Northumbria Research Link

HEALING THROUGH CURATORIAL DIALOGUE

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Abstract

Healing Through Curatorial Dialogue reports on a project developed within a collaboration between the Department of Arts at Northumbria University and Northumbria Healthcare NHS Foundation Trust. As an artist-photographer who took on the project as a practice-led doctoral investigation, my ambition has been to advance the role of the artist-curator for hospital users at Hexham General Hospital (HGH) in Northumberland, the host venue for my research. As a result, my thesis discusses not only what the exhibiting of artworks in hospitals adds to healthcare concepts such as healing and wellbeing (Kaye & Blee, 1997; Haldane & Loppert, 1999; Kirklin & Richardson, 2003; Staricoff & Loppert, 2003; Staricoff, 2004) but also how the socially engaged curatorial practices of artists, an area of fine art research that addresses experimental exhibition production and audience development (Gablik, 1997; Hannula, 1998; Putnam, 2001; Jacob, 2003; Kester, 2004), stimulates and facilitates dialogue between patients, hospital staff and local artists, an interaction that I explore throughout my thesis in relation to an apparently irreconcilable 'art world' at the University and 'medical world' at HGH – two socio-cultural domains that my project was set up to harmonize.

In order to maximize the intersection between these two worlds my research has sought to make connections between people and artworks as well as between creators and viewers of exhibitions. This has happened at multiple levels. The exhibiting of artworks by local artists in a local hospital involves many formal and informal conversations; many intentional and spontaneous engagements with art objects; and countless multi-sensory interactions with the busy spaces in which the exhibitions have been installed. In order to transform these interactions into a research method I have explored three concepts: 1) 'healing' as a process of

'making whole' (Jackson, 2004; Egnew, 2005); 2) 'curatorial' as an adjectival term associated with the non-authoritative intermediary practices of artist-curators (O'Neill, 2007a); and 3) 'dialogue' as a transformative group activity that promotes a 'unity of an aspect' in divisive situations such as those I encountered between artists and members of staff at HGH (Gadamer, 1979, 1996; Bohm, 2004; Freire, 2004).

As with many practice-led doctoral projects in the arts, my investigation has involved a range of introspective and interpersonal frames. In my case this has been especially true of the impact of my Buddhist background on my dealings with the UK healthcare system. Here I have utilized the action research cycle described by authors such as Kemmis and McTaggart (1998) and modified the process to incorporate, not only the successive stages of my personal growth as a creative and empathetic practitioner, but also the crucial influence of healthcare staff, patients and local artists within the expansion of my ideas during my research journey. The most important consequence of my action research was the development of workshops using table-top handling exercises that helped the HGH 'medical world' appreciate artworks, not as fixed exhibits on the wall, but as objects loaned by artists that could be passed around and considered from different points of view. Therefore, my thesis demonstrates how an artist-photographer can utilize and adapt curatorial practices for NHS environments and then evaluate the creative connections that the exhibiting process has generated for art communities and hospital users in the catchment area of HGH. Most importantly, *Healing Through Curatorial Dialogue* considers the potential for harmonious action by artists and healthcare professionals and speculates on future 'art and healthcare' projects in which the intersection between local artists and hospital staff have overlapped to such a degree that the intermediary role of a curator is no longer necessary.

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Declaration

I declare that the work contained in this thesis has not been submitted for any other award and that it is all my own work. The work was done in collaboration with Northumbria Healthcare NHS Foundation Trust (NHCT).

Name: Poyan Yee

Signature:

Date: 2 January 2011

Introduction

A journey of a thousand miles begins with a single step.

~ Lao Tzu (Chinese philosopher, 604BC-531BC)

My research was like a journey. The aims and objectives set the destination for me. However, there was no map to look at. Doctoral research by practicing artists is still in its infancy (Elkins, 2009). Therefore, I had to learn from my practice, and find my way through my practice, working within a community of practice-led fine art researchers at Northumbria University who were all roughly in the same position as myself. Despite all the challenges, it was a very rewarding and exciting experience to carry out a doctoral research in the context of art and healthcare.

Before I recall this research journey, I would like to first describe the research project, and then go through all the key steps prior to the beginning, followed by the key territories and directions I was heading towards. Lastly, the outline of the thesis structure is presented.

0.1 The research project

My research project was called *Healing Through Curatorial Dialogue,* which sought to re-envision the role of art in healthcare for hospital users in North East England; investigate how contemporary art practice shaped our understanding of the concept of healing, and in particular, explore how exhibition curation stimulated an effective dialogue between patients, doctors and the healthcare staff as well as the local community, and helped enhance the healing process. Three objectives were identified: (1) to demonstrate the positive impact of contemporary visual art practice; (2) to bridge the medical world and the art community; and (3) to define a research model for art practitioners doing research in the healthcare context.

The research project was in collaboration with Northumbria Healthcare NHS Foundation Trust (NHCT). Geographically speaking, NHCT is one of the largest Trusts in the United Kingdom providing healthcare services to over half a million people from Tyneside to the Scottish border and to Hexham and Haltwhistle in the west of the county of Northumberland. It employs more than 6,000 staff serving over 350,000 patients per year (NHCT, 2006). Of the three general hospitals and seven smaller community hospitals, I was the artist-curator of Hexham General Hospital (HGH). As a result, my research took place in a modern facility (officially opened in January 2004), which provides state-of-the-art services for the population of Tynedale (NCHT, 20006). During the period in which I was undertaking my research, the hospital started constructing a new phase (phase III) to provide additional services to the existing inpatient ward, the Emergency Care Centre and the General Practice in the community. Completed in the summer of 2008, the new phase also housed a Chronic Disease Management Centre (Tynedale Patients Centre), a laparoscopic surgical training

institute (Northern Skills Centre) and an education centre. Most of the patients who use HGH do not stay overnight. However, for those who have to be accommodated in the wards, the duration of stay can vary from one to five days, except in the elderly care / stroke unit where older patients can be in residence from six to eight weeks. Thus, the environment that hosted my research project had a shifting population. In contrast, there were approximately 500 members of staff working in rotas at HGH and this group represented the largest and most consistent audience for my research activities, a point that is of significance when interpreting my use of the term 'hospital users' throughout this thesis.

Northumbria University has been working with the Trust to deliver art projects since 1999. *Healing Through Curatorial Dialogue* was a 3-year project fully funded by Northumbria University. When I learned about this research funding opportunity in 2006, I applied and received the Northumbria University Studentship from September 2006 to August 2009. Before my doctoral project began, a rolling programme of exhibitions had been devised by Chris Dorsett, Reader in Art School Practices, in the School of Arts and Social Sciences at Northumbria University. Dorsett had been supported by fellow artist and colleague Keith McIntyre, and a number of fine art students. At the outset, I found that there was a gap between the two institutions that had formed a partnership. In my research the University and the Trust represent two distinct worlds, namely, those of the art and the medical communities in the North East region of England. The character of these two worlds was defined by the openness of the art community to experiment on new ideas and the apprehensiveness of the medical sector in relation to the practices of contemporary artists. This division was, of course, an oversimplification that does not fully describe the situation set up by Dorsett but I have been able to use the opposition as a formal device

throughout my thesis to explore the theoretical and methodological dimensions of *Healing Through Curatorial Dialogue*.

I have to point out that, the more I researched, the more I learned that the situation was more complex than my 'two worlds' idea allowed. First, there were similarities between the artists and healthcare practitioners. Though some people in the hospital disliked contemporary art, many also loved paintings, sculptures and photographs and believed in the potential that artworks and art activities have to improve wellbeing, even healthiness, in clinical environments. Second, there were various sub-groups within the two domains that had different views on, and feelings about, the role of art in healthcare and thus formed dissimilar relationships with my research. In the medical world, there were members of staff, carers, volunteers, patients as well as visitors (including families and friends of patients). At the hospital, the staff body included medical and non-medical employees. Within the medical category, there were different disciplines, implying different trainings, practices and approaches to healthcare (for example, through my research I came into regular contact with doctors, nurses, occupational therapists, radiologists, dietitians and podiatrists). This diversity was also apparent amongst the non-medical staff.

Similarly, within the art world, the practices and approaches were very diverse. For example, the range of activities represented by fine art doctoral researchers at Northumbria University included drawing, painting, printmaking, photography and sculpture as well as video projection, sound recording, installation work and interventionist actions in public spaces (Dorsett, 2010). A brief account of two fellow PhD students, Christina Kolaiti and Ikuko Tsuchiya, illustrates the rich diversity of our practices in relation to just one of the above categories: photography. At the time I was undertaking my research, we were all

photographers researching within the framework of art and healthcare, but our approach was very different. Kolaiti used portrait photography to help medical students recognize the role of highly subjective and imaginative storytelling within the development of clinical empathy whereas Tsuchiya used her skills as documentary photographer to record, as sympathetically as she could, life within the NHS Trust at the beginning of the 21st century. In my research, my photographic practices were extended into a curatorial dialogue with hospital audience using the vehicle of art workshops.

Within the activity of making exhibitions, curators, artists, artist-curators and audiences can have very different views on the same exhibition. As an artist-curator at HGH, my audience included the staff members, patients and visitors, some of whom had been involved with the exhibitions when Dorsett was setting up the programme. As I shall describe below, an important part of my project brief was that the exhibitors were mainly from the catchment area of the hospital and throughout this thesis the artists I refer to are either permanently based in the region or temporally linked to Northumbria University. Some of the local artists had loaned artworks to exhibitions at HGH before I took over responsibility for curating the programme.

The broader context of my project was the rapid evolution of the artist-curator from the 1980s (O'Neill, 2007a) and the widely felt impact of community art practitioners. As I shall discuss below, since the late sixties a genre of community art has developed, in which artists became socially engaged in order to provide an alternative voice from museum institutions (Dickson, 1995). The incorporation of curatorial strategies into fine art practice has been an important part of the embedding of art production within a community context. Art critic Suzi Gablik has described how artists became frustrated by the limitations of working in a

museum using examples such as Mary Jane Jacob, a chief curator at the Museum of Contemporary Art in Los Angeles, who gave up her post in order to work as an independent curator so that she could 'find a place for art' in the 'real world' (Gablik, 1997: 291). In her own writing Jacob (1995) has claimed that the purpose of the community-based art she promotes is to improve society, to contribute to the quality of life, as well as to save lives.

Therefore, the interaction between artists and their audiences was incorporated into the artwork itself, making fine art practice an interpersonal experience that was as much the creative vehicle of a curator as a maker of art objects in a studio. Kester (2004) calls this development 'dialogical art' and Jacob (2003) talks about her creative conversation with exhibition viewers as a 'public practice'. These concepts are of great significance within the background context in which my doctoral project was created but, in my thesis, the scope of my research concentrates on the relationship between healing and the activities of an artist-curator and so these interesting concepts are only briefly discussed. Nevertheless I am aware that the creative practices I employed during my project were situated in the genre of community art and that the curatorial dialogue I generated in my research was both dialogical and public. My thesis is focused on what happens when the artist-curator practices cross the boundary between contemporary art and medical worlds in order to remove the barriers and produce one community through a combination of practical and research activities.

0.2 Buddhist practice

Although this research is not about Buddhism, I would like to briefly introduce my religious philosophy and practice here because it has had a big impact on my life, and so has influenced the way in which I have approached this project. Without

my Buddhist practice, I do not think I would have committed myself to the opportunities afforded by this research. I was introduced to Buddhism when I was three by my grandmother and mother. As I grew up, it became my ambition to allow these practices to make me a happier, better and stronger person. As a result, I believe I have developed a clearer vision of what I want to do with my life. I want to contribute to a better world through art. Therefore, when I knew there was a studentship available at Northumbria University in 2006, I worked very hard to apply because this studentship would offer me a great opportunity to improve my art practice and contribute to the healthcare landscape without having financial worries. I chanted a lot and exerted myself to submit the proposal and was very grateful to receive the award. Although Buddhism is a key philosophy in my approach, it is not a topic that needs extensive explanation within the research I have undertaken. Furthermore, it is a philosophy of life that cannot be explored in adequate depth in this thesis. However, I would like to acquaint my readers with some concepts that are relevant to my research at HGH. These concepts are: Buddhahood, equality, action, and interconnectedness.

Firstly, 'Buddhahood' acknowledges the four sufferings of birth, aging, sickness and death. Buddhism aims to enable human beings to 'overcome sufferings by unlocking our innate positive potential' (SGI-UK, 2007), in other words, our Buddha nature or Buddhahood:

> a state of life inherent in all beings, characterised by unlimited courage, boundless wisdom and compassion and life-force (SGI-UK, 2007).

Shakyamuni Buddha perceives Buddhahood as the true nature of life, but ordinary people may not know their unlimited life potential. Therefore Buddhists regard suffering as an opportunity to bring out their innate courage, wisdom and compassion and transform sufferings into happiness.

Secondly, 'equality' is described in *The Lotus Sutra*, one of the major teachings by Shakyamuni, as a manifestation of the Buddhahood that all beings (sentient and non-sentient) possess. Everyone strives for equality within their search for enlightenment:

> Shariputra, you should know that at the start I took a vow hoping to make all persons equal to me, without any distinction between us, and what I long ago hoped for has now been fulfilled (*The Lotus Sutra*, Ch. 2, p. 39).

Regardless of one's social status, wealth, age, sex, race, everyone is equal. The teaching that everyone has Buddhahood enables me to reveal my infinite potential, and recognize other people have the same potential too. It also helps me to avert many conflicts with people I find unreasonable and offensive. I do have to remind myself that these difficult people do have Buddhahood. Because of this teaching, I am able to stay calm and find myself becoming more embracing and tolerant.

After some months of my active research at HGH, I set up a series of art workshops in an attempt to invite hospital users to investigate how to create art and exhibitions to enhance the healing process (see Chapter 4). It was because I believe that everyone has potential to be an artist. Some may find this related to the German artist Joseph Beuys' (1921-1986) famous saying, 'everyone is an artist' (Sacks, 1997), as well as the ideal embraced by community artists that people are born creative (Morgan, 1995; Corner, 1995). But my belief in people's art potential derives from the above two Buddhist concepts.

Thirdly, because Buddhism is a practical philosophy that teaches us how we should live as human beings, 'action' is what matters in our conduct and our deeds (Ikeda, 1997). As Jacob writes:

> …I would add practice as a daily routine and, even more, a life's path, describing the artist's way of working – a way of being – that is integral and ongoing (Jacob, 2004: 165).

Buddhist philosophy will become meaningless if Buddhists do not practise the teachings in their daily lives. For example, when I was offended by someone, I would remember that he/she has Buddhahood. I then practised to respect his/her Buddhahood. I have resolved many difficult situations when I put the Buddhist teachings into daily practice. The emphasis on action may explain why I took action research as my working methodology (see Chapter 3).

Fouthly, 'interconnectedness' is a cardinal value in Buddhism, which can be expressed in the following terms: 'dependent origination' or 'dependent arising':

> No beings or phenomena exist on their own; they exist or occur because of their relationship with other beings and phenomena. Everything in the world comes into existence in response to causes and conditions. That is, nothing can exist independent of other things or arise in isolation (*The Soka Gakkai Dictionary of Buddhism*, 2002).

I understand that there is an invisible bond between myself and other people, my life and the universe. Everything is interconnected and interdependent. One can also notice that members of the art world such as Gablik and Jacob are already embracing this Buddhist concept in their philosophies and practices. For example, Gablik (1991) has been proposing a new paradigm of 'connective aesthetics' for artists to engage with life and the world. Jacob (2004) organised a two-year project *Awake* with artists, Buddhists, philosophers and the like to experience the resonance between art and the concept of interconnectedness. For me, pursuing a harmonious relationship between the art world and the medical world would become the core value of my curatorial practice. On the other hand, I endeavoured to convey the message of interconnectedness through my photographic work (see Chapter 4).

0.3 Before the beginning

In this section of the Introduction to my thesis I want to revisit the preliminary steps that led to the starting point of my research journey. My interest in art and healthcare began with an encounter with a photograph in 1996, ten years prior to my PhD. As a result of seeing this image I created a solo exhibition, undertook a Master's degree in photography and made a photographic project about the illness of my husband. These events took me from Hong Kong to Britain, and an underlying interest throughout this thesis is the contrast between Eastern and Western cultural influences on my artistic practice.

Fig. 1: World Press Photo of 1992 by James Nachtwey.

It was 1996 when I first engaged myself with photography: an encounter with a photograph changed the path of my life. I was so overwhelmed. Though I could not see the face of the woman, I could feel her grief, and hear her weeping. Not only did the photograph show me the tragic impact of famine on people in Somalia, it also stirred a lot of emotions within myself. This was a revealing experience. Since this encounter, I started to learn photography by myself. At that time, I was a journalist working in a newspaper in Hong Kong. I shifted my

focus from texts to images. Instead of writing texts, I took photographs to tell stories.

I paid attention to the works by documentary photographers, especially James Nachtwey. I was inspired by his humanistic concern for ordinary people in dire circumstances, and his ability to convey the extraordinary experience and emotions of those people. At the end of the 1990s I was very worried about the political conflicts around the world and the direction of humanity towards the new century. Unlike Nachtwey, who risked his life in the conflict zones, I tried a very different approach. I set myself a project, *P.E.A.C.E,* and aimed to have my own photographic exhibition suggesting ordinary people could contribute to world peace in their daily lives in five aspects, namely, P for prayer, E for education, A for art, C for care and another E for environmental concern. Because of my background in journalism, I took documentary photographs, which can produce persuasive evidence of what has happened and arouse attention in society. In order to find evidence of ordinary people contributing to world peace, I reached out to religious organisations, schools, and artists to explain my project and asked for permission to photograph and exhibit. By doing so, I was able to connect with different groups of people in my society. The whole process was not only about taking photographs, but also about building relationships with people, and gaining trust from them.

P.E.A.C.E was exhibited in December 2001 in Hong Kong Cultural Centre. In making this exhibition happen I also acquired first-hand experience of acting as a curator. At that time I did not know the word and, looking back, my first exhibition was not well curated. It showed around 40 images of various styles. I was not critical enough towards my work. However, the making of *P.E.A.C.E* was not only a testimony to my pursuit of being a humanistic photographer, but also as a

stepping stone in the extension of my art practice. I was the artist-curator for my first solo exhibition.

Fig. 2: From the *P.E.A.C.E* series (2001).

I was introduced to the concept of 'curating' exhibitions when I pursued my MA in Photographic Studies at the University of Westminster, London, from 2002 to 2003. My course leader encouraged us to see as many exhibitions as possible. Visiting galleries and museums became one of the core lessons of my MA studies. I accumulated practical knowledge in curating when I organised two group shows and one solo exhibition in London.

This MA course not only widened my horizon of the contemporary art world, but also deepened my understanding of contemporary photography. Before the course, my knowledge of photography was confined to documentary photography and photojournalism. But with the nourishment of contemporary practice, I started fabricating stories by photographing the constructed scenes, and playing with texts and images. Moreover I had experimented with elements of performance in my graduate project, *Smile*. It was created in response to the SARS epidemic in Hong Kong, where six million people wore masks. This photographic project investigated how a mask affects communication and relationships between people. It was my first project made in a studio and directed rather than my usual practice of capturing images as they arose.

Fig. 3: *Smile* at Hanbury Gallery, London (2003).

