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## The art of medicine: aesthetic deprivation in clinical settings

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# **The art of medicine**

## **Aesthetic deprivation in clinical settings**

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There are some very striking examples of the major therapeutic benefit of engaging with art in the illnesses of great artists, from the therapeutic narrative of van Gogh's paintings in the asylum at St Remy de Provence to the burning desire of Alfred Schnittke to compose a new movement of his cello concerto and Lovis Corinth to continue painting after devastating strokes. Yet translating the transformative experience of these exceptionally gifted individuals to everyday practice is a major challenge.

Many clinicians (including those favourably disposed to a greater presence of arts in healthcare) remain uncomfortable with the often fulsome language and relatively uncritical stance of evangelists of the arts and health movement, despite the maturing of medical humanities and arts programmes in health care and medical education. Phrases such as the 'healing arts' seem to overstate potential benefits and contain uneasy echoes of obscurantism and mysticism. Indeed, many of us may harbor a subconscious association of the golden age of art in hospitals with the worst forms of speculative and unscientific treatment – the four humours, purging and blood-letting.

Equally, reviews of the 'efficacy' of arts in health care (as opposed to formal arts and music therapy) rarely stand up to sustained academic scrutiny, with a tendency to mould weak data and speculative associations into an often less than convincing polemic. Medicine and physicians need to sense a more reflective and critical line of reasoning if they are engage with further development of arts in healthcare. This is not a surrender to scientism, the conviction that we can no longer understand science as one form of form of knowledge, but rather must identify knowledge with science: rather, it is the need to develop a common language and intellectual framework between medicine and the humanities.

A helpful insight comes from a pioneering study on the impact of music on recovery after stroke. Purporting to show a positive impact on cognitive recovery and mood after stroke, a Finnish/Canadian group led by Sarkamo showed a convincing difference between the control and intervention groups. However, the intervention consisted of access to the patient's five favourite CDs and a CD player. This prompts the question as to what is wrong with our health systems that patients recovering from stroke do not routinely have access to their five favourite CDs? Is it not a more valid

interpretation of this important study that denying access to usual sources of aesthetic support – aesthetic deprivation- impairs cognitive recovery and depresses mood when recovering from stroke?

Re-orienting the debate in this fashion allows us to reconsider the importance of aesthetics in health and sickness, the aesthetic impoverishment of most healthcare environments, and the role of arts and aesthetics in private and public life in a manner accessible to clinicians.

The concept of aesthetic deprivation facilitates access to a continuum of philosophical thought on the importance of art and aesthetics in human existence. From Plato through Aristotle, Kant and Scruton, philosophers have identified aesthetics as markers of human identity, pathways for exploration of the human spirit, and key elements of personal self-expression.

This deep significance is reflected in everyday life. An Irish study indicated that 90% of the public believe that the arts play an important and valuable role in a modern society and 85% had attended at least one arts event in the last 12 months: film was the most popular art form followed by rock and pop music. Consumer and government spending on arts is also revealing, greater than expenditure on alcohol and tobacco in Canadian surveys. In health, further support is drawn from a recent large Norwegian study showing a positive association between receptive participation in the arts and well-being.

At a societal level, cultural sociologists highlight the role that art galleries and museums play as important instruments of the state, acting as preservers of a community's cultural heritage and important markers of a progressive society, concerned about the spiritual life of its citizens and a constant reminder of past and current achievements. The role for the state in arts is also visible in investment in art in public buildings, although hospitals have until recently been poorly endowed in this regard, and community facilities to an even lesser extent.

A further benefit of the Sarkamo study is that the use of patients' own choices of music liberates us from an over-narrow perspective of aesthetics as purely linked to

Western fine arts, and engages us with an emerging interest in the impact of aesthetic deprivation in everyday life. The philosopher Yuriko Saito has been a leader in philosophical and practical approaches to everyday aesthetics. Seemingly insignificant everyday aesthetic preferences and decisions are more significant than experiences of high art in forming and informing one's identity and view of the world. The aesthetics and presentation of food and consumer goods or the impact of natural beauty may have more effect on us than artifacts in a museum, but the aesthetic quality of these everyday experiences are often ignored. Saito argues that more attention to the beauty of everyday objects can enhance our appreciation of them and our environment.

