evident even to them and will persist into the future in ways that can't be anticipated. So for example, beside all the accolades for *Converging Lives* one anecdote stands out. When a former participant passed away many months after project completion, his family chose to show the audio-visual artwork at his wake – a proud moment for him, the family and the health professional.

The fierce pride family has for their loved one sits alongside the responsibility for caring for someone with dementia - analogous I am told 'to caring for a child who will never grow up'. Speaking with a family member who cares full-time 24/7, 365 days a year, it is impossible to escape the commitment to personal dignity, and also the passion to expose the reality of dementia care to public attention. But the demands made on time by caring confines attempts at advocacy. From this family carer's perspective participation in *e.gress* might increase the visibility of

dementia, 'the more people who know about it the better'. His Mum, he says, 'is still her own person in a lot of things; she still has self-determination in knowing what she wants'. In consenting to allow his Mum to participate, he says it doesn't matter to him what happens in the artwork. He is 'looking for a reaction, something happening, anything is better than looking out a window'. Starkly put, these are the realities presented by dementia care. Something happening is preferable to nothing happening. There is an honesty to this that departs from social convention and academic rule.

The family member and the health professional see the participant as someone with potential to make something happen, to establish relations through which capacities can be realised. It displays a confidence in a future orientation for that person distinct from a regret for what was. Yet this is uncertain territory. In an arts project it is not possible to know in advance what that 'something happens' might be, nevertheless they honour it through their consent and their advocacy. *E.gress* has had many different levels of engagement. Right now in this catalogue it is stepping out from a sheathed environment into a spotlight of critical reflection. It is too early yet to say what *e.gress* might do. But I can say that what it has done, is to make something happen in the lives of the arts project participants, family carers and health professionals. How they diversely describe that 'something happens' forms part of the rich legacy of the project.

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