Many people found *Smile* 'clinical', probably from the use of white background, clothing and masks, even though I did not intend the work to focus on illness. Interestingly, the succeeding project after my graduation was about illness, the illness experienced by someone very close to me. I started to explore the topic of illness when I returned home to Hong Kong.

Imagine yourself experiencing numerous kinds of pain over various parts of the body, always having nausea, and feeling feeble and tired, 24 hours a day for over 20 years. What would you think and feel? Worse, you saw many doctors and did all the body checks, and the readings were all normal. You were told maybe your illness was caused by your mind. This has been the experience of my husband Nomis Fung since 1984. At that time in Hong Kong, doctors did not know about Chronic Fatigue Syndrome (or Myalgic Encephalomyelitis [ME]). They could not give appropriate treatments for Nomis. Despite the frustrations, Nomis has been trained to be more positive about life and more enduring about his physical suffering. However sometimes he gets depressed because of the pain and tiredness. Still he has not given up.

As a photographer I try to relieve the suffering of my husband. Inspired by the British photographer Jo Spence's (1934-1992) photo-theatre, a form of self-

therapy that helped this artist live with her breast cancer, I proposed a photo-theatre project with Nomis, in which he expressed his feelings towards his illness in front of my camera. The resulting images presented a very ill person. I was worried if the images would upset him. Surprisingly, Nomis felt better because he found that the images clearly illustrated his illness and thought that his family and friends would understand him by seeing the images. This was the first time I gained first-hand experience about the positive impact of photography on illnesses.

Meanwhile, I developed a form of photo diary that used recorded 'voice-over' commentaries to document how Nomis coped with his illness. Nomis has been trying various kinds of treatments used in traditional Chinese medicine. I photographed each treatment and then asked Nomis to narrate his feeling about each treatment. The use of sound and image seemed to be able to extend the scope of the (re)presentation of the story of a patient. I returned to documentary photography but with an added element of vocal narratives. The trials with Nomis laid the foundation for me to develop a photographic project in my PhD research.

Fig. 4: Photo-theatre experiments with Nomis.

0.4 The journey journal

The research journey that was made possible by the platform I have described above can be broken down into five stages. Each of these stages is described and discussed in the five chapters of my thesis. Chapter 1 explores the issues and concerns that made me want to contribute to the development of fine art practices in a healthcare context. Composed of two parts, this chapter seeks to understand the position of an art practitioner undertaking practice-led research through a programme of exhibitions at a hospital and then investigates the key concepts outlined in my project title, namely 'healing', 'curatorial' and 'dialogue'. Chapter 2 traces the development of art in hospitals in the UK, and of the collaboration between Northumbria University and NHCT. By understanding the history that informs the partnership between the two institutions, I describe how I learnt from the past and made plans for my future journey. In chapter 3 I define my working methodology and discuss the similarities between art practice and action research. I then explore why I chose action research as my approach and describe how I adapted the protocol used in this method for my own purposes. Having established a viable method, in chapter 4 I discuss what happened when I began to curate exhibitions in the real life healthcare setting. This chapter documents how my research developed and my practice improved during my 'active research' period between January 2007 and September 2009. I report on the four action research cycles I completed before writing up this thesis. My concluding chapter (5) reflects upon, and evaluates, the contribution I believe I have made to our understanding of what an artist-curator can achieve in an NHS hospital. I outline the scope and limitations of these 'findings' and discuss the opportunities I have generated for further research, and the impact *Healing Through Curatorial Dialogue* will have on my personal career plan.

Chapter 1

Drawing the Map

1.1 Mind the gap

This chapter is composed of two parts. The first part seeks to find the position of an art practitioner situating herself in the context of healthcare. By reviewing the current literature in the field of art and healthcare, it is found that the concept of healing is not well defined. Therefore an art practitioner may be able to contribute to the development of art in healthcare by exploring the potential of art in relation to healing, by defining her own way of researching health whilst exploring her own vision as a practitioner.

In the second part I will be examining an under-researched area that also needs more definition - the role of an artist-curator in the healthcare environment. This is because the context of my research is a working hospital (Hexham General Hospital [HGH]) with a rolling programme of exhibitions (set up within a research partnership between Northumbria University and Northumbria Healthcare NHS Foundation Trust [NHCT]). Here I will investigate the concept of healing in relation to the curatorial practice I developed at the hospital. I will also discuss the dialogue between myself and the hospital community that was the main process by which my work as a curator might have, speculatively speaking, a healing role. As I gained a deeper understanding of the interaction between exhibition curation, group dialogue and health/wellbeing, I suggest that my research takes on a clearer direction and begins to establish some ideas about how art practitioners might contribute to the healing process within the healthcare environment.

1.2 The concept of healing is confusing

In order to 'draw the map' of my project I will begin with some definitions. 'Healing' is an important concept in both my research and my practice and it may

be defined as the purpose, process and outcome of medicine (Buetow, 2002). The 'healthcare' setting in which my research has been undertaken is a place where medical interventions aim to help people to achieve health (Gilpin, 2003). The key concept within this term 'healthcare' is 'health', which is the proxy outcome of healing (Buetow, 2002). These definitions are derived from two independent sources, Buetow and Gilpin, who are both medical practitioners exploring attitudes to health. In the studies of health attitudes, some are disappointed that healing is poorly defined, a view voiced by researchers in nursing literature (Glaister, 2001; Jackson, 2004) and in medical literature as a whole (Egnew, 2005; Hsu, et al., 2008; Scott, et al., 2008). Nor is the concept of 'healing' clarified from 'curing', 'recovering', 'coping' and 'surviving' (Glaister, 2001). This confusion of terms also occurs in the literature of art and healthcare. I notice that even art and health studies using the words 'heal' or 'healing' in the title do not explain what 'heal' or 'healing' means (Senior & Croall, 1993; Senior, 1997; Ulrich & Gilpin, 2003). Therefore as a researcher seeking to curate art and exhibitions in a healthcare setting, my reading has suggested to me that it is important to fully grasp the meaning of 'healing' in order to develop and complete a doctoral project entitled *Healing Through Curatorial Dialogue*.

Much literature has shown that art has a positive impact on the patients and hospital staff in the healthcare environment (Miles, 1997a; Ulrich & Gilpin, 2003; Staricoff, 2004; Hecht, 2006; Rae, 2006; Arts Council England [ACE], 2007; Department of Health [DoH] with ACE, 2007). Some of these studies employ quantitative methodologies to present statistics on various clinical measurements such as the reduction of anxiety levels and blood pressure (Staricoff & Loppert, 2003; Ulrich & Gilpin, 2003; Staricoff, 2004). Staricoff and Loppert (2003) carried out scientific research that aimed to answer 'the fundamental question of whether arts can play a meaningful role in the practice of medicine' (Staricoff & Loppert,

2003: 63). Observing the rising interest in art and healthcare, Staricoff and Loppert (2003: 64) argue that 'the need to quantify and evaluate the effects [has] become more pressing'. However, from my experience as an art practitioner, there are many ways of understanding our world, and the scientific method is only one of them. Having investigated the nature of health, German philosopher Hans-Georg Gadamer (1900-2002) criticized the incompleteness of the scientific worldview in medical treatment and argued that health cannot be measured 'because it is a condition of inner accord, of harmony with oneself that cannot be overridden by other, external forms of control' (Gadamer, 1996: 108). As an artist, I hope that my practice-led research will have a role, however small, in offsetting the incompleteness of the scientific worldview when it comes to our understanding of concepts such as 'health' and 'healing'. Given that scientific research has dominated the development of contemporary healthcare, the role of artists in hospital environments may be to counterbalance the view that science has all the answers.

Although there is documentation of artists and art organisations sharing their experience of working in the hospital or health-related areas (Senior & Croall, 1993; Kaye & Blee, 1997; Silver & Lucas, 1997; Rae, 2006), I am disappointed to find that the leading researchers in this field are not art practitioners but behavioural scientists (e.g. Ulrich), physicians (e.g. Staricoff), art historians/critics (e.g. Loppert) and a multi-disciplinary team led by clinician Macnaughton at the Centre for Arts and Humanities in Health and Medicine at Durham University. Similarly, in the report *A Prospectus for Arts and Health* (2007) (published by the DoH with ACE), of the 6 examples and 14 studies cited visual arts practitioners had not been involved in organizing any project. The only practice-led project was the six-year-long 'Developmental Movement Play' which was carried out by dancers who used action research to understand 'the importance of early

movement play in building foundations for future health and wellbeing' (ACE, 2007: 49). Having read this report I feel encouraged to contribute new knowledge to art and healthcare research from the perspective of an artist.

My literature review suggests that there is no published material that directly addresses the role of an artist-curator in the healthcare setting even though artists organize group exhibitions in hospitals. As a result there are also no publications that explore the relationship between curatorial practice and the healing process. As an artist-curator, I have undertaken research on this topic with the ambition of encouraging debate on curating hospital exhibitions and my thesis attempts to provide material for discussion that is based on my own experience of developing a curatorial practice at HGH and establishing a research methodology for this PhD. These practical and methodological developments will be examined in detail in the third and fourth chapters.

In order to develop my research framework and methodology, as well as to provide a common ground to communicate with my readers, it is imperative to investigate the meanings of the three key words of my research title, 'healing', 'curatorial' and 'dialogue'.

1.3 'Healing': what does it mean?

What is healing? How does healing work? What are the factors contributing to healing? As an artist-curator working in a healthcare environment, I am very concerned about how my practice can enhance the healing process.

According to the *Oxford English Dictionary* (*OED*, 1989), 'healing' has the following meanings:

(1) restoration to health; recovery from sickness; curing, cure; and (2) mending, reparation; restoration of wholeness, well-being, safety, or prosperity; spiritual restoration, salvation.

From this dictionary definition, the notion of healing concerns not only a physical condition but also a mental and psychological state. Glaister (2001) describes healing as physical and non-physical happenings. Physical events include bodily recovery such as wound healing and tissue repair. Non-physical events are associated with spiritual, religious or psychic healing processes. For example, Native American shamans perform healing ceremonies to help the ill return to a state of balance and harmony (Glaister, 2001; Bloom, 2005). Healing is defined as a process that facilitates health and restores harmony and balance between the mind and the body (McGlone, 1990 & Quinn, 1984 cited in Glaister, 2001). Traditional Chinese Medicine (as originated from *The Yellow Emperor's Classic of Internal Medicine,* or *Huangdi Neijing*) also emphasises that health can only be attained when there is harmony between the two opposing elements: *yin* and *yang*. These two elements must be balanced not only in the body but also within the body's relationship with the environment as a whole. Traditional Chinese Medicine regards *yin* and *yang* as the two cosmic forces that bring this world and human beings into existence.

In English, the word 'healing' derives from the Anglo-Saxon root '*haelen*'. Egnew (2005) explains *haelan* is 'the condition or state of being *hal*, whole' (Egnew, 2005: 258). Jackson (2004: 68) says '*haelen*' means 'to be, make, or become whole'. The idea of wholeness is also represented in the Chinese language. In Chinese, 'healing' is made up of two characters: 痊癒, which literally means 'recovery' and 'curing of diseases'. But originally, 痊癒 comes from 全愈. The first character 全 means 'whole' and 'all' while the second character 愈 means 'cure', 'recover', 'better', 'more' and 'becoming' (Ministry of Education, R.O.C., 1994). It

is very interesting to see that both the English and Chinese languages share the same meaning of 'whole' for the word 'healing'.

So what does 'whole' mean? In the healthcare context, 'whole' means the whole person. Some medical professionals have already stressed the purpose of medicine: the healing of a person, not the curing of a disease (Upledger, 1989; Barnum, 1997 cited in Jackson, 2004; Egnew, 2005). A whole person includes the physical, psychological and spiritual aspects of life. After carrying out in-depth interviews with seven experienced physicians, Egnew (2005: 258) defines healing as the process of developing 'a sense of personal wholeness that involves [the] physical, mental, emotional, social and spiritual aspects of human experience'. Egnew's definition is supported by Keegan and Dossey (1989 cited in Jackson, 2004), who propose wholeness is the integration of body, mind and spirit. Quinn (2002 cited in Jackson, 2004) even coins a portmanteau term 'bodymindspirit' to convey the notion of wholeness, the integral and inseparable nature of the Self.

However, wholeness has a broader meaning that exceeds the singular and the personal. In expressing the fullness of everything, the concept of wholeness also embraces the integral and inseparable nature of our lives as they are lived within the environment (Moss, 1989; Jackson, 2004; Egnew, 2005; Mount, et al., 2007). In *The Enigma of Health* (1996), Gadamer refers to wholeness as a 'unity of being' that includes:

> the sense of the movement of the stars above and the changes of weather below, the rise and fall of the oceans and the living nature of the woods and fields. It is what surrounds and encompasses the nature of human beings that determines whether they find themselves in a condition of safe health or exposed to dangerous threat (Gadamer, 1996: 115).

Gadamer's view on wholeness is echoed by the Buddhist principle of 'interconnectedness'. The Japanese Buddhist philosopher Daisaku Ikeda (1928-) explains that 'each form of life supports all others, together they weave the grand web of life' (Ikeda, n.d.). In other words, wholeness implies an intricate nexus of relationships.

To become whole is to make connections within oneself, with other people and with one's environment. Therefore isolation and disconnection deter healing while connections and relationships are determining factors for healing (Remen, 1989; Jackson, 2004; Egnew, 2005, 2009; Mount, et al., 2007; Hsu, et al., 2008; Scott, et al., 2008). Drawing on the accounts of 21 patients who had coped with life-threatening diseases, Mount, et al. (2007) found that patients who expressed the strongest sense of the wholeness of healing were those who had made connections at multiple levels: that is, within themselves, with others, with the environment, and ultimately with the universe. This study concludes that even the seriously ill enjoyed a sense of wellbeing and wholeness when they had the scope to form bonds with others that gave greater meaning to their suffering. Therefore if people find positive meaning within their experience of illness, then healing occurs (Mount, et al., 2007). It seems that when positive meanings are created out of negative ones, people have successfully made connections between their inner Self and a greater Self who seems to represent existence as a whole. This suggests that when patients connect to themselves on some kind of spiritual level, their self-transcendence can transform their suffering into healing. Mount, et al. (2007) defined these psychological and spiritual bonds as *healing connections*. There are four types: (i) with the Self; (ii) with others; (iii) with the phenomenal world experienced through the five senses; and (iv) with religion or the ultimate meaning conceived by that person (Mount, et al., 2007).

As an artist, I can relate these four types of connection to my practice as a photographer. For example, I always have an inner dialogue with myself throughout the process of taking photographs. If the photograph is to be a portrait, the image I produce will be more successful if I connect with the sitter at a personal and professional level. During a photographic session I will also be deeply connected to the phenomenal world that surrounds my sitter with changes in light- and colour-value. Given that Mount, et al. link each of these levels of connection to the healing process, my research could use the bonds that develop within my practical work to understand, and perhaps evaluate, how an exhibition curator might contribute to healing in the healthcare environment.

It will be clear from the literature I have quoted above that when medical practitioners facilitate healing, they must help their patients make connections with themselves, others, the environment and the universe (Egnew, 2009). For example, the core practice of Gawain (1989), Simonton (1989), Upledger (1989) and Rossman (1989) is to help patients listen to their inner voices. In addition, when medical practitioners attentively listen to the voices of patients, connections with others are made for both parties. Here it is possible to understand that the clinician-patient relationship is itself part of the healing process.

Many health practitioners agree that the interpersonal aspect of the clinical process plays a crucial role in healing. In *Healers on Healing* (1989), Carlson and Shield asked 37 professionals to share their views on the basic factors involved in healing. There are different focuses according to different kinds of therapeutic procedures in use. Even though some writers emphasized the power of shared love (Siegel, 1989; Prather, 1989) and others the innate healing power of the patient (Upledger, 1989; Rossman, 1989), most focused their discussion on the caring, empathetic, respectful, and compassionate openness they experienced

within the connections they made with their patients or clients (Carlson & Shield, 1989). Similar studies based on in-depth interviews with experienced clinicians (Egnew, 2005), medical staff and patients (Hsu, et al., 2008), and patients (Scott, et al., 2008) also support this view. Pellegrino (2001) even goes as far as to suggest that a healing and helping medical relationship is the main purpose of the clinical encounter.

With these ideas about the therapeutic value of connections and relationships in mind, it seems that the 'healing' dimension of my research will be focused on my relationship with my audience: that is, on my 'curatorial dialogue' with the physicians, members of staff, patients and other user-groups at HGH.

1.4 'Curatorial': what does it mean?

As I have described in the section above, the literature on my key word 'healing' establishes an important role for interpersonal relationships in healthcare contexts. As an artist-curator at HGH I was responsible for organizing a rolling programme of exhibitions in any part of the building in which the staff and patients wanted to see artworks on display. Therefore, my main vehicle for creating healing connections of the kind discussed above was the curatorial process: that is, the creative practice of selecting artists and assembling artworks into coherent and interesting displays that enhance the architectural environments in which they are placed.

At the beginning of my doctoral project, when I introduced the aims and objectives of my research to the healthcare community at HGH, an administrative secretary and a doctor both asked me: 'what does curatorial mean?' Similarly, when I outlined my research to a friend, who is a teacher in a secondary school, he also asked the same question. It seems that the term is not familiar outside

the arts. According to the *OED*, the noun 'curator' is derived from the Latin word 'curare', the same word root as 'cure', which means: 'care for, take care of, and cure'. Therefore, a curator is someone 'who has the care or charge of a person or thing': for example, 'the officer in charge of a museum, gallery of art, library, or the like; a keeper, custodian' (*OED,* 1989).

What does a curator do? The definition seems to have expanded, departing from the traditional museological concept of looking after artefacts (Busa, 2004) to refer to a variety of activities within the contemporary gallery and museum sector (O'Neill, 2007a & b). O'Neill reports that in the 1990s the noun 'curator' was supplemented by a new application of the verb 'curate' and argues that this word is now used as 'floating signifiers, fluctuating between different meanings' (O'Neill, 2007a: 13).[1] At the conference *Stopping the Process* (Lofoten Islands, Norway, 1997), the influential sociologist Zygmunt Bauman described the diverse roles that are now associated with this verb. These include:

> …being an animator, pusher, brother, inspirer, someone who makes people work and things happen, who inspires artists with ideas and programs and projects, who helps them in their work. Then there [is] an element of interpreting, of making sense for people, of making them understand, giving them some sort of alphabet for reading what they see, but cannot quite decide about. Then a community maker, organizing and putting together the artists, … and also creating a permanent public for the gallery, so that the public knows what to expect (Hannula, 1998: 13).

This creative and enabling range of activities can be seen at work throughout the contemporary art world. Busa (2004) proposes that the main task of the contemporary art curator is as 'the mediator of a dynamic communication process between artists and audiences' (Busa, 2004: 3). 'Mediator' is also the

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[1] According to O'Neill this verb is neither found in the *Oxford English Dictionary* nor recognised by *Microsoft* spell check. However the *OED* (1989) does list 'curate' as a transitive verb meaning 'to act as curator of (a museum, exhibits, etc.)' as well as the traditional 'to look after and preserve'. Whilst my spell check accepts 'curate', it does not approve of the gerund 'curating'.

term used by the celebrated Swiss curator Hans Ulrich Obrist (cited in Andreasen & Larsen, 2007). Despite the fluidity of the definition, it seems that acting as a 'mediator' or 'community maker' is a way of saying that a curator is someone who creates connections. Therefore the concept that was important in the discussion of 'healing' above also serves as the common ground between different forms of curatorial practices. It is the ambition to connect exhibitors or exhibits with audiences that links curators in museums and galleries.