For example, awareness of the aesthetic beauty of food can lead us to care more about how it is served and prepared, as confirmed in studies of food presentation and better nutrition in patients with dementia. Such everyday aesthetic appreciation can also affect how we damage or support the environment through our choices of products and farming methods and can thus have serious environmental, moral, social, political and existential implications. Attention to everyday aesthetics such as food, texture of bed sheets, crockery and interior design may be more important to patients than introducing the fine arts to the health care environment.

However, it seems unhelpful and limiting to generate an artificially dichotomous choice between the two manifestations of aesthetics - fine arts and everyday - and a combined approach would be preferable, particularly as arts and health programmes are likely to provide the nexus for reflection and action in implementing a range of aesthetic enrichment in healthcare environments. In turn, such programmes need to engage in a more sustained way with clinical and humanities research programmes to investigate in more depth the relationship between aesthetics and well-being. Formal academic linkage between arts and health programmes and university departments of medical humanities is clearly a logical development, and we have found significant interest among a range of both clinical and humanities disciplines in practical and academic aspects of our arts and health activities.

The research opportunities are significant and the potential to impact on health tantalizing. That the health system is unprepared for aesthetic dialogue is underlined

by a series of studies by Caspari in Norway. A review of 86 hospitals revealed very few concrete guidelines or directions for the aesthetic aspects of hospitals. In addition, a survey of 400 patients of aspects of the aesthetics of hospitals showed that they were most dissatisfied with the provision for choosing different kinds of aesthetic input, a finding supported by a qualitative survey with a range of experts in aesthetics and healthcare.

Among outstanding research questions are how to measure aesthetic preferences, the development of indices of aesthetic deprivation, and the formulation of a better understanding of the mechanisms by which aesthetic deprivation impacts on well-being. For example, it may be possible that a part of the positive effect of meeting aesthetic needs is mediated through a heightened locus of control, and by providing a possibility to reshape the immediate environment so as both to reduce aesthetic injury – such as noise pollution and ugly physical environments - and augment a sense of personhood and individuality through exposure to favoured aesthetic stimuli.

Appropriately focused research can also help us to develop a language that patients, families and staff are comfortable with: terms such ‘aesthetics’ may be seen as elitist, and even discussing ‘beauty’, a value of enormous importance, is rendered challenging by a term that is deeply unfashionable. Here again, the concept of exploring a positive construct through its absence may be helpful, and defining that which people find aesthetically undermining in their healthcare environment and practices can direct us to that which is aesthetically pleasing.

Healthcare staff also suffer from aesthetic deprivation. If the healthcare settings in which they practice are poorly designed, aesthetically barren, and polluted by noise it is not surprising that has a negative influence. Aesthetic enrichment is likely to have a significant impact on staff well-being and empowerment, and promote a clinical framework which rises above task and technique-oriented healthcare. Our own experiences with a programme of live music have been striking in this regard, with equally positive responses from patients, visitors and staff. Active involvement and enthusiastic participation of healthcare staff in supporting arts and health projects is an almost universal finding, and may be an indicator of unrecognized need and pent-up demand.

If aesthetic deprivation can be seen as an important factor in well-being, it may also liberate arts and health initiatives from disproportionate constraint over issues such as funding. It may allow a more active programme of intervention: Wikstrom showed that Swedish nurses addressed aesthetic concerns in a passive manner, despite strong belief in the value of aesthetic activities.

A better understanding of these fundamental issues would allow for a more considered approach to the design of aesthetically pleasing and supportive environments, including arts programmes. Such insights would also prompt a reconsideration of how we prioritize arts and health initiatives by adding a welcome articulacy and focus to tackling aesthetic deprivation across a range of healthcare settings. Instead of wearisome recourse to the increasingly fatigued trope of CP Snow's two cultures, we will find that unpicking the elements of aesthetic deprivation and enrichment not only supports good biopsychosocial care, but also a more robust model of interdisciplinarity between the life sciences and the humanities.

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