However, the process of acting as a 'mediator' or a 'community maker' suggests that a power relationship always develops within the connections that a curator builds between artists and their audiences (Ault, 1989 cited in Putnam 2001; Brenson, 1998; Esche, 1998; Shaw, n.d.). My second supervisor Jane Brettle has put it this way:

> Usually, the power resides with the curator to decide on the theme, concept, artist, venue for the curated 'product'. This will include and exclude certain artists or works and deliver a product and concept to audiences who on the whole have little say in the process up until the point of delivery.[2]

According to Brettle, since the 1980s, this kind of power relationship between curators and artists has begun to mutate. Artists began to incorporate curatorial strategies into their practices. As a result, the phenomenon of the artist-curator gathered momentum (O'Neill, 2007a) with individual practitioners and groups of artists initiating their own exhibitions often using vacant warehouses or disused industrial buildings that were cheap to rent. Notable examples include: *Freeze* (1988) by art students from Goldsmith's College, London and *Windfall* (1991) by a collective of 26 artists in Glasgow. The Scottish curator Charles Esche (1998) has observed that the *Windfall* artists sought to challenge the authorities of 'institutions and the traditional role of the curator as selector and definer of new

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[2] Brettle is a photographer. This quote is from a discussion held on 29 September 2009.

art' (Esche, 1998: 248). There have been a growing number of artists running their own curatorial organisations and exhibition spaces such as Beaconsfield[3] in London (Stallabrass, 1997), Transmission[4] in Glasgow (Esche, 1998) and Group Material[5] in New York (Ault, 2007). The expansion of art practices to include the activities of the curator has resulted in a widening range of exhibition venues and cultural events that bring the public into contact with contemporary art. Esche (1998) has described the collaborative approaches that realize these artist-curator projects as 'the pursuit of the art experience as a transformative, hopefully life-enhancing thing' (Esche, 1998: 249).

Artist-curators have also drawn the attention of museum curators. Putnam (2001) observes that more and more artists[6] have been invited by museum curators to curate exhibitions using museum collections. My supervisor Dorsett collaborated with the curator Hélène la Rue at Pitt Rivers Museum between 1987 and 1994 curating a sequence of large-scale interventionist exhibitions with other artists under the title of *Divers Memories* (Putnam, 2001).

Alongside the rise of the artist-curator, the development of biennials and large-scale international survey exhibitions has made it possible for exhibition curators who are not themselves artists to extend the creative scope of their activities (O'Neill, 2007b). Using the theory of the *auteur* developed by French film director François Truffaut (1932-1984), Hoffmann (2007) proposes new terms such as

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[3] Founded in 1994, Beaconsfield is a London-based curatorial organisation run by artists David Crawforth, Naomi Siderfin and Angus Neill.
[4] Founded in 1983 by graduates from Glasgow School of Art, Transmission seeks to provide exhibition spaces and opportunities for young artists in Glasgow.
[5] Founded in 1979, Group Material is an artists' collaborative organising art events and exhibitions with social and political agendas.
[6] Examples include: British artist Eduardo Paolozzi's *Lost Magic Kingdoms* at Museum of Mankind, British Museum, London (1987); American artist Joseph Kosuth's *The Play of the Unmentionable* at Brooklyn Museum, New York (1990); and British film director Peter Greenaway's *The Physical Self* at Museum Boijmans-Van Beuningen, Rotterdam (1991).

'exhibition-author' and 'author-curator' to recognize the fact that curators are also 'creators' of exhibitions. Hoffmann models the creativity of the curator on the author-directors of 1950s' French cinema who took charge of all the creative aspects of producing a film (Hoffmann, 2007). Therefore the boundary between artists and curators has become blurred suggesting that the phenomenon of the artist-curator is still a contested concept in the discourse that surrounds curatorial practice (O'Neill, 2007b).

In my research I call myself an artist-curator because my curatorial interests have grown out of my artistic practices as a photographer. I also use this title because, when considering the creative potential of the healthcare environment as an exhibition venue, I have been influenced by the way contemporary artist-curators have sought alternative approaches from those of traditional museum and gallery curators. I was aware that, like the gallery world described by Brettle, hospitals have a hierarchy of power that makes the doctor the active authority and the patient a mere recipient (Widdershoven, 2000). Therefore, the anti-authoritarian examples set by many artist-curators suggested to me that curatorial practice could generate a balanced connection between giving and receiving in the hospital as discussed above.

In relation to the concept of curatorial practice explored in this section, the key word 'healing' discussed in the section above will serve as a beacon for my role as an artist-curator at HGH. Instead of acting as a traditional curator making all the decisions, I will put aside my authority and try to promote a harmonic relationship between the participating artists and healthcare audiences. As discussed above, people experience healing when they feel connected. As a result, I will seek to make connections between local artists and the various communities that live and work in the catchment area of HGH, using the process

of exhibition making as my vehicle of connection. The ancient root of the word 'curator' - curare – offers me an ethical frame for my research: I will 'care for' and 'take care of' the exhibited artworks, as well as the feelings and emotions of the audience that comes across the exhibitions I organize while they are visiting the hospital.

1.5 'Dialogue': what does it mean?

We learnt above that the key word 'healing' means wholeness, and that connecting relationships are crucial to achieving a sense of a healthy whole. Furthermore, we have also discovered that the kinds of connections that support healing can inform the activities of an artist-curator. As a result, I now turn to the aspect of my practice as a curator that embodies the concept of a 'healing connection': the notion of a curatorial 'dialogue'. Gadamer (1996) sees the importance of dialogue in the healthcare environment as a humanising of the unequal relationship that prevails between doctors and patients. A successful clinical dialogue is 'an important part of the treatment' (Gadamer, 1996: 112).

Before I explore the relationship between healing and dialogue any further, I would like to examine the meaning of the word 'dialogue' first. As the dictionary explains, 'dialogue' refers to 'conversation or verbal interchange of thoughts or literary work in the form of a conversation between two or more people' (*OED*, 1989). I realise that sometimes a conversation can become boring or annoying when one party just talks without considering the others' feelings. This kind of conversation is not equal. One party tries to take control while the other is forced to be silent or passive. Bråten (1988 cited in Seikkula & Trimble, 2005) regards this kind of conversation as a monologue, which he illustrates with an example of a medical encounter:

> The physician is guided in her questioning of the patient by a well-established internal map of the pattern of symptoms of a heart attack and a clear set of instructions for action if the diagnosis is confirmed. The patient's responses to the physician are under the control of this monologic discourse (Bråten, 1998 cited in Seikkula & Trimble 2005: 465).

Other examples include a boss 'speaking at' his/her employees and a teacher 'lecturing' his/her students. In both cases an unequal power of relationship exists between the parties involved. The Brazilian educator Paulo Freire (1921-1997) criticized the way that many teachers 'deposit' their ideas on students. In contrast, Freire realized that he himself relearnt and re-discovered the world by engaging in dialogue with his students - they created and recreated meaning together (Shor & Freire, 1987; Freire, 2004). Freire (2004) argues that it is impossible to 'receive' the ideas of others without digesting them. The idea that people who learn have to actively internalize meanings brings out an important aspect of dialogue: reflection and action.

Throughout his writing, Freire describes the essence of dialogue as *the word* and explains that this basic unit of human interaction has two inseparable dimensions: reflection and action. Speaking words to others without carrying them through into actions is verbalism and acting without the reflectivity made possible in conversations becomes activism. Such a view on dialogue strikes a deep chord with me because creative practice always seems to be an attempt to unite personal reflections with communicative actions (see Chapter 3).

However, there are other ways of thinking about the word 'dialogue'. Whilst Freire (2004) says that dialogues need reflection and action, Gadamer (1979, 1996) identifies 'questions and answers' as the two dimensions that identify the role of dialogue (or conversation) within the hermeneutic tradition that this philosopher made his specialism. As Gadamer says:

> …language is only properly itself when it is dialogue, where question and answer, answer and question are exchanged with one another. The idea of speaking to someone else who is to respond is already implied in the word 'dialogue'. These two aspects are inseparable (Gadamer, 1996: 128).

In other words, language is only meaningful when people are engaged with each other through dialogue. However, when extreme points of view are in dispute – for example, when politicians engage in heated parliamentary debate – both parties are charged by emotions that make their positions irreconcilable. This kind of verbal engagement is not a dialogue for Gadamer, rather a genuine dialogue needs the participants to build a conversation on shared interests: they have to begin by being 'with' each other. If two people talk at cross purposes, the conversation is doomed to fail. Having established a platform, the resulting dialogue is structured by the interplay of questions and answers. Instead of trying to out-argue each other, questions will be used to explore the weight of opposing opinion expressed in the answers received (Gadamer, 1979). As a result, knowledge will emerge and personal positions will be transcended, enabling a 'unity of an aspect' to replace disagreement with a sense of common meaning (Gadamer, 1979: 331).

Drawing on his extensive research into collective thought processes, the British physicist David Bohm (1917-1992) believed that genuine dialogue requires each person to partake of 'the whole meaning of the group' (Bohm, 2004: 31). For Bohm, when a number of people enter into a dialogue, a flow of meaning will emerge and new understandings will be formed. This flow is clearly dynamic and creative enough to help groups of people, even whole societies, build platforms for connecting together within a 'unity of an aspect' (as Gadamer would have put it). Bohm explains the concentrated dynamic of the flow of group dialogue using the analogy of a laser beam. As a physicist, Bohm compares the coherence of a laser beam to the unified power of collective thought:

> The power of the group goes much faster than the number of people. I've said elsewhere that it could be compared to a laser. Ordinary light is called 'incoherent,' which means that it is going in all sorts of directions, and the light waves are not in phase with each other so they don't build up. But a laser produces a very intense beam which is coherent. The light waves build up strength because they are all going in the same direction. This beam can do all sorts of things that ordinary light cannot (Bohm, 2004: 15-16).

Here Bohm is defining dialogue as a social energy that can transform the incoherence of human thoughts into a focused collective entity. Therefore dialogue not only creates connections, it also generates social coherence.

Like Bohm, Freire sees conversations between groups of people as a powerful instrument of social change, describing dialogue as an 'encounter between men, mediated by the world, in order to name the world' (Freire, 2004: 88). Accordingly, groups of people who name the world have chosen not to be silent, they have decided to change the world they want to live in. Thus the active participation of both parties in a dialogue entails a strong desire to learn and 'name the world' and so effect social change.

Freire's career seems to prove that dialogue between teachers and students can actually change the world.[7] The process of what Freire calls 'dialogical' education is open and democratic allowing the teacher to become a student and the student to become a teacher. Both teacher-student and student-teacher are thus able to develop critical thinking that has the potential to extend transformational attitudes from the context of the classroom to society as a whole (Shor & Freire, 1987; Freire, 2004). As an artist working in the social context of organizing exhibitions

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[7] For example, Freire successfully taught 300 illiterate sugarcane workers to read and write in 45 days in Brazil in 1962. In Brazil at that time, only literate people could vote. His practice paved ways for the setting up of thousands of dialogical classes across the country with the approval from the Brazilian government.

for an NHS hospital, I am interested in the idea of a transformative power that is unlocked by group dialogue.

By exploring the concept of dialogue as used by the philosopher Gadamer and examining the complementary social and psychological perspectives of an educationalist, Freire, and a quantum physicist, Bohm, we learn that dialogue can not only connect people, but also transform the world. Now it is time to go back to the role of dialogue in the healing process.

I find that common ground exists between the nature of dialogue and the meaning of healing. Given the discussion above, it seems safe to say that the dialogues that occur between a physician and a patient constitute an important part of treating an illness (Katz, 1984 & Brody, 1992 cited in Widdershoven, 2000; Gadamer, 1996). As we have seen above, Gadamer's book *The Enigma of Health* (1996) argues that dialogue between the physician and the patient can enhance the healing process. As the philosopher says:

> Genuine dialogue is concerned with creating the opportunity for the other to awaken his or her own inner activity – what doctors call the patient's own 'participation' – without losing their way once again. What takes place here between doctor and patient is a form of attentiveness, namely the ability to sense the demands of an individual person at a particular moment and to respond to those demands in an appropriate manner. It is in these terms that we must understand what is involved in therapeutic dialogue. It is an attempt to set in motion once again the communicative flow of the patient's life experience and to re-establish that contact with others from which the person is so tragically excluded (Gadamer, 1996: 138).

Traditionally, the doctor dominated the dialogue (Widdershoven, 2000). However, in a genuine dialogue, both the doctor and the patient become active participants by listening, accepting and considering the viewpoint of each other. Therefore, Gadamer's idea is that medical treatment is improved when the physician and the patient can really understand what each other says, when they agree on the subjective experience of illness. In this way the physician connects with his

patient and the patient reconnects with her life and her environment suggesting that a sense of wholeness is possible that, as we have seen in the discussion above, is synonymous with healing.

In terms of healthcare, this dialogic wholeness happens at the micro, or individual, level because a physician is always focused on how to help a patient begin their journey back towards health. In contrast, Bohm was addressing the macro level at which dialogue 'heals' the fragmentation of the world. For Bohm the conflicts that break up human society are caused by the limits of our thought and only communication can promote harmonious living. It is therefore, in Bohm's view, through dialogue that human beings are able to acknowledge and tackle the shortcomings of the human mind. By engaging in dialogue at this macro-social level, Bohm hoped that humankind can rediscover and re-establish the unbroken wholeness described by the Jewish theologian Martin Buber (1878-1965) in his influential work on I-Thou relationships. Here it is not just subject-to-subject encounters but also many subject-to-object interactions (e.g. between humans and their ecological environment) that are enhanced by the model of a caring person-to-person engagement. The lost dialogic wholeness that Bohm had in mind was based on Buber's idea that all relationships should emulate the respect felt by one whole person for another, for one 'thou' by another (Senge, 2004). Therefore, in relation to the use of the word 'dialogue' in my research, it is very important to keep in mind that the kind of human interactions that Gadamer and Bohm describe can help us live in harmony with ourselves and with our environments in a changing world. For these authors there is even a possiblilty that dialogue can help human beings to reconnect with an 'unbroken wholeness' and, as I said above, this is what 'healing' is about – to make whole.

Perhaps we will find an affinity between art and the concept of dialogue (as defined above) in the work of Joseph Beuys (1921-1986). This influential artist's concept of social sculpture is a utopian idea that promotes the creative potential that each human being has to transform society. What Beuys advocates is an active and reflective engagement with society through the creative use of language and thought (Sacks, 1997). This idea occurred to the artist because – as a German who had directly experienced the consequences of the Nazi regime, the Cold War, and the building of the Berlin Wall – the society in which he lived seemed to have been wounded by the history of the twentieth century: Germans were only able to see life as a set of fractured parts, not as a functioning whole. Beuys was committed to making art that would help heal the wound of the world and thus positioned his practice as "a form of homeopathic therapy' which he described as an 'art pill' (Temkin, 1993 in Brenson 1995: 30).

Throughout her career as an art critic, Gablik (1991, 1997, 2000) has often observed that contemporary artists fail to engage with society as a whole. In order to compensate for the growing separation of art from life, Gablik has called for a new paradigm – connective aesthetics – in which artists practise interconnectedness through listening and dialogue, and develop greater levels of social responsibility by shifting their focus from 'objects to relationships' (Gablik, 1991: 7). A social relationship formed in this way is, for Gablik, an artwork, with the kind of healing power that Beuys envisaged, a creative form of interaction and interconnectedness that addresses social alienation and the need for people to live as a communal whole.

Gablik's 'connective aesthetics' can be associated with Kester's notion of 'discursive practice', 'aesthetics of listening' (1999) or 'dialogical art' (2004) in which artists engage with communities in order to seek 'dialogical exchange and

collaborative interaction' (Kester, 1999: 19) and provide an alternative voice from the museum or gallery. In addition, one should also include the publications of Bourriaud (1998) and Bishop (2006), the key promoters of 'relational aesthetics', within this short survey of the literature on art and dialogue, although this approach is more concerned with political provocation and dissent than social healing. Bourriaud is a curator and the concept of 'curatorial dialogue' is certainly an aspect of books such as *Postproduction* (2002). It seems that throughout the 1990s, curators were experimenting with the interpretive relationship that an exhibition establishes with an exhibition-going audience. For example, Jacob (1998) claims that she has been engaged in 'curating conversations'[8] within exhibition projects[9] that provoke 'multilayered interpretations' and initiate 'unplanned directions' (Jacob, 1998: 19). As a result, Bhabha (1998) has coined the term 'conversational art' to describe Jacob's ambition to shrink the distance 'between contemporary art and popular audiences' (Bhabha, 1998: 40).

1.6 Healing through curatorial dialogue

With the example of Jacob's 'conversational art' we have established a basic understanding of the use of the concept of 'dialogue' within art and completed the introductory part of my thesis that has explored the three key words on which my research project has been constructed. I hope that the terms 'healing', 'curatorial' and 'dialogue' have been given enough definition for me to now move forward into a discussion of the historical context of the healthcare culture in which my research was undertaken. I have discovered that 'healing' means 'making whole' and, as the discussion in this chapter has explained, this idea involves making connections in order to establish relationships both with the different parts of my

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[8] The term 'curating conversations' was used by Jacob as part of the title of one of the essays that appears in the book, *Conversations at the Castle* (1998).
[9] Examples include *Places with a Past* in Charleston (1991), *Culture in Actions* in Chicago (1993), and *Conversations at the Castle* in Atlanta (1996).

artistic life and with different parties in my social environment. This may be seen as a promising starting point from which to begin describing a research project that aimed to contribute to the development of art in healthcare. As this thesis proceeds, it will become clear that my main objective throughout my project has been to use art to make connections with members of staff, patients and other hospital users at HGH. As an artist-curator, my research has focused on the kind of creative connectivity that is generated by curatorial dialogue. Eminent authors such as Gadamer and Bohm have, from the perspectives of very different disciplines (hermeneutics and neuropsychology), linked dialogue to the healing process. Therefore, *Healing Through Curatorial Dialogue* has a theoretical platform that now needs to be complemented with a history of the art and healthcare movement in the UK in order to provide the background to my research project.

Chapter 2

Tracing the Path

2.1 A short history of healthcare

This chapter aims to trace the history of the concept of exhibiting art in hospitals in the UK and, more specifically, the development of the collaboration between Northumbria University and Northumbria Healthcare NHS Foundation Trust (NHCT), which is the context in which my doctoral project was established. By understanding the history of Art in Hospitals in the country and in NHCT, I have learnt from other people and found ways to make my own journey.

Almost 40 years ago, in the 1970s, when artist Peter Senior was appointed as the first artist-in-residence in a hospital in Manchester, the idea of exhibiting artworks in healthcare facilities entered into a new era in the UK. Until this time, completed artworks had been either donated or purchased for hospitals in an attempt to offset the institutional nature of the buildings but with Senior's appointment, a precedent was set for artists to actually create art in the midst of a healthcare setting (Senior & Croall, 1993; Senior, 1997). Two decades later, in the 1990s, healthcare practitioners and artists working in the healthcare environment began to debate the benefit of integrating art into the healing process. Lara Dose, Director of the National Network of the Arts in Health, has described art in healthcare as a 'living, breathing and growing area of practice' that has four strands: (1) art in healthcare settings; (2) community art in health; (3) medical humanities; and (4) art therapy (Dose, 2003: xi). As my research seemed to fall into the first category, I briefly looked into the role of art in British hospitals to better understand what has happened in the past.

The roots of the modern hospital can be traced to medieval times. Initially they were not specially made for the sick. Organised by Christian churches and charitable institutions, hospitals gave food and shelter for travelers, pilgrims, orphans and the needy (Park & Henderson, 1991). Examples included the Hotel-

Dieu in Paris in the 7th century, the 12th century Eastgate Hospital in Canterbury (Baron, 1999), as well as the 15th century Santa Maria della Scala in Sienna, where leading artists and sculptors were employed to enhance the spiritual mission of these institutions (Marsh, 2001 cited in Wells-Thorpe, 2003). In medieval times, religious images were believed to have healing powers (Jones, 2008). Therefore, the purpose of art in early hospitals was associated with the role of worship in healing the soul. At that time people believed that illness was sent from God.

Nevertheless a significant shift was taking place under the influence of the British artist William Hogarth (1697-1764). In the 18th century, St Bartholomew's Hospital was rebuilt and redesigned after the Great Fire of London (1666). Hogarth decorated the Grand Staircase with two magnificent paintings that depicted the biblical stories of *The Good Samaritan* and *Christ at the Pool of Bethesda* to illustrate the spirit of the hospital's work. However these paintings were not for the patients, but were used to impress the governors and important visitors (Baron, 1999; Loppert, 1999). It seems that, during Hogarth's lifetime, art in London hospitals had less of a spiritual role than a promotional and philanthropic function: paintings helped funders reach into their pockets.

Hogarth was a leading benefactor to the London Foundling Hospital.[10] Apart from this institution being a vehicle for the painter's sense of charity, it was also a setting in which to display artworks before visiting notables who were art collectors as well as philanthropists. As one of the governors of this hospital of

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[10] Founded in 1739 by the philanthropic sea captain Thomas Coram, Foundling Hospital was home for abandoned children. At that time, the word 'hospital' had the more general sense of 'hospitality', and was used to show hospitality to and take care of anyone who needed help.

abandoned children, Hogarth encouraged leading artists of the day, namely Reynolds, Gainsborough, Wilson, Hayman, Highmore, Roubiliac and Rysbrack, to donate works to the children's home, so as to attract wealthy benefactors. The artworks that were donated were no longer limited to religious subjects and the hospital became a renowned centre of artistic experimentation, an achievement that paved the way to the formation of the Royal Academy of Arts in 1768 (Baron, 1999). From the perspective of this research, Hogarth's approach to art at the Foundling Hospital was pioneering. In the first place, works of art were not limited to the internal function of inspiring the resident foundlings, they were also used to attract the interest of an external public. Secondly, the hospital provided a worthy social context for exhibiting the advanced art of the day. Thirdly, the artworks stimulated a sense of generosity on the part of both artists and benefactors. Fourthly, Hogarth believed that the collection of artworks that had been donated was worth looking after and so Benjamin West was appointed as the curator (Baron, 1999). West was, perhaps, the first person to engage in a curatorial dialogue in a healthcare context.

There was another prominent creative personality of the eighteenth century involved with Foundling Hospital: the composer George Frideric Handel (1685-1759), who was both a governor and benefactor. Handel's celebrated oratorio, the *Messiah*, was performed annually to raise money for the foundlings. Though the hospital was not a healthcare institution in the contemporary sense, Hogarth and Handel anticipated the concept of art and healthcare in many respects: they provided a model for many to follow.

2.2 Hospital design, hospital art

The Victorians thought that pictures, plants and decorations in hospitals benefited the lives of patients (Baron, 1999). This idea was due to Florence Nightingale's

(1820-1910) advocacy of the concept of hospital design. She argued for the therapeutic potential of physical environments, expressing forceful opinions on the form, colour and lighting of hospital wards. Nightingale also believed that the view seen from a ward window was important. In the mid-nineteenth century Nightingale set up her nursing school at St Thomas' Hospital in London, which was rebuilt according to her 'pavilion principle'. The same buildings are in use today and contemporary artworks form part of the therapeutic environment that the Victorian pioneer of healthcare created following her experiences as a nurse in the Crimean War (1853-1856).

Figs. 5 & 6: An exhibition at St Thomas' shows the exterior of the hospital in the Victorian days (left); Image and sound installation at St Thomas' (right).

Despite the advances made during the nineteenth century, it was only in the last two decades of the following century that hospitals in the UK began to take Nightingale's ideas about hospital design seriously. Baron (1999) observes that following the First World War the use of interior colour and decoration in hospitals became taboo subjects. Given that many members of healthcare staff either trained or grew up in a culture that denied the healing potential of interior design, it seems that the context in which I am undertaking my research is a recent reversal of negative feelings about the role of art in hospitals.

Changing attitudes towards art and healtcare gathered momentum in the early 1990s. Two hospitals were planned and built to include commissioned site-specific works of art. These were St Mary's Hospital, Isle of Wight (1991) and Chelsea and Westminster Hospital, London (1993). Such integration of visual arts in hospitals was unique in Britain and, at its most ambitious, the hope was that the arts would complement, rather than merely adorn, the architectural design (Senior & Croall, 1993; Burton, 1997; Eades, 1997; Staricoff & Loppert, 2003). Senior was the consultant for the St Mary's project, which benefited from his expertise and experience in Manchester (Burton, 1997). At Chelsea and Westminster Hospital, the design of the atrium allowed a flood of natural light to illuminate the diversity of commissioned artworks. Furthermore, this airy space was also used for live music, making the building a model of art in healthcare projects throughout the country. Its vibrant art programme set examples for many hospitals that followed (such as University College Hospital, London, and James Cook University Hospital, Middlesbrough). Much of the success is due to the vision of the art director at Chelsea and Westminster Hospital, Susan Loppert (1999), who saw this hospital as a community centre. She writes that '[t]here is no longer a division between the healthy outside world and the hidden world of the sick' (Loppert, 1999: 73). According to Loppert, the impact of this idea was that healing began to be regarded as an art form and the integration of the arts into the healing process fostered new audiences for the practices of contemporary artists.

As a result of these pioneering efforts it was possible for writers such as Macnaughton (2007) to shift their focus from the role of the arts in a therapeutic environment to hospitals contributing to the development of art and culture within the community. Macnaughton commends the approach of Chelsea and Westminster Hospital in opening its doors to the public so that they can 'enjoy a

cultural event' (Macnaughton, 2007: 91). Here we can detect a version of using visual arts to engage the public that dates back to Hogarth and Foundling Hospital.

Fig. 7: Artworks are installed throughout the public area of Chelsea and Westminster Hospital.

The view that hospitals are cultural, as well as medical, spaces was shared by the artist-curator Chris Dorsett and the management at NHCT during the planning of a new hospital for Hexham in Northumberland. Before 1999, there was very little art in the hospitals within NHCT. Even though there was a rising interest in the discourse around art and healthcare across the UK in the 1990s, art was not taken seriously by the management of NHCT. However, Ross Forbes, then Director of Policy and Communication of the Northumbria Healthcare NHS Trust,[11] wanted to introduce art as a 'healing instrument' to the Trust.

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[11] NHCT became a Foundation Trust in 2006, six years after Forbes' resignation.

Being the fourth generation photographer in his family, Forbes had developed a strong interest in visual arts, especially the scope that interesting images have to enrich a patient's experience in 'the threatening environment' of hospitals. He felt that some of the Trust's buildings were, in terms of décor, run down and that the miles of empty corridors 'must be an awful experience for the patients.'[12]

A funding opportunity occurred in 1999 that allowed Forbes to fulfill his ambitions. Because Forbes had no direct experience of running an art project, he sought help from the artist Keith McIntyre who was teaching at Northumbria University. In turn, McIntyre introduced the project to his Head of Department, Professor Gerda Roper, and his colleague Dorsett.[13] As the partnership began to take shape, with McIntyre and Dorsett engineering exhibition ideas, Brenda Longstaff, Forbes's junior colleague, assisted the process of writing the funding application. Longstaff later played a key role in the development of a further set of art projects when Forbes left the Trust in 2000. When the funding was granted, McIntyre, Dorsett and Longstaff realized Forbes's vision with the *Images of Trust* photographic project, which was launched in 2001. In the hands of Ikuko Tsuchiya, the Japanese photographer appointed to undertake *Images of Trust*, this project was an extensive, but highly empathetic, documentary survey of NHCT at the beginning of the new millennium. Tsuchiya's activities had a lasting impact on the collaborative relationship between the Trust and the University.

2.3 Images of trust

For Tsuchiya[14], *Images of Trust* was an ambitious project, in which the photographer was asked to focus her lens on the life of the Trust covering an

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[12] Interview with Ross Forbes on 22 November 2008.
[13] Interview with Keith McIntyre on 4 December 2008.
[14] *Images of Trust* project earned Tsuchiya the Miki Jun Award, the most prestigious photography award in Japan (Northumbria Healthcare Charity, 2006b).

area of more than 500 square miles and over 10 hospital sites. Tsuchiya went into hospitals to meet staff members and patients, explain the project, and take the photographs. Every encounter with people in the Trust was an opportunity for interaction and communication. The resulting images show the intimacy between the subjects and the photographer. As a Japanese person whose first language is not English, Tsuchiya skillfully used photography to communicate with her sitters and audience. The Trust found the approach raised the profile and importance of art in the healthcare environment.[15] Forbes remarked that this was the power of photography.

Fig 8: *Images of Trust* series (2003), by Ikuko Tsuchiya.

As the first collaborative project, *Images of Trust* affirmed the role of art in the healthcare setting in a number of ways: it provided patients with a new level of interests that was not associated with illness; it cultivated a sense of pride amongst staff members for the place in which they worked; it captured historic moments in the daily life of the Trust; it supplied images for health promotion campaigns; and promoted a greater sense of positive self-image amongst patients (Northumbria Healthcare Charity, 2006). However, photography can also be very powerful in a negative way. The exhibiting of Tsuchiya's images

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[15] Interview with Brenda Longstaff on 10 November 2008; and interview with Ross Forbes on 22 November 2008.

sometimes provoked ill feeling among staff members, occasionally for reasons that seemed trivial. For example, two laundry workers were teased by colleagues because a photograph showed them with hairstyles that they had changed. Despite the fact that the two employees had signed a consent form, the photograph had to be removed (Dorsett, 2007). Since it was the Trust's first art project, the reception of the exhibitions in a healthcare setting was uncharted territory.

Notwithstanding the above incident, *Images of Trust* changed people's perception of the role of art and in the Trust's buildings. Forbes described the project as an 'ice breaker' and McIntyre agreed that it 'opened the door for other projects.'[16] Since then, more projects emerged to explore the principles of healing art. Examples include the *Teardrop Garden* by Ryu Art Group,[17] the *Just Well Loved* photographic project by Greek photographer-artist Christina Kolaiti[18] and *The Tyne Track* project for the exterior of HGH[19] (Dorsett, 2007). As the collaboration progressed, the art projects became more diverse and more people participated.

The nature of the projects has also expanded. As Dorsett became more involved, practice-led doctoral projects were established to investigate the nature of the art

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[16] Interview with McIntyre on 4 December 2008.

[17] Ryu Art Group is a group of Japanese art students at Northumbria University. The group was enlisted to design the garden with consultation from the maternity staff of former Ashington Hospital. *Teardrop Garden* is built as space for bereavement at Wansbeck General Hospital, and was awarded the Newcastle Building Society Trophy at the regional Britain Bloom competition.

[18] Steered by Keith McIntyre, this project is about toy stories of local school children. Christina Kolaiti's resulting photographs are in display in the children assessment unit at Wansbeck General Hospital.

[19] The idea of this art project, *The Tyne Track – a marathon walk by the children of Tynedale immortalised in clay*, comes from the geographical location of Hexham, a meeting point between East and West, North and South. By inviting the school children to put their footprints on the clay, the project aimed to generate a sense of ownership among the children as well as to celebrate the spirit of community involvement in modern marathons.

and healthcare concept as it was unfolding within the collaboration between the University and the Trust. Prior to my research, Tsuchiya turned her *Images of Trust* project into an MPhil on the concept of *Therapeutic Touch* and Kolaiti undertook a PhD entitled *The Influence of Photographic Narrative in Healthcare Dialogue*. My doctoral project was the third to be set up by Dorsett within the partnership with the Trust.

My research was a continuation of the curatorial scheme initiated by Dorsett for the opening of HGH in 2003. Both Dorsett and the Trust management were interested in the idea that the new building would be a place where people could go to view art exhibitions by local artists without any healthcare reason.[20] The purpose of this curatorial scheme was to heighten the awareness of staff members and patients to the benefits of art within the hospital setting. Under Dorsett's curatorship, local artists were invited to redefine 'the cultural identity of Hexham Hospital in the public imagination' through a series of rolling exhibitions of loan artworks from local artists (Dorsett, 2007).

Limited by a very small budget from the charity fund, Dorsett's expertise helped NHCT to run a dynamic art programme that benefited both the local art community and the hospital users. The curatorial scheme established an alternative platform for local artists to engage with their public, and offered the local audiences a cultural frame through which to consider the value of their healthcare resources. NHCT has recognised the benefits in the following way:

> The scheme has been widely acclaimed by patients, visitors and staff at the hospital. … the expertise and commitment of the curator is pivotal to the success of a curatorial project. Therefore, the link with a higher education institution is much needed to provide a wealth of expertise within the design, performance and fine art areas which would otherwise not be accessible to NHS Trusts (Northumbria Healthcare Charity, 2006a).

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[20] Discussion with Dorsett on my thesis in January 2010.

Three years after the curatorial scheme began, Dorsett set up a PhD research project *Healing Through Curatorial Dialogue* to examine the nature of the activity that had emerged as he curated hospital displays of current visual art from the region of the North East of England. Dorsett said this research idea was a response to the interesting curatorial potential of mixing together artworks produced in studios situated in the most isolated rural region of England and the strongly youth-oriented social environment of the Northeast metropolitan art schools. Thus the project aimed to build upon a genuinely localized social engagement that respected what was there rather than relied on pre-existing models of 'appropriate' art derived from tired community art models.[21] He was deliberately focusing on what he calls the 'post-community arts' situation. Having been artist-curator at the Pitt Rivers Museum, Dorsett's museum work was partly influenced by the notion of 'participation-production' exhibitions described by British art critic Guy Brett (1991), especially the *Eskimo Carver* installation (1977) by Philippine artist David Medalla:

> The experimental installation work of David Medalla sought to exploit the creative power of exhibition-goers…Medalla provided gallery visitors with scrap material and invited them to invent and label their own exhibits. The result was a parody of an anthropological museum like the Pitt Rivers (Dorsett, 2007).

Dorsett was interested in developing the idea of 'participation-production' practice in the healthcare environment. Therefore, it was my task to explore the 'participation-production' practice at HGH.

The interactions between artists and hospitals have shaped the roles of modern hospitals as a community space on the one hand and extended the social practices of artists to an unprecedented level on the other. As an artist-curator, Dorsett aimed to bring the experimental ethos of the art school to the healthcare

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[21] Ibid.

settings in order to re-define the role of hospital in a community. His interest in 'participation-production' was linked to the curatorial experiments that had shaped installation, site-specific and interventionist practices from the 1970s and his idea for *Healing Through Curatorial Dialogue* was to explore the legacy of these avant-garde activities in the contemporary notion of an artist-curator.

What would result from my interaction with HGH through my curatorial dialogue? How could I integrate the idea of 'participation-production' into my project? Let us define my methodology first in order to develop my curatorial dialogue and evaluate my interaction.

Chapter 3

Taking a Bearing

3.1 A reflective turn

In order to achieve my research aims and objectives, and to ensure the quality of my inquiry, I am now going to define my working methodology. As a photographer, my methodology involves a series of actions and reflections resembling what Schön (1983) called 'reflection-in-action', the reflective practice of professional practitioners working to solve a problem. I learned that such reflective practices echo the inquiry process of action research. In this chapter I will examine the features of reflective practice and action research, and then argue that these particular modes of investigation were well suited to the challenge of working as an artist-curator at Hexham General Hospital (HGH). My task was to construct a model that suited my particular situation using an existing action research protocol designed by educationists Stephen Kemmis and Robin McTaggart. This chapter will also discuss how I arrived at a personalized form of action research that helped me to extend my photographic practice to curatorial practice at HGH.

As a photographer, my aim has been to perfect the photographic artworks I create and strengthen the impact of the photographic projects I undertake. I keep a workbook to record my ideas, my feelings, the way I photograph, and the resulting contact sheets and selected photo-prints. I reflect on the contents of my workbook, and imagine how to advance my practice in the future. There are cycles of photo-taking, recording, looking and reflecting. Sometimes, I invite peer photographers to join in the process of looking and reflecting. This is how I develop my photographic practices - a spiral process in which action, documentation, group-critique and reflection all form my way of understanding and improve my scope as a photographer. Improvement here has two dimensions. One is an increased level of self-understanding and insight in relation to my personal aims as a photographer. The other is an enlarged

capacity to generate interesting dialogues with the various audiences that view my work. My version of action research needed to embrace the creative skills I have developed in my own educational and professional past. It also had to have the potential to transform the physical actions and reflections that constitute all art practice into a convincing doctoral research process.

Barrett (2007) finds that artists learn and create knowledge through action and reflection because art practice is subjective in nature. She argues that art practice is actually the production of knowledge and philosophy in action (Barrett, 2007). Observing that active and reflective learning makes practice and research inseparable for art and design practice-led researchers, Gray and Malins (2004) suggest that the concepts of 'reflective practitioner', 'reflective practice' and 'reflection-in-action' have benefited artists doing research in a systematic way.

In his seminal book *The Reflective Practitioner: How Professionals Think In Action* (1983), Schön develops the reflection-in-action model for practitioners to generate new knowledge from their repertoires of experience, knowledge and skills. The reflection-in-action model helps practitioners to re-frame a problem, and then to conduct 'experiments' to test if the problem is solved. Means and ends are framed interdependently. I realise I have already employed the reflection-in-action model in my practice before learning of Schön's idea. If my problem is to perfect my practice and photographs, then the reflection-in-action answer will be to practise, keep taking photographs. For me, the process begins with experimental photo-taking before showing the photographs to a group of photographers for feedback. Meanwhile, I reflect on the experience in my workbook. After the group-critique and personal reflection, I reframe my ideas and plan for another set of actions. This process continues until I am pleased with all the photographs I have taken. Schön (1983) recognises that there is, in

real terms, little or no separation of research from practice. Reflective practice attempts to unite thought and action into a framework of inquiry (Schön, 1983).

It has been observed that Schön's model of reflection-in-action complements the iterative and investigative natures of action research (Gray & Malins, 2004). Simply speaking, pursuing an inquiry through action research follows a series of cycles of action and reflection. As the cycles develop, learning will inform action, and henceforth action will inform new learning. This is how researchers gain an understanding of their practices and situations (Heron & Reason, 2001; Marshall, 2001). I think of myself now as this kind of reflective practitioner, and recognize that my reflective practices echo features of the inquiry process of action research and, as a result, I have extended my reflection-in-action in order to explore the breadth and depth of the creative activities involved in my photographic and curatorial practices.

3.2 An encounter with action research

In my project, action research is informed by a philosophical system that aspires to generate wellbeing. The knowledge gained from the research process should be useful to people. My research is participatory and seeks to be democratic. In this way I hope to bring together 'action and reflection' as well as 'theory and practice'. Such a research process is, for an art practitioner such as myself, as important as the research outcome (Reason & Bradbury, 2001). If both researchers and people participating in the research project find that their bodies, minds and spirits are liberated 'in the search for a better, freer world' (Reason & Bradbury, 2001: 2), then the very aim of action research is achieved. Hall (2001) suggests that action research is an attitude, even a way of life, not simply a method.

Action research is a big family of different kinds of approaches to inquiry. Working with 62 contributors from across the globe, Reason and Bradbury (2001) include participatory research, participatory action research, human inquiry, co-operative inquiry, appreciative inquiry, clinical inquiry and systems thinking within their 'heavy-weight' *Handbook of Action Research – Participative Inquiry and Practice* (composed of 45 chapters on 510 pages)*.* Given the breadth and depth of approaches, practices, theories and philosophy, Reason and Bradbury admit that it is very difficult to give a 'short answer' to the question 'What is action research?' (Reason & Bradbury, 2001: 1) Still there are core characteristics that unite projects and researchers from diverse backgrounds. Action research seems to be 'participative, grounded in experience and action oriented' (Reason & Bradbury, 2001: xxiv). After seven years of development and debate within the action research community, Reason and Bradbury confidently give a definition for action research in the even heavier and thicker second edition of the *Handbook of Action Research* (2008):[22]

> Action research is a participatory process concerned with developing practical knowing in the pursuit of worthwhile human purposes. It seeks to bring together action and reflection, theory and practice, in participation with others, in the pursuit of practical solutions to issues of pressing concern to people, and more generally the flourishing of individual persons and their communities (Reason & Bradbury, 2008: 4).

The participatory, experiential and action-oriented characteristics of inquiry are still valid but, in this final definition, the emphasis is on developing useful and helpful knowledge for the flourishing of humanity.

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[22] In 2008, the second edition of the same book was published with the contributions from 82 writers. The second edition was expanded to 49 chapters on 752 pages.

Action research is participative when it emphasises research by the people, for the people, never 'on' the people (Reason & Bradbury, 2001: 34).[23] The process of inquiry is collaborative and communicative, during which the contribution of researchers and participants are taken seriously (Levin & Greenwood, 2001). Dialogue within the group of people is vital in the process of inquiry. Gustavsen (2001) observes that the setting for action research is made of moments of dialogue where the researcher is not a supreme authority. It is the aim of the research design to generate as much dialogue as possible (Gustavsen, 2001). Through dialogue, participants in an action research project are co-researchers, co-learners and co-authors (Reason & Bradbury, 2001). Therefore, knowledge is 'co-generated' (Levin & Greenwood, 2001) from a participative way of seeing and acting (Reason & Bradbury, 2001). The idea of participative inquiry fits well with the collaborative nature of my research project. I am enabling a partnership between academia and a healthcare institution as well as establishing connections between artists and audiences. As discussed in Chapter 1, dialogue is crucial in my research process. Participative insight and dialogical inquiry have guided me throughout my research journey.

Because of its participative nature, action research is infamously regarded as a risky methodology (Carr & Kemmis, 1986; Reason & Bradbury, 2001, 2008). It is often reported that it takes time and effort to sustain the collaborative relationship between the project participants (Hampshire, 2000 cited in Gray 2009; Whitehead & McNiff, 2006; Wong, et al., 2001). But it is not uncommon for scientists to invest a great deal of time and effort on experimentation. For

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[23] Interestingly, a book on the community art in the UK is titled *Art With People* (edited by M. Dickson, 1995). By reading the book, one may find that the vision and practices of community art are very similar to that of action research.

example, Marie Curie[24] and her husband Pierre Curie (both made Nobel Laureates in Physics in 1903) after suspecting a new element (which they named radium) responsible for radioactivity took more than four years to finally reach a point where they could present their findings in Marie's doctoral thesis (Froman, 1996). As researchers using action research methods have to work closely with participants, they may not know the response of participants and the outcomes until an action is taken. Such a risky approach poses problems for the evaluation of a research project. Gray (2009) warns that the involvement of participants could make the evaluative process too adaptive to changing situations and compromise the intellectual freedom of the researchers (Whitehead & McNiff, 2006). However, even in a laboratory, the researcher would not know the response of chemicals and the outcomes until an action of experiment is taken and so it seems that these kinds of risk are also found in other research methods. The issue of intellectual freedom is not only thought problematic in action research. When they are undertaken in the context of commercial or political initiatives, many funded science projects also face the same dilemma.

Despite the risks caused by its participative nature, action research within a participatory context benefits from the experiences of all those involved. Since action research sees experience as an important source of knowing, the diversity of experience within any participatory group is valued. Levin and Greenwood (2001) find that this diversity allows for an 'enrichment of the research/action process' (Levin & Greenwood, 2001: 15). It follows that, in choosing action research as your method, the task is to understand one's own experiences and the responses of others in what seems to be a very dialogic approach to establishing knowledge.

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[24] Marie Curie was awarded Nobel Prize in Chemistry in 1911, due to her contribution to the advancement of chemistry by discovering the elements radium and polonium.

Most importantly, action research values creative knowing. Not satisfied with the conventional research paradigms (which privilege objectiveness in relation to subjectivity and distance researchers from their subjects, theories from practices, and academia from societies), action research welcomes any creative actions that seek to explore ways of knowing, and offer creative understandings of our world. The use of non-canonical approaches, such as art, photography, video, theatre, oral history, storytelling, music, dance and other expressive media are not uncommon in action research because they can unveil 'the more submerged and difficult-to-articulate' facets of the problems involved (Park, 2001: 81). Cited examples have included projects as diverse as Schwartz's mural art project that examined education movements in Arizona, USA (1999 cited in Hall, 2001), Mienczakowski and Morgan's *ethnodrama* projects that surveyed health related issues through performance (2001), and Lykes' use of photography in Guatemala to explore the problems faced by women in rural Mayan communities (2001). As Reason and Bradbury put it:

> Conversation and paper writing are valuable tools, but the worlds of theatre, dance, video, poetry and photography invite us to be inspired in the service of better theory and practice (Reason & Bradbury, 2001: 452).

In this light, action research offers my research project a promising methodological framework to conduct a dialogue in a healthcare context using the contemporary practices of an artist-curator. My aspiration is that the investigation I undertake using action research methods will increase our knowledge of the participatory potential of both organizing and viewing exhibitions in hospitals. In turn, my hope is that my doctoral project will shape the idea used to continue the rolling programme of exhibitions at HGH.

Action is, of course, the key component of an action research inquiry. According to Levin and Greenwood (2001), if actions can solve the problems, or help

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participants have more control over their situation then the research is valid. Thus it was my focus to plan, take actions, and reflect on the creative curatorial actions that would answer my questions.

Outside of practice-led research by artists, there have been countless projects using action research to solve problems in clinical settings (Winter & Munn-Giddings, 2001; Hughes, 2008). Examples included: research into the introduction of the preventive measure of knee-length anti-embolic stockings in a surgical ward in Middlesex Hospital, London, led by Kennedy and her nursing team (Kennedy, 2001); changing the traditional nurse-to-nurse handover to an interactive bedside event in which patients give feedback to the incoming nurse in a coronary care unit in a university hospital in Preston, by Searson (2001); health promotion for women from different ethnic groups in the UK by Chiu (2008); to name but a few.

Schein (2001, 2008) even suggests action research as a form of clinical inquiry, supporting research in a way similar to that of the medical profession. In contrast, Reason (1994) argues that action research is not so much a search for scientific fact but an attempt to heal alienation:

> To heal means to make whole: we can only understand our world as a whole if we are part of it; as soon as we attempt to stand outside, we divide and separate. In contrast, making whole necessarily implies participation: one characteristic of a participative worldview is that the individual person is restored to the circle of community and the human community to the context of the wider natural world. To make whole also means to make holy: another characteristic of a participatory worldview is that meaning and mystery are restored to human experience, so that the world is once again experienced as a sacred place (Reason, 1994: 10).

Reason here suggests that action research can help us to understand our world as a whole, an idea that chimes with Bohm's (2004) belief that only group dialogue can return human beings to a state of wholeness. In relation to my

research it is very interesting to see that there is a connection between dialogue, action research and healing.

The experience and knowledge of the above practitioners and theorists have constituted the focal point for my own methodological interest in the healing potential of a curatorial intervention at HGH. As a result, the design of my research project has attempted to combine the theory of action research with the practice of delivering an exhibition programme at HGH.

3.3 An action research cycle

The action research process is iterative or cyclical in nature and is intended to foster a deep understanding of the situations in which action takes place. The process begins with conceptualizing and identifying a problem and moving through several interventions and reflections. Kemmis and McTaggart (1988) develop a model of the typical 'self-reflective spiral of cycles of planning, acting, observing and reflecting' (Carr & Kemmis, 1986: 165).
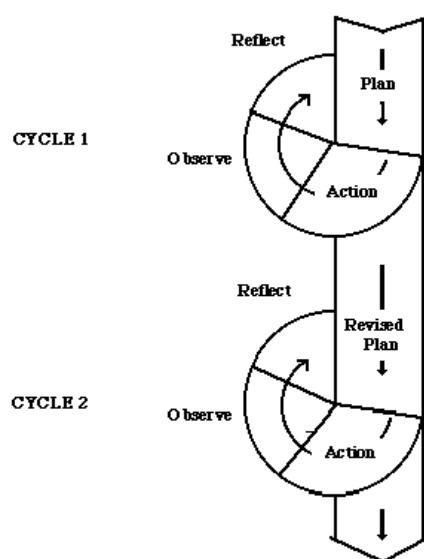
Diagram 1: Action Research Protocol modified after Kemmis and McTaggart (cited in MacIssac, 1996).

Carr and Kemmis (1986) argue that all action researchers should aim 'to *improve'* and increase their involvement as one cycle moves to another. It is suggested that the practitioner should get fully involved in the four phases of the research cycle in order to achieve improvement in the following aspects, namely, the practice of the practitioner, the understanding of the practitioner, and the situation or context in which the practitioner's practice takes place (Carr & Kemmis, 1986). Consequently, the practitioner will improve her practice, her understanding, and the situation. Ideally, more and more people will get involved in the research process and be affected by the practice.

Because the action research protocol designed by Kemmis and McTaggart is mainly for teachers and administrators doing action research in schools, I modified their design to fit my research plan.

Firstly, I added the concept of a 'concern' to the planning phase because I had to understand my situation and identify my concern before I carried out my research. My main concern was how to extend my practice from a photographer to an artist-curator to create art and exhibitions to enhance the healing process. This issue was derived from my research aims: to re-envision the role of art in healthcare for hospital users in North East England; to investigate how contemporary art practice shaped our understanding of the concept of healing; and in particular, to explore how exhibition curation formed effective dialogue between patients, doctors and the healthcare staff as well as the local community, and helped enhance the healing process. In fact, in the *Action Research Planner* (1988), Kemmis and McTaggart propose that researchers should scrutinise 'the nature of a **thematic concern**':

> People describe their concerns, explore what others think, and probe to find what it might be possible to do. In the discussion they decide what it is that it would be feasible to work on – a group project. The group identifies a

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thematic concern. The thematic concern defines the substantive area in which the group decides to focus its improvement strategies. Group members plan action together, act and observe individually or collectively, and reflect together. They reformulate more critically informed plans deliberately – as the group consciously constructs its own understanding and history (Kemmis & McTaggart, 1998: 9).

Even though action research is always a collaborative group inquiry, a point made very clear by Kemmis and McTaggart, the most pressing part of my thematic concern was to construct a cyclical inquiry that a lone practitioner could use. This was important because art practitioners are very likely to start a project on their own. This was my first step towards planning my research cycle.

Concern

Cycle 1

Reflection

Plan#   # plan for art & curatorial interventions

Documentation: audio-recording, photographs, photo-diary, written notes

Action*   * art & curatorial interventions: exhibition installation, photo-taking & art workshops

Reframed Concern

Reflection

Cycle 2

Revised Plan

Documentation: (same as Cycle 1)

Action*   * revised art & curatorial interventions

Diagram 2: My action research plan outline.

Secondly, after addressing this initial problem I planned actions to address my concerns about organizing exhibitions, workshops, and other kinds of art events.

Thirdly, I took actions such as developing contemporary art and curatorial interventions that realized planned actions such as exhibitions, workshops and events.

Fourthly, I substituted the word 'observation' with 'documentation'. I used photographs, a photo-diary, written notes and an audio recorder to document what I observed. My observations included not only objective study but also subjective responses such as my own and other people's personal feelings. Kemmis and McTaggart (1988: 13) define this kind of observatory process as having 'the function of documenting the effects of critically informed action'. As the process of addressing a thematic concern, planning and undertaking an action and then observing the results moved on to the second or third cycle, I became increasingly able to reflect critically on what had happened.

Fifthly, I reflected on the documentation. Carr and Kemmis (1986) suggest that reflection is not only about retrospective understanding but also a prospective action, for which new 'plans are prospective to action, retrospectively constructed on the basis of reflection' (Carr & Kemmis, 1986: 186). Schön (1993) argues that professional practitioners reflect in action. Integrating the ideas of the above theorists I devised the following four kinds of reflection: (1) reflective writing - I kept a workbook which was made up of my reflective writing on my actions, and visual and audio recording; (2) reflection-in-action – I reflected on taking photographs and selecting photographs for my own photographic projects, and also reflected while moving artworks around in order to install them for exhibition in the healthcare environment; (3) reflection on action: from the first two

categories of reflection, I reflected on the whole scenario in my mind; and finally (4) reflection for action: planned the next research cycle.

Hopefully, as the research cycles evolved, my practice as an artist-curator in a healthcare setting improved; my understanding of the healing process deepened; the art and curatorial intervention enhanced the healthcare environment; and staff members, patients and local artists became involved in the project. However the research process was very complex and difficult to evaluate. Reason and Bradbury (2008) suggest that the quality of action research inquiry depends on the awareness, ability and integrity of the researcher as they make choices at every stage of the inquiry. It also requires the researcher to express and explain their decision-making process to the public in a transparent and clear manner. The quality and validity of this process will be discussed in the following chapter.

In the section above I have navigated the reader from the creative practices I developed as a photographer to the methodological approaches I required as a reflective practitioner, finally arriving at a discussion of the evaluative procedures needed to judge the effectiveness of an action research project. This journey represents a search for a working process that could embrace every aspect of a research project based on curatorial dialogue. Schön's 'reflection-in-action' model served as a platform from which I could view my creative practices as a systematic process. Action research quickly began to provide a methodological paradigm because I already used cycles of action and reflection in my approach as a photographer. More importantly I was very inspired by the democratic and humanistic ideals of this method, and the open-mindedness it clearly encourages in its users. In accepting diverse forms of knowing, action research allows different values to be honoured and properly represented. This mode of pursuing an inquiry involved an ideological approach that seemed to liberate me from my

initial worries as a researcher; it made me feel that I was free to carry out my project in a way that was meaningful to me. In the next chapter I will consider in detail the personal significance of the approach I developed as I followed the cyclical programme of an action researcher and began to understand how an artist-curator who specializes in photography could use curatorial dialogue to enhance the wellbeing of different kinds of hospital user groups.

Chapter 4

Charting the Journey

In this chapter I will describe my research journey. With my modified version of Kemmis and McTaggart's action research cycle (explained in the previous chapter) I was able to develop my research at Hexham General Hospital (HGH) as a sequence of four cycles. Cycle 1 was the very early stage when I knew nothing about the hospital and was not sure how I was going to operate as an artist-curator. By the time I was engaged in Cycles 2 and 3, I had learned more about the hospital and gained practical experience in the organizing of exhibitions at HGH. At this point I launched a series of workshops in which members of staff, patients and local artists joined me in a dialogic exploration of the healing potential of art exhibitions. In the last Cycle I concentrated on working closely with hospital staff in order to train them to run a sustainable exhibition programme after my doctoral project was concluded.

4.1 Cycle 1: photographer-oriented

Cycle 1 ran from January to July 2007. At this stage, I had very little idea about how I was going to curate the programme of exhibitions at the hospital. Before my intervention, my supervisor Dorsett had developed a curatorial scheme structured as a rolling sequence of temporary exhibitions. Whilst the programme had been successful, there had been complaints about some of the artworks loaned to the hospital by artists. For example, a piece by the Buddhist Thai artist, Apichart Pholprasert, was removed from the waiting area of the Radiology Department because a member of staff interpreted the collaged hands in the image as 'severed limbs' (Dorsett, 2007). Pholprasert's artwork is now in the estate management office where it is appreciated by the hospital staff. Similarly, in another exhibition, a work by McIntyre was taken off display because people using the corridor in which a series of this artist's animal drawings had been hung were upset with the way a pig had been depicted. As I began the first Cycle of

my action research plan I became aware that the reception of the artworks was going to be a very challenging issue in a hospital environment where the conventions of gallery interpretation (for example, a respect for artistic intention) would have little impact on people's reactions.

Fig. 9: This piece of work is a synthesis of the processes of painting and farm work by the Thai artist Apichart Pholprasert.

The problematic nature of exhibition reception raised above meant that there was an urgent need to introduce and consolidate my practice of artist-curator at HGH. To achieve this end, I needed to have the fullest possible understanding of the actual context in which I was operating. Finally, I needed to be thoroughly briefed on the ethical issues involved. I was the artist-curator but my knowledge of, and experience as, a curator was limited. I was very concerned about the meaning and practice of being a curator. The curator Guy Noble (2005), at University College London Hospitals NHS Foundation Trust, states that his role is to:

> establish and integrate a programme of arts activity across the Trust which will provide a welcoming, uplifting environment for patients, visitors and staff and in so doing improve patient well-being, boost staff morale and widen access to the arts across the Trust (Noble, 2005: 4).

However, Loppert, as Art Director of Chelsea and Westminster Hospital, had a more robust (from the perspective of the arts) attitude to displaying artworks for a

wider audience in hospitals. Loppert (1999) was determined to install artworks that invigorated patients, provoked discussion and challenged expectations, believing that it was her role to break down the barriers between illness and health so that a hospital can function, rather like a cathedral in the Middle Ages, as a centre of a community's life (Loppert, 1999).

However, Miles (1997b) argues that the curatorship of works of art in Chelsea and Westminster Hospital has not changed the culture of power and hierarchy in the healthcare institution:

> It has an extensive collection of contemporary art chosen by 'experts' whose art knowledge is used to replicate the power structure of medical knowledge. The art collection is housed in a building without intervening in its life (Miles, 1997b: 274).

In arguing that hospital exhibitions should be patient-centred, Miles echoes my discussion of curatorial power in Chapter 1 (pp.13-16). In fact, the selection of art at Chelsea and Westminster Hospital has involved staff consultation, but Loppert (1999: 76) insists that 'originality and creativity' cannot be compromised and it should be the artists and the art director (or curator) who translates the needs of the staff and patients into an artistic and creative experience. Miles' advocacy of patient choice and Loppert's insistence on curatorial vision are both important considerations for an artist-curator working in a healthcare setting. Here the selecting of artworks and the installing of exhibitions need not be a reflection of the institutional power of medical knowledge; rather these processes reflect the history of the artist-curator, a history that is rooted in provocative and challenging approaches to the reception of artworks (see Section 1.4).

Undertaking research at HGH as an artist-curator meant that I had to manoeuvre between a sense of caring concern (being patient-centred) and a feeling that the arts could change the experience of those who use the hospital environment (an

insistence on curatorial vision). Given that most of the people I was working with at HGH were not used to contemporary art, even in its most conservative forms, the latter experience was always going to involve a degree of provocation.

Until I began researching curatorial dialogue at HGH I had not worked before in a healthcare environment. Apart from having experience as a hospital visitor, I knew very little about hospital culture. My first impression was that there was a huge gap between contemporary art practice and the aesthetic responses of hospital users (members of staff, patients and the visitors). My concern as an artist-curator was to bridge the distinctive cultures of the art world in which my research project had been initiated and the medical world in which the reception of my research would take place.[25] Here, the term 'art world' refers to the socio-cultural domain in which Dorsett, McIntyre, local artists and I share an understanding of art history and contemporary art practice. In contrast, the 'medical world' encompasses (1) medical staff such as physicians, nurses, and other allied health professionals; (2) non-medical staff such as Brenda Longstaff, the Development Lead-Charities at NHCT (who also oversees the art projects of the Trust) and the administrative and other support staff (such as porters and cleaners) and (3) other hospital users such as patients and visitors.

In the relation to both the art and medical worlds, an important definition of health is provided by the constitution of the World Health Organization (WHO). Here the ambition is to restore a state of complete physical, mental and social wellbeing, not simply maintain the absence of disease or infirmity. The medical world is a place where therapeutic interventions aim to achieve a state that approximates

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[25] For the sake of brevity, I will continue to use the terms 'art world' and 'medical world' to represent the two groups of people throughout the thesis. Readers are mindful of the limitation of such demarcation, as discussed in the Introduction.

the WHO definition (Gilpin, 2003). For the purposes of my research health can be described as a proxy outcome of healing (Buetow, 2002). As we know from Chapter 1, the healing process restores harmony and balance between the mind and the body (McGlone, 1990 & Quinn, 1984 cited in Glaister, 2001). Furthermore I have defined this balance as a form of 'wholeness' and it is possible for the physically unwell to still be 'whole'. Mount, et al. (2007) have concluded that even seriously ill patients can also enjoy a sense of wholeness whilst they have the ability to form social bonds and add meaning to their suffering. 'Meaning unfolds in the context of relationships' (Mount, et al., 2007: 383). Therefore, the scope that an artist-curator has to explore 'healing' is linked to his or her ability to foster good relationships between curated artworks and an exhibition audience.

My research was carried out in accordance with the directions of the Northumbria University Ethics in Research & Consultancy Policy. I also received NHS induction training for the hospital and was made fully aware of the health and safety regulations that obtain to that building. In addition, as I was going to work closely with patients, a Criminal Record Bureau clearance (Appendix 1) was necessary. During the first Cycle of my action research plan I read the *Hippocratic Oath*, named after the Greek physician Hippocrates, which was written as a set of ethical instructions for doctors. One of the most important guidelines states:

> I will prescribe regimens for the good of my patients according to my ability and my judgment and never do harm to anyone (National Library of Medicine, 2002).

Even though I was certain that my own conduct as an artist-curator should do no harm to anyone in the hospital, it was clear from the difficulties experienced by Tsuchiya, Pholprasert and McIntyre that ill feelings were easily generated by

artworks on display in a hospital. In turn, the artists felt offended and frustrated. These incidents have already caused disharmony between the art world and the medical world (dividing people, the opposite of making whole). An exhibition can cause ethical controversies even though a curator intends no harm. It is clear that curators cannot, and should not, control how people respond to artworks. Even so, I made it my priority to consider the feelings and emotions of the patients. If there were any complaints I made it my job to respond with understanding as quickly as possible.

My plan for the first research Cycle was divided into two aspects. First, I planned to visit the hospital in order to acquaint myself with the space and the people in order to understand the context of my practice. Second, I put up two exhibitions of my own artworks as to introduce myself to the hospital. In placing my photographs on display I was aware of the problems encountered with the exhibiting of Pholprasert's and McIntyre's work and I wanted to experience in my own terms the reception of art in the hospital.
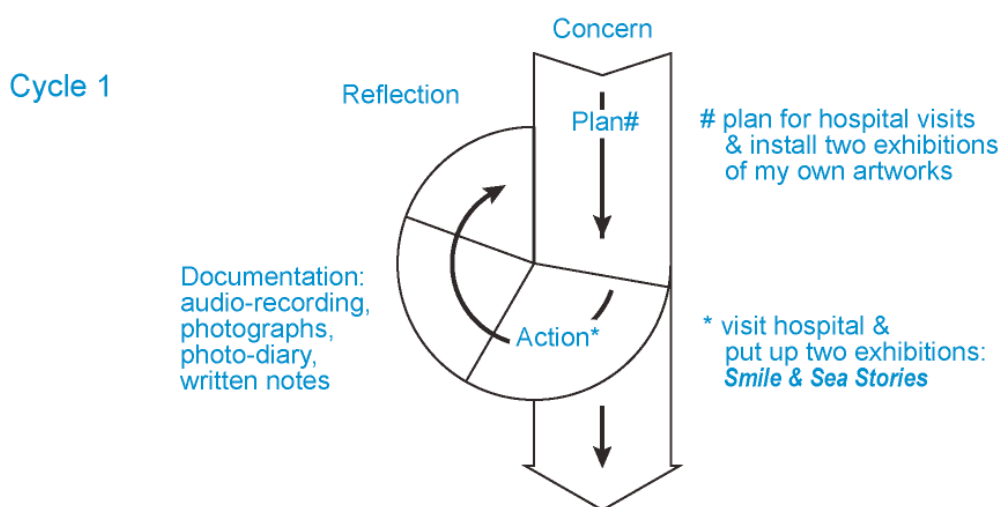
Diagram 3: My action research Cycle 1.

I visited HGH regularly and, during each visit, I photographed the spaces currently used for exhibitions and the artworks already on display. I also took a journal along to write down my observations and make sketches of the setting. Sometimes, I approached people to introduce myself and ask them their views on art exhibitions in the hospital. Although these conversations were important to the first Cycle of my research, I did not document them because I thought it was important to get to know people, and for them to meet me in a relaxed and informal way.

I found that I could freely wander around the hospital using the various public routes that led from the main entrance to various departments of the hospital. Wherever I spotted a potential space for an exhibition, I would take photographs and make notes although, as advised by Longstaff, I did not include anyone in my visual documentation, especially a patient, without permission. Here I was following the procedure recommended in both the University's and the Trust's ethics policies. However, I found it difficult to approach members of staff and patients because I was both too shy and afraid to hear something critical about the exhibitions.
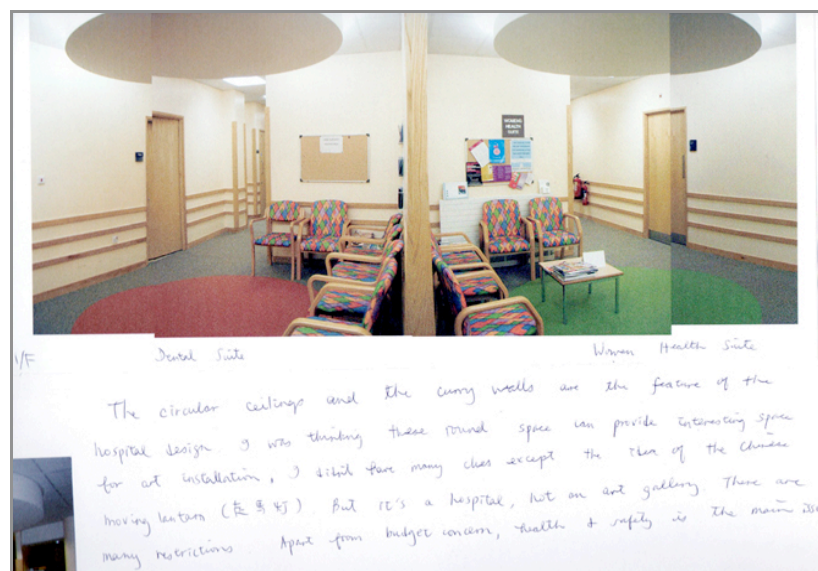
Fig. 10: I documented my visits to the hospital in my workbook (detail).

By the time I had completed my first visits, I identified the spaces for my two exhibitions. As a result, one show, entitled *Smile*, was displayed at the waiting area of the Radiology Department from which Pholprasert's artwork had been removed, and another, *Sea Stories*, was exhibited in the inpatient wards area to replace McIntyre's drawings.

The nine colour photographs that form *Smile* were my MA graduate project. I chose these works for my first exhibition at HGH because I thought they suited the healthcare context. *Smile* had investigated how a facemask (of the kind widely used in public spaces in Hong Kong during the SARS epidemic) affects our ability to express pleasure, or kindness, or amusement. Since some staff members wear masks at HGH, I hoped this exhibition would provoke thought and discussion on the clinical use of masks and on the impact that simple healthcare procedures have on the way we communicate, and build relationships, with one another. *Smile* was shown from April to November 2007. Since Pholprasert's artwork was displayed in the same waiting area, I was anxious to know if my photographs would attract criticism.
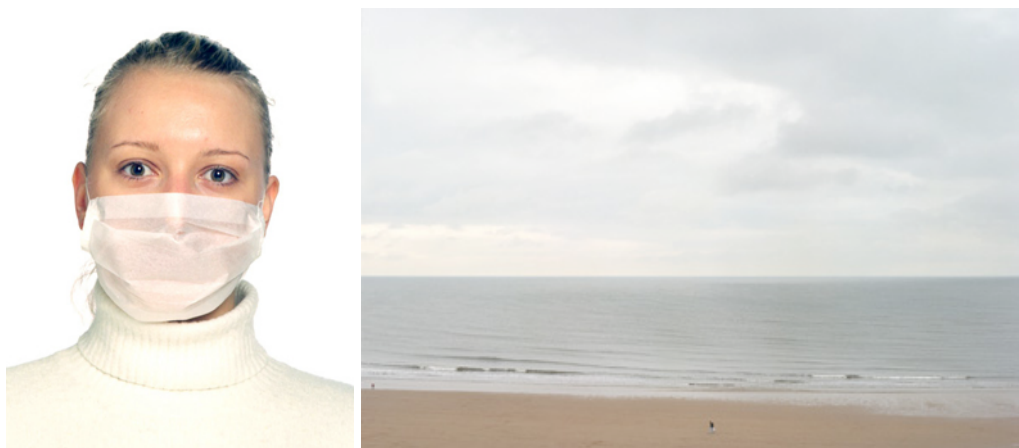
Figs. 11 & 12: *Smile#6* (left); from the *Sea Stories* series (right).

Sea Stories was the second photographic exhibition I curated of my own artworks. On visits to the Northumbrian coast I began taking photographs in an attempt to capture the serenity and vastness of the sea. Through the lens of my camera my mind travelled over the surface of the sea to my home in Hong Kong. *Sea Stories*, which included nine colour images taken in Hong Kong and North East England, was exhibited from May 2007 to December 2009.

Figs. 13 & 14: *Smile* in the Radiology Department (left); *Sea Stories* in the inpatient wards (right).

The two exhibitions had a mixed response. I was told that *Smile* created a feeling of fear and trepidation amongst patients in the Radiology Department. Looking at the mask photographs, patients felt as if they were waiting for surgery because masked faces are associated with operating theatres. A receptionist in the department thought the *Smile* photographs were nice but would have preferred to see images that did not remind her of hospital life. From her reply, I could feel how stressed she was in her work environment. There were compliments though. A young male patient enjoyed imagining what the people in the photographs actually looked like underneath their masks. Lastly, a nurse seemed to praise my work by suggesting that 'they should go to BALTIC'.[26] This comment both categorized my photographs as contemporary art (a positive or negative

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[26] BALTIC Centre for Contemporary Art, the leading art institution in North East England, situated in Gateshead, near Newcastle upon Tyne.

classification?) and suggested that the exhibition was inappropriate for a hospital context (also ambiguous). Despite these (mostly) uncertain responses, no one asked for *Smile* to be removed.

Sea Stories received more positive feedback. When I installed the exhibition, staff members kept coming to see the images. Shortly after it was up, a cleaner stopped her work so that she could study the photographs. In addition, a visitor told me about his stay in Hong Kong. Weeks after this exhibition was installed, a senior manager sent me a compliment.

I made a presentation on the first Cycle of my research at a reception ceremony arranged by Longstaff on 18 September 2007. Local artists, the Trust's management team and members of the public, including the Mayor of Hexham, attended this meeting. I illustrated the gap between the art world and the medical world by discussing the feedback the hospital audiences had given me about my *Smile* exhibition. I also outlined my plans for the next Cycle of my research.

Reflections

Despite committing myself to doing no harm, *Smile* attracted negative feedback from a medical world audience. Since contemporary art welcomes multiple interpretations, a contemporary art curator should, on the one hand, clear up misconceptions and misunderstandings and, on the other, initiate a dialogue between art and society (Busa, 2004). My first attempt at installing exhibitions in the hospital had not generated enough dialogue to create connections between the two worlds.

Since I was responsible for all the curatorial decisions at HGH, I had to be very critical about the quality of the exhibitions I delivered, which directly affected the

validity of my research. The selection process was bound to be subjective but I could offset my own predilections by consulting with other artists such as my supervisors, my colleague Ashley Hipkin,[27] as well as the community of practice-led artist-researchers at the University. Within this latter group, the advice of the photographers Kolaiti and Tsuchiya was particularly useful. At the Trust, because of my responsibility, I automatically became a member of the Healing Art Committee chaired by Ian McMinn, Non-executive Director of the Trust. Longstaff, the Matron and Dorsett were other key members. The committee met three or four times a year to discuss all the art projects within the Trust. At each meeting I reported on the progress of my research and proposed new exhibition plans. The committee collected feedback on the exhibitions from hospital users. As a result, I was able to gather opinions from different sources and use this feedback to inform my curatorial decisions.

As I received comments from the committee I became increasingly alert to the fact that other people's interpretations of art could be very different from mine. These differences were clearly the cause of the tensions that had arisen in earlier exhibitions curated by Dorsett. From my limited experience at HGH, I observed that contemporary art practitioners such as myself, Dorsett, McIntyre, Tsuchiya and Kolaiti would welcome challenging ideas about art whilst the healthcare staff found even the slightest feeling of conflict unacceptable.

In discussing this difference I am aware that I am reducing the role of the artists and the reactions of the hospital community to a simple opposition between the art world and the medical world. However, as I discussed in the Introduction above (pp.xiv-xvi), this distinction does not reflect the fluidity of cultural life in

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[27] As assistant of British artist Anthony Gormley, sculptor Hipkin was the Leverhulme Artist in Residence at HGH in 2007-08.

which artists easily become members of a hospital audience (Dorsett attended the Hexham Radiology Department as a patient soon after Pholprasert's artwork had been removed) and nurses enthusiastically visit exhibitions at the BALTIC to engage with contemporary experiments in visual arts. This overlap is inevitable but confined to particular people who, for one reason or another, find themselves crossing boundaries. The polarity between artist-exhibitors and hospital audiences in my research is clearly a generalization. However, I could define my terms in a more limited way. In this thesis, the art world I refer to is the group of artists, art workers and art academics that were immediately involved in the existing partnership between Northumbria University and NHCT, while the medical world is composed of the management staff within the Trust, and members of staff, patients and visitors, who are supposed to be the audience of art exhibitions, at HGH. A series of diagrams is used below to analyse the different scenarios in which these two worlds came together in relation to my research.

Scenario 1: no relationship

This scenario describes the situation before any art and healthcare projects had taken place at HGH. The artists and the hospital users have no relationship. Their values, ways of living and perception of art are very different. The two realms have no intersection at all.
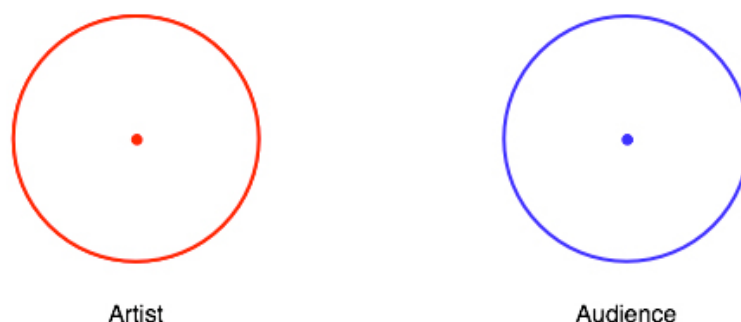
Diagram 4: No connection between Artist and Audience.

Scenario 2: audience interested in art

An audience who is interested in art would go to galleries to see artworks. Members of staff came to see the photographs of *Sea Stories* even when they were still in the installation process. This suggests that, if an audience is interested, they will reach out into the realm of the artist.
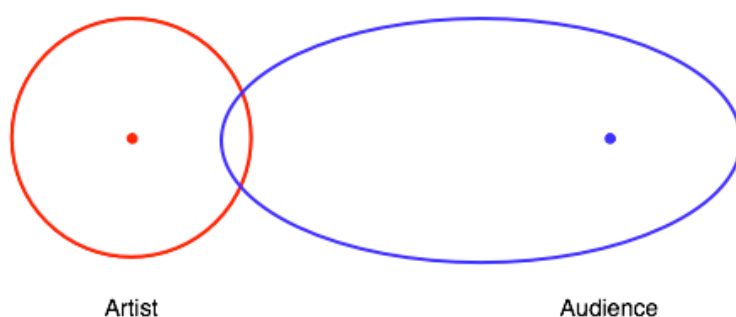
Diagram 5: Audience reaching out to Artist.

Scenario 3: artists reach out to the audience

In setting up a curatorial scheme for the new building of HGH in 2003, both Dorsett and the Trust management hoped that people would visit the new hospital without a healthcare reason.[28] Indeed, some NHS managers aspired to make HGH as much a social space as a healing place and sought to increase the local community's engagement with its hospital by asking Dorsett to curate exhibitions. This was the reason Dorsett invited local artists to loan works to his curatorial scheme. Local artists reached out to their local community by lending their artworks for a period of time so that the hospital users had the opportunity to enjoy art. Because of this, the realms of the artist and the audience have some intersection.

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[28] Discussion with Dorsett in January 2010.
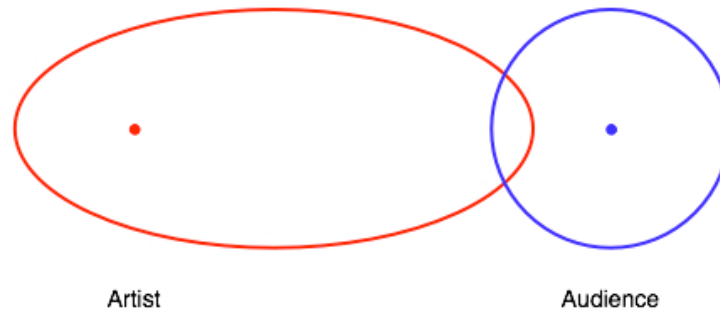
Diagram 6: Artist reaching out to Audience.

However, it was found that some of the audience did not appreciate the artists or the artworks. Rather, they interpreted the artworks very differently from the intentions of the artists. Worse, some even felt offended when viewing the artworks. When these viewers complained to the management, the artists were frustrated because, on the one hand, their work had been misinterpreted, and on the other, the generosity of their intentions (in loaning artworks) had been ignored (as in the case of McIntyre, p.57). Dorsett recalled:

> What was so offensive about the early removals was that the 'local' artists had been invited to engage with the new Hospital by the NHS itself and would have removed their work if the host institution (as a single voice) thought their (generous, non-profit-oriented) **loans** inappropriate. The problem was that the institution was trying to embrace conflicting positions.[29]

Dorsett regarded the ill feeling generated by Pholprasert's artwork as disguised aggression against managerial power and, as a result, objected to the projection of those feelings onto totally undeserving artists caught up in NHS politics. It seemed that feedback from the 'audience' (medical world) was not represented accurately by the management of the Trust. The voice of a single person from the management could override the rest of the staff members, not to mention the patients and the visitors.

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[29] Ibid.

At HGH there were many hurdles for artists who wanted to reach out to their healthcare audience. In a sensitive environment like a hospital, challenging artworks may not be welcomed. How should artists respond? Certainly healing is the main purpose of a hospital space and this 'holistic' concept, as defined throughout this thesis, represents the ideal relationship between artists and their hospital audiences. There should be a harmony and balance within the interaction of the two worlds in order to enhance the healing process. If one side makes an effort but the other side remains static, the relationship will not be healthy or long-lived.

Senior and Croall (1993) point out that it may be difficult for artists to have a sound relationship with healthcare staff, at least in the beginning. They remind artists working in the healthcare environments of the following:

> It is necessary to be aware of the pressures, concerns and constraints of the jobs of the health care staff, and to get to know how the organisation works. Artists have to be educated to look at art in a different way. Too much of it is self-centred: artists are being trained who can't communicate at a basic level. Many are surprised to find, when they take up a residency, that the general public are intelligent and interested in the arts, and that knowledge and fresh ideas are not confined to the narrow world of arts practitioners and critics (Senior & Croall, 1993: 7).

On the other hand, Senior and Croall also think that healthcare staff should appreciate the contribution of artists who bring their talents, creativity and labour to the healthcare environment (Senior & Croall, 1993). I was not sure that either side at HGH understood the situation in the terms used by experienced practitioners such as Senior. The first Cycle of my research had helped me recognize the difficulties of bringing the two worlds into a state of harmony. As a result, I decided that more actions needed to be taken in the next research Cycle to cultivate a balanced relationship.

As I reflected on the disharmony between the two worlds, I asked myself what would make both the artist and the hospital audience accept one another, form connections together and appreciate art in a mutually supportive way. In the art world, it is the job of a curator to bridge the gap between artistic production and audience reception. Busa (2004) summarizes the current situation by saying that 'the main task of contemporary art curators has become the mediator of a dynamic communication process between artists and audiences' (Busa, 2004: 3). At this stage, I have to admit that my curating practice was not developed enough for me to understand how audiences make meaning out of displays of artworks and so the first Cycle of my research should be thought of as photographer- rather than curator-oriented.

The four steps (plan, action, documentation and reflection) of Cycle 1 had helped me learn that there was very little curatorial dialogue at HGH. Indeed, my own first efforts were more like a monologue. If I was going to bridge the art world and the medical world, I needed to achieve the ideal intersection illustrated in Diagram 7. Here, both the artist and the audience reach out to each other's realm and maximize the intersection between the two encircled areas that were depicted in my Diagram 4 as irreconcilably separate entities.
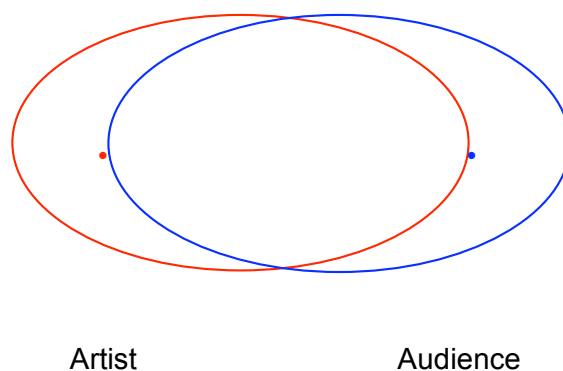
Artist   Audience

Diagram 7: Ideal relationship between Artist and Audience.

54°58'22"N 1°45'48"W

4.2 Cycle 2: curator-oriented

In the second Cycle of my research (August 2007 to February 2008) I sought to give greater definition to the practice of stimulating curatorial dialogue. In my planning I proposed to facilitate the healing process within a dialogical exchange between the art world and the medical world working on the principle that an artist-curator could extend her sphere of activity to that of artistic production and audience reception:
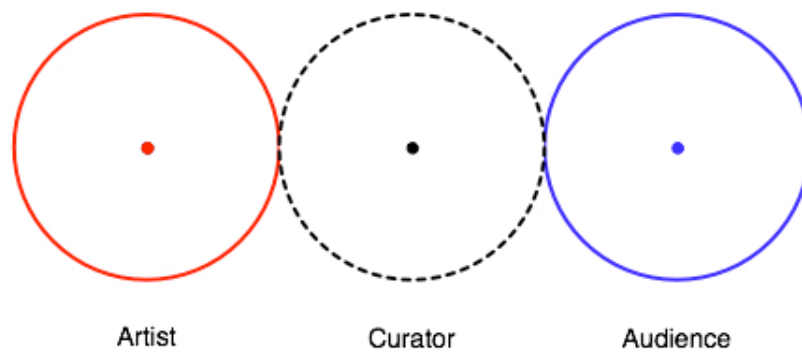
Diagram 8: Curator to connect Artist and Audience.

Action research has a cyclical nature because the researcher keeps reframing the concerns of the previous cycle in the new sequence of making plans, taking actions and being reflective. In the new Cycle I was asking myself to engage once again with the difficult concept of curatorial dialogue. However, the difference in this Cycle was that I had improved my understanding of the concept by identifying the two sides in the dialogical exchange: the two worlds in which the artist and the audience resided. As a result, I was ready to explore the communication opportunities initiated within the process of producing exhibitions and running art workshops. The ideas of Bohm, Gadamer and Freire offered me guidelines for evaluating the effects of my actions.

As we saw above, Bohm (2004) believed that genuine group dialogue 'heals' human beings into a harmonic whole. To conduct any kind of dialogue in a hospital is a challenging task involving the interaction of doctors and patients, administrative and maintenance staff as well as the families and friends of those who are being treated. However, the process is even more of a challenge if the list of participants also includes local artists and members of the various art communities that support the creative culture of the region. Here the dialogue still has to recognize, as Gadamer (1996) suggests, the innate healing power of balancing different positions. However, once artists are involved, the difference is the opposition of science to art.

It is clear that Gadamer (1996) believed that dialogue humanizes unequal power relationships and helps people to reconnect with themselves. Therefore, a curatorial dialogue would: (1) balance the power relationship between the curator and the audience; and (2) offer opportunities for exhibition viewers to find new ways of connecting with themselves and others. This kind of dialogic process also puts Freire's ideas into practice. For Freire (2004) dialogues go beyond verbal language and so my curatorial version would employ the visual and tactile aspects of communication provoked by the presentation of artworks. Similarly, Freire's dialogue moves between acts of creation and re-creation and so it is possible to engage in personal re-learning and re-discovery when using exhibitions of artworks to communicate to the medical world. Therefore to evaluate the healing effects of curatorial dialogue, it is necessary to explore how personal and shared meanings emerge and transform the interaction between the two worlds.

In research Cycle 2, I focused on generating more dialogue with the medical world. The core vehicle for realizing a curatorial dialogue was to be a series of art

workshops in the hospital, which would provide time and space for connections to take place and relationships to build up. The workshops were designed for members of staff, patients, the local community and artists. Each session had three parts: (1) a presentation of artworks (most probably from the forthcoming exhibition); (2) a follow-up discussion; and (3) a practical activity such as making art or curatorial decision-making (in which artworks would be selected and arranged for installation). The workshops were intended as a platform for listening and understanding as well as an opportunity to engage with practical activities. I was the facilitator. Stories of participants would be shared and represented through art. Apart from seeing how people interacted and responded, it was crucial to investigate how the group discussions and interactions shaped the creative process and the resulting exhibition.

Setting up a series of art workshops meant that I had to liaise with Longstaff and other administrative staff. I sought help from Longstaff to book venues for the workshops, and to recruit patients and members of staff. I wrote an invitation letter (Appendix 2) and designed posters. Aims, objectives and formats of the curatorial intervention were clearly explained in the invitation letters as well as a leaflet. Meanwhile, I approached local artists to ask if they would be interested in attending the art workshops as guest artists.

Each new exhibition would be integral to the series of workshops. For every new exhibition I planned, I invited the artist(s) to present their work and guide the participants in some related creative activity. The art produced by the workshop participants would form another exhibition, which would be displayed close to the exhibition by the guest artist. I thought of this method as 'visual dialogue' between the medical world and the art world.

Table 1: A visual timeline of the art workshops from research cycles 2 to 4.

			Actions
Cycle 2	**2007**	8	Preparation for workshops.
		9	**06.09.07** **Focus:** Introduction of art workshops at HGH　　**Outcomes: -**
		10	**03.10.07** **Focus:** Presentation by the student artists on their upcoming exhibitions **Outcomes:** Agreed exhibitions→ *Untitled* (Nov 07 -) *Limbo* (Nov 07 -)
		11	**06.11.07** **Focus:** *Healing Colour* **Outcomes:** Table-top object handling exercise as the core of curatorial dialogue; transformation of participants' attitude; paintings by artist and participants for exhibition of visual dialogue → *Untitled* (Nov 07 - Feb 08) (Left) *Colour Cards* (Nov 07 - Jun 08) (Right)
		12	**03.12.07** **Focus:** *Healing Touch 1* **Outcomes:** Face drawings made by the participants; suggestions made to improve the touch-with-eyes-closed exercises for comparison
	2008	1	**07.01.08** **Focus:** *Healing Touch 2* **Outcomes:** Face drawings by participants; sharing on this touch exercise; suggestions to widen workshops accessibility; *Watch This Face* exhibitions *Watch This Face* series (Jan-Dec 08)	**23.01.08** **Focus:** *Healing Touch 3* **Outcomes:** Clay sculpture by the participants and the artist; written feedback on the first series of workshops
		2	
		3	
Cycle 3		4	**18.04.08** **Focus:** *Curating for Phase III* **Outcomes:** Understanding on the diversity of art practices within the group; agreed group show → *The Expedition (Jul 08 -)*
		5	
		6	**03.06.08** **Focus:** *Navigation from Newcastle to Hexham* **Outcomes:** Understanding on artist's work; paintings by participants; agreed exhibition ↓	**13.06.08** **Focus:** *From A Child's Eyes* **Outcomes:** Table-top photo handling exercise; agreed curation of the exhibition ↓
		7	*Navigation from Newcastle to Hexham* (Jun-Dec 08) *From A Child's Eyes (Jun 08 -)*
		8	**15.08.08** **Focus:** *Curating for Phase III* **Outcomes:** Understanding of artists' ideas; table-top photo handling exercise; *in situ* curatorial exercise; discussion on art exhibitions in hospital	**22.08.08** **Focus:** As left **Outcomes:** as left + transformation of attitude of participants + agreed curation of the exhibitions → *Untitled (Sept 08 - Jun 09) & Middle Kingdom (Sept 08 -)*
		9-12	Preparation for next series of workshops

Table 1: A visual timeline of the art workshops from research cycles 2 to 4 (continued).

			Diabetes Team	Radiology Department
Cycle 4	2009	1	**20.01.09** **Focus:** Introduction - to produce exhibitions for the Tynedale Patients Centre (TPC), a regional chronic diseases management centre **Outcomes:** Shared understanding on living with long-term diseases from the patients' and the healthcare professionals' standpoints; table-top photo handling exercise to express vision for healing art	**23.01.09** **Focus:** *Curating New Exhibitions 1* **Outcomes:** Understanding the audience's reception of modern art; table-top photo handling exercise to find the theme for the upcoming exhibitions
		2	**10.02.09** **Focus:** to understand the group's reception of art and introduce my proposed work, *Flow* **Outcomes:** Table-top photo handling exercise on hospital experiences; debate on the purpose and content of workshops	 *Looking Down* (Mar 09 -)
		3	**03.03.09** **Focus:** Appreciative Inquiry for the best healing art in TPC **Outcomes:** *in situ* curatorial exercise; discoveries and dreams for the space of TPC **24.03.09** **Focus:** Experiencing Illness through Arts **Outcomes:** Open up opportunity for Rowe to work with patients to investigate how art can help cope with long-term health condition; raise the awareness of both doctors and patients to communicate the experience of illness	**06.03.09** **Focus:** *Curating New Exhibitions 2* **Outcomes:** Discussion and sharing on the workshop experience; agreed curation for exhibition, *Ode to Light* series (Mar 09 -) in Patient Waiting Area; discussions on the artist's art; agreed curation for her exhibition *Looking Down* in the corridor (above)
		4		
		5	**05.05.09** **Focus:** Exhibition Proposal for TPC as the conclusion of this series of workshops **Outcomes:** Agreed 3 exhibitions: *Wishes, Flow* and *Tree of Hope*; realisation of the impact of art on clinical space; group's trust endorsement on the curator to finalise the curation of the exhibitions in TPC	 *Wishes* (Jan 10 -)
			 Flow (Jan 10 -) *Tree of Hope* (Jan 10 -)	
		6-9	Actions to execute the exhibition proposal in TPC	

Diagram 9: My action research Cycle 2.

The first series of workshops ran from September 2007 to February 2008. As the facilitator and researcher, I took photographs and kept a photo-diary that narrated every workshop. I video-recorded the last workshop in order to give this concluding session increased presence in the documentation I used to reflect on my progress. This new series of art workshops was realised with the support of the Matron of the Trust and Longstaff. The Matron helped me to explain the idea of the art workshop to the members of staff while Longstaff distributed the posters at HGH and sent invitation letters and leaflets to potential participants.

The content of the workshops and exhibitions depended on the choices I made as a curator. Like the decisions I made in Cycle 1, my selections were subjective although I continued to consult my associates in the art world and the medical world to make sure my choices met with general approval. More importantly, in this Cycle I was able to explore my decision-making within the face-to-face dialogues made possible by workshops.

In this second Cycle, six workshops were launched in various venues of the hospital. Four local artists (3 painters and 1 sculptor) were invited to be guest

artists. Workshop participants included patients, patient representatives, medical staff and a project officer, a local art manager and artists who are residents in the catchment area of the hosptial. Details of each workshop are summarised in Appendix 3.

The number of participants was far from satisfactory: we moved from 2 to 13 and then fell back to 2 in the last workshop. Even though some members of staff told me that they would be coming, in the end, they failed to turn up. A few sent emails explaining that unexpected commitments had prevented them from attending the sessions but, despite my disappointment, I was pleased to meet the local artists who turned up following recommendations from hospital staff or other guest artists – they kept returning and provided a valuable input to the development of the art projects at the hospital.

In each session I explained the purposes of the workshop and a consent form (Appendix 4) was given to the participants before I took photographs for the use of my research. On most occasions, the guest artist presented works as an exhibition preview, and then engaged the participants in dialogue. One workshop in particular was the occasion for a marked change of atmosphere from tension to joy, from heated discussion to relaxing jokes. I am going to explore this event in more detail because it represents a defining moment in the development of my research into curatorial dialogue.

The third workshop of Cycle 2, *Healing Colour,* was held on 6 November 2007 at the Trust Management Meeting Room. Guest artist Tuesday Nesbitt is a painter and was, at that time, a fellow student at Northumbria University. Her work is about colour. As a curator I was interested in her simple and beautiful abstract paintings. More importantly, I thought that, together, we could discuss the healing

potential of colour with the participants. Therefore I asked Nesbitt to lead a workshop that would create abstract paintings that could be exhibited near Nesbitt's works in order to form a visual dialogue. The participants included six patients who had been referred from the Occupational Therapy Department, one carer, one patient representative, two members of staff, two local artists and one local art manager. In the beginning Nesbitt struggled to communicate with her patient participants: for example, one participant declared that 'this is not a landscape so it is not a painting'. Another patient shouted, 'I don't want to understand!' Some participants could neither grasp what the artist was saying nor interpret her art.

Fig. 15: Nesbitt explained the concepts behind her paintings.

The atmosphere was very tense. I then suggested Nesbitt put the paintings in order on a table (as they would be shown on the wall). The participants helped Nesbitt to move the paintings into the right order. An exhibition suddenly appeared on the table. This table-top presentation offered participants an opportunity to view the artworks from a new perspective. The participants began to understand Nesbitt's idea and appreciated her works. They could not help touching the works and expressing their opinions. This led to a more appreciative relationship between the artist's work and the participants.

The atmosphere became much more joyful when Nesbitt led the group in a workshop to create oil paintings. The group finally realised how difficult it was to get the correct colour. During this painting session, patients started asking Nesbitt questions.

One patient asked the artist: 'Tuesday, how long does it take you to get the right colour?'
Another patient answered: 'Wednesday.'

Discussions and jokes were in the air during the making of this visual dialogue. At the end of the workshop the participants said how much they had enjoyed the session and said they would come back for the next one.

Fig. 16: An exhibition on the table: this table-top presentation set a new direction for me to develop art workshops in the future.

During the second research Cycle, all the exhibitions, including two solo shows and two displays of visual dialogue, were a direct result of the six workshops (see Appendix 3). The responses were positive except in relation to the Nesbitt

workshop and exhibition described above. Here hospital audiences expressed their discontent with the 'colour boxes' placed on display (an incomprehensible form of modern art). However I found that passers-by showed interest in the work during the installation. Sadly, this praise did not reach the management.

Fig. 17: The exhibition of visual dialogue resulting from the workshop. Works by Tuesday Nesbitt (left) and the participants (right).
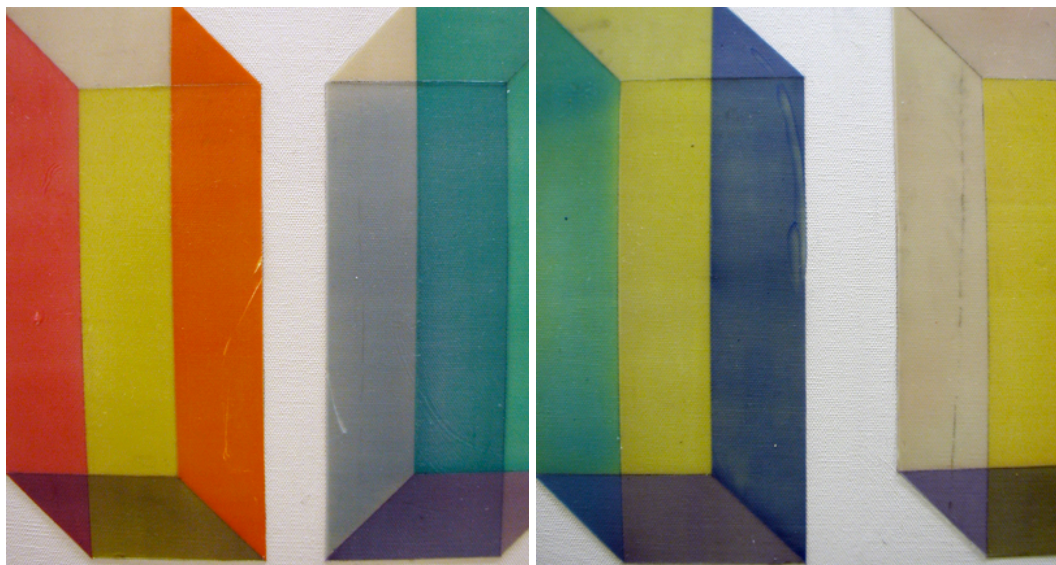
Fig. 18: Scratches were found on two of Nesbitt's paintings in January 2008.

Whilst Nesbitt's exhibition was in place there was, in January 2008, a suspected case of vandalism. Unfortunately it was impossible to judge if the scratches on

two of the works had been deliberately made or caused accidentally.[30] Meanwhile, I was continuing to extend the range of my curatorial projects at the hospital. For example, I began using a wall in the Out Patients Unit – the most visited area of the hospital - to exhibit the progress of my research project (Appendix 5).

Reflections

The workshops aimed to generate dialogue so that the medical world and the art world could understand each other more. I observed that the participants felt free to express themselves and share their visions as the artists unfolded their ideas and stories about their art practices. The workshops were set up for the patients and the members of staff but their participation was very low. I struggled to recruit participants for the workshops. I had a group of 13 participants for the November workshop, but sadly they did not return for the following workshops. In the six workshops I held, the Matron attended three times, an occupational therapist and a project officer each came once. I only got full support from the local artists who came as regular participants. As a result I found the workshops incapable of bridging the two worlds, but I did not want to give them up as I noticed they had potential as a platform for dialogue. Importantly in the fifth workshop on 7 January 2009, the participating artists and the Matron discussed how they could make the workshops more accessible. I now felt that I was gaining more support in this journey.

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[30] The damage to Nesbitt's painting raised ethical issues. Although I cared for the feelings of the audience in the hospital, I also had a responsibility to protect the works of the artists. Artists had to sign a liability agreement (Appendix 6) with NHCT stating that the Trust would not pay any compensation for any damage made within the hospital premises, and so it was the artists who had to bear the sole risk. It was very kind of the artists to lend their works for exhibition for free and it seemed very unfair that their works were so vulnerable to vandalism.

During the course of workshops, local artists became active participants in the curatorial dialogue, becoming committed to their local hospital by attending the workshops regularly. Two of them volunteered to facilitate the workshops when I was not in the country. They also proposed to Longstaff that they apply for more funding for the curatorial project in the new wing of HGH (Appendix 7). These workshops offered opportunities for local artists to extend their influence within their community. The initiatives were taken by the artists without my asking and it was suggested that their proactive actions for the hospital echoed what Gadamer calls the 'inner activity' of people awakened by a genuine dialogue.

The active participation of patients in one workshop (6 November 2007) brought about a transformation in the reception of abstract art and the artist-audience relationship. Although Nesbitt had some difficulty in communicating her ideas to her audience, she managed to do so both in the curating process (table-top object handling exercise) and more successfully, in the practical oil painting session. Nesbitt shared her experience, skills and enjoyment of mixing the right colour while the participants followed her instructions. The active participation of putting the paintings in the right order, mixing the oil and getting the right colour enabled the participants to find a shared language with Nesbitt. I felt this was similar to what Bohm (2004) suggests: suspension in a dialogue - suspend your opinion, just listen and try to understand. The resulting visual dialogue was the shared meaning of both worlds. Bohm (2004) explains:

> If we could all share a common meaning, we would be participating together. We would be partaking of the common meaning – just as people partake of food together. We would be taking part and communicating and creating a common meaning. That would be participation, which means both "to partake of" and "to take part in." It would mean that in this participation a common mind would arise, which nonetheless would not exclude the individual. The individual might hold a separate opinion, but that opinion would then be absorbed into the group, too…. Each person is participating, is partaking of the whole meaning of the group and also taking part in it. We can call that a true dialogue (Bohm, 2004: 31).

Fig. 19: Shared meaning emerged in this practical oil painting session.

However, such 'shared meaning' was only shared by people in the workshops. Negative comments were still made towards Nesbitt's paintings. It seemed that although the November workshop bridged the contemporary art world and the medical world to a certain extent for the participants, the resulting visual dialogue exhibitions failed to reach the exhibition audience.

The workshops were a testimony to my attempt to address one of my research concerns: how to create art and exhibitions to enhance the healing process? Using the four healing connection parameters (Mount, et al., 2007) mentioned above in Chapter 1 (pp.9-10), I observed that participants experienced connectedness at one or more of the three levels: (i) connection with the Self, an experience of realized personal potential achieved by engaging in making art and the curating process; (ii) connecting with others, in which the relationship with the artist improves with better understanding (in the November workshop, the relationship with the artist was transformed from confrontation to understanding); and (iii) connection with the phenomenal world experienced through sight, hearing and touch. In comparison with Cycle 1, in this second Cycle, I made more connections and developed collaborative relationships with the artists and the people of the medical world. Esche (1998) values the collaboration between the curator, artists and the audience: 'we are all collaborators in the pursuit of the

art experience as a transformative, hopefully life-enhancing thing' (Esche, 1998: 249). Here I found I was bringing the two worlds closer together than in the previous cycle.

Nevertheless, I still had a closer relationship with the local artists than with the audience in the hospital. The following diagram demonstrates what I achieved in terms of reaching out to the art world: the roles of the artist and the curator have expanded, so there is a large intersection. But it was necessary for me to reach out towards the medical world (audience). The diagram also visually suggests how the relationship between the art world and the medical world improved as the result of a curatorial dialogue. However, the relationship I established with the two worlds was only confined to those who came to the workshops. Artists participated more actively than the audience in the curatorial dialogue but I still had control over the research process and so I designed some sessions in which an artist, rather than the curator, would lead the workshop. More actions were needed to encourage the audience to engage with the art world.
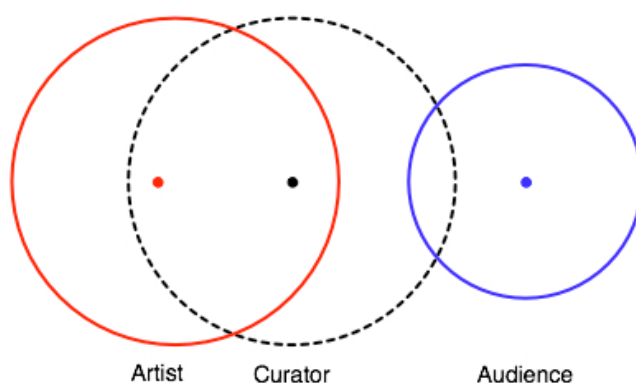
Diagram 10: Connection made in Cycle 2.

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The November workshop paved the way for a new approach to the workshops. At this point I began to encourage the participants to handle the exhibits whilst they sat round the table with the artist. These table-top handling exercises became an essential part of the workshops, helping the audience to appreciate the art, not as fixed exhibits on the wall, but as objects belonging to the artist that could be passed around and considered from different points of view. This was a more direct and physical method of engaging with the contents of a future exhibition. This experience helped me rediscover and relearn the potential of the workshops.

This table-top method is derived from the museological practices of Lieutenant-General Augustus Lane Pitt Rivers, the founder of the Pitt Rivers Museum in Oxford. Dorsett (2008) argues that Pitt Rivers used a table to testify and visualise his ideas on the evolution of design and technology by classifying his ethnological collection into 'typological series'. Such typological displays were adopted as the prevailing style of display at the Pitt Rivers Museum. A photograph in the archives of the Museum suggests that Pitt Rivers developed curatorial ideas by moving objects around on his billiard table. This method was built on non-textual, sensory and embodied meanings (Dorsett, 2008). When an artist like Nesbitt handed round her paintings in the workshop, the participants not only experienced a preview of the exhibition, they also gained a behind-the-scenes insight into curatorial planning. With this discovery I began to relearn what the workshops offered to my medical world audience.

As a result, in the second Cycle, I was establishing a non-verbal curatorial dialogue in my workshops that was helping me refine my curatorial practice. In addition, I found that I benefited from listening to the first-hand feedback, which was offered to me as artworks were passed around the table. This was an

advance on the previous Cycle, where I only heard indirect feedback at the Healing Arts Committee.

At this point I was managing an increasing number of constraints that were hampering my research. In the first series of workshops, I acted as facilitator, researcher and photographer at the same time. At times I found that it was an arduous task to handle a group of people all by myself, as in the November workshop. I missed a lot of conversations between participants while taking photographs and assisting the artist to prepare materials for the practical session. I was trying to do too much: on the one hand, I was pleased to see so many participants attending the workshop, but on the other, I knew I could not handle a large group of people alone. I had to be more prepared in the next series of workshops.

Another constraint was that, since I was focusing my attention on the curatorial aspects of my research, I was sacrificing my photographic practice. I now only took documentary photographs and had neither time nor energy to develop my own photographic work on the subject of healing. I needed to balance my practice as a photographer with my research as a curator.

From the low participation rate of the medical staff, I learned that there were a lot of unexpected urgent cases for the healthcare professionals to deal with. Even though staff members said they would attend, they rarely had the time available to participate. The same situation occurred when I worked with hospital maintenance staff to install new exhibitions: sometimes I had to wait whilst they responded to an urgent request in some other part of the building. After all a healthcare facility is not a gallery: the purpose of the hospital and the staff is to save people's lives and help the ill regain their health. Therefore, art can never

be a priority in a healthcare context. Sometimes I wondered what I was doing at HGH. However, there were members of staff who encouraged me to persevere. For example, the Matron regarded the workshops as a precious time for reflection away from her busy schedule.[31] Despite the constraints that hindered my sense of progress during the second Cycle of my research, it was clear that key people at HGH were now seeing the value of my curatorial dialogues with the art world and the medical world.

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[31] Interview with the Matron to reflect on the first series of workshops in March 2008.

4.3 Cycle 3: researcher-oriented

At this point I saw that I now had a model for bridging some of the differences between the medical world and the art world. As the table-top method developed, I began to receive requests for new exhibitions from the hospital departments that had not previously hosted artworks. These requests offered opportunities for new both exhibitions and workshops. For regular participants, particularly those who had reacted negatively to Nesbitt's work, the continuing programme of curatorial projects created a space for further dialogue with exhibiting local artists. As a result, I planned a third Cycle that would both maintain the coherence of the research steps (plan, action, documentation and reflection) and offer me more opportunities to develop my curatorial and photographic practices.
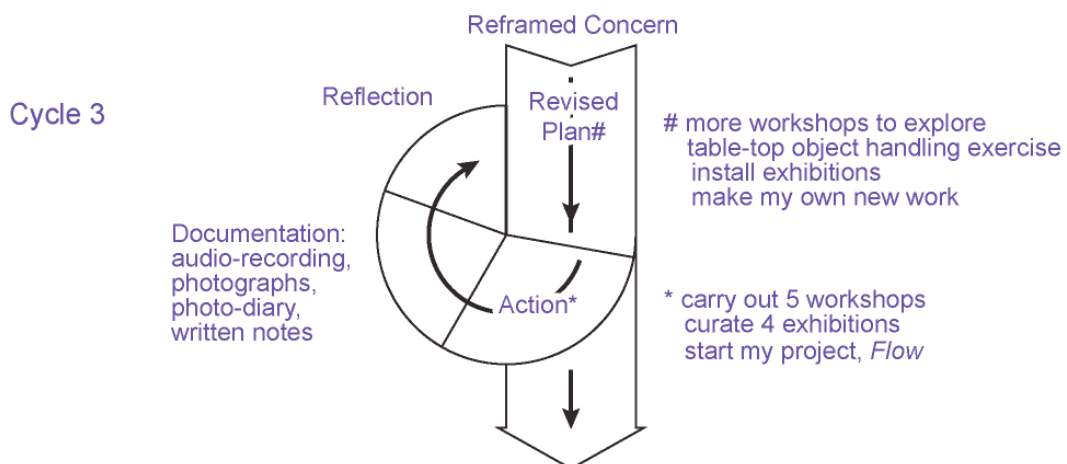
Diagram 11: My action research Cycle 3.

Curatorial Practice

In the third Cycle, I planned to work closely with members of staff to improve the participation rate of the medical world in the workshops. Instead of sending invitations to people in general, I invited specific members of staff to get involved in the planning. They could suggest possible dates and more convenient venues. Since the staff members knew their clinical environments better than I, I could

listen to their opinions and respond within the process of curatorial dialogue. As a result, I hoped I could understand more about the occurrence of 'negative feedback' towards the exhibitions.

Between April and August 2008, five workshops were held in three departments of the hospital. Seven local artists (5 painters, 1 sculptor and 1 mixed-media artist) were invited to lead the sessions.[32] The first two workshops were similar to those held in Cycle 2. Starting from June, a new form of art workshop emerged. On the one hand it developed the table-top art object handling exercise from the previous cycle; but on the other hand, it showed the benefits of working with the members of staff closely. The August workshop developed into two sessions because the members of staff invited had different work schedules. To make this workshop more accessible, I decided to run the same workshop twice with two groups of staff members. I regarded the August workshop as a breakthrough because these sessions set up new directions for me to work in the future. I will feature these two sessions here.

More experiments of table-top art object handling exercises were devised in these two sessions as curatorial meetings for a new exhibition in the newly-built Education Centre, which forms part of phase III of the HGH building development. The Education Centre is home to the hospital's library and conference facilities. Next to the Education Centre is the Northern Skills Institute, a regional training centre for laparoscopic surgery. This brand new centre is busy with visitors from across the country and from overseas. Hence new artworks were needed.

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[32] For details of the workshops, see Appendix 3.

Local artist Teresa Toms approached me and offered her large-scale pencil drawings of a park for an exhibition. On a visit to Toms' studio, I met her husband Colin Cuberth and had an opportunity to see his landscape photographs. I saw that it would be interesting if the couple could make an exhibition together in the Education Centre. I imagined that the emphasis on landscape in the work of these two artists would convert the Education Centre into a park. I followed up this idea by asking if the couple would contribute to my workshop series. The resulting workshop was run twice to fit the schedules of the members of staff in the Education Centre and the Northern Skills Institute. The first session (15 August) was attended by a senior surgeon and a senior nurse from the Upper Gastro-intestinal Surgery Team, whereas the second event (22 August) included a manager and a librarian from the Education Centre as participants. Both sessions took place in a conference room in the Education Centre. I was the moderator, researcher and photographer and Toms was the guest artist leading practical sessions based on her drawings and Cuberth's photographs. These two workshops comprised five parts: (1) a PowerPoint presentation of my previous workshops; (2) a presentation by Toms about her drawings; (3) discussion on Toms' drawings; (4) presentation of Cuberth's photographs (documentary images of Haltwhistle, a town two miles west of Hexham, where the couple have lived for many years); and (5) a group curation of Cuberth's photographs in preparation for the exhibition in the Education Centre.

The photographic curating session was a development of the table-top art object handling exercise from the previous workshops. Participants were asked to select 10 photographs to make an exhibition. Though the staff had difficulties in making choices, they still made interesting selections and gave sensible reasons for their decisions. For example, the surgeon and the nurse liked two photographs of fences because fencing is a technique used in laparoscopic surgery. And a

photograph of an industrial backyard was related to the chaotic operating theatre, the work environment of the medical staff.

My original intention was to ask each participant to select photographs so that each one could narrate a story that could be used as an exhibition theme. As the photographs were chosen I could discern the dynamics and interactions of the participants. In the first session (15 August), the surgeon consulted and listened to the nurse and they made decisions together. By observing this interaction I came to the conclusion that they were already a very close team in their workplace.

The second session (22 August) worked differently. Instead of making decisions together, the participants selected images one at a time, with each person taking turns in choosing a photograph. The particpants included two hospital staff and one local artist, who invited Toms and me to join them in the selection process. As a sequence of exhibition images emerged, the group tried to make sense of the selection in order to construct a coherent story.

Fig. 20: Group dialogues were different in these two sessions during table-top photograph handling exercise.

After seeing the final selection of photographs on the table, I proposed that the participants curate Cuberth's images and Toms' drawings, taking into consideration the space in the Education Centre. I did not impose my ideas on

the process, preferring to let the participants reveal their own talent for curating an exhibition. For example, the surgeon recommended putting a drawing of a path at the end of the corridor in order to extend the view of the corridor. Both Toms and I were impressed by his suggestion.

Fig. 21: As a user of the Education Centre, the surgeon made a very good curatorial suggestion.

In the second session, I showed the participants the curatorial decisions made by the first group. They praised the surgeon's idea to put the drawing with a path at the end of the corridor. However, the second group disagreed with the first group's curation of big drawings interspersed with small photographs. They found that Toms' drawings were powerful, so the photographs would be better displayed seperately.

Fig. 22: Group curations in the actual exhibition space.

They modified the decisions of the first group by putting the photographs on one side of the corridor, and the drawings on the other side. Both Toms and I agreed

that the visual impact was stronger. As a result, the final arrangement of the exhibition was largely based on the decisions made by the second group.

The exhibition in the Education Centre was installed in September 2008. It proved to be very popular. The librarian[33] worked in the Education Centre so she received a lot of first-hand feedback. She was proud to tell me that people enjoyed the exhibition. The surgeon sent me an email[34] after he saw the finished exhibition:

> I am so pleased that you had included us in your curatorial decisions – it makes the whole exercise of showing the pictures more dynamic if the people who use the facility understand the background to the images. I have never had this experience before and both S. C. (the nurse) and myself were delighted that you thought to contact us. We send our very best wishes.

This email was very encouraging because it indicated that the workshop benefited both the medical and art worlds. The participation of the members of staff generated a lot of data for the research process and contributed valuable opinions for the exhibition curation in their clinical environment. Meanwhile their hospital experience seemed to be enriched during and after the workshop.

More encouragingly, as the drawing at the end of the corridor received a lot of positive feedback, it was anticipated that hospital users would be sad to see it leave at the end of the loan period. Therefore, in order to keep this drawing at HGH, the charity at the Trust purchased the work from Toms. For the Trust, this purchase was an unusual event because of the charity's tight budget.

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[33] She retired in summer 2009.
[34] Email from the surgeon dated 25 November 2008.

Fig. 23: This exhibition in the Education Centre was co-curated by the participants in the two sessions in August 2008.

Reflections

I worked with some members of the hospital staff to determine dates and venues for the new exhibitions and workshops. At this point there were five members of staff attending the workshops, and the librarian attended three times. Though the quantity was small, the quality of their input had a significant effect on my research during the third Cycle. These participating staff revealed artistic talent when they curated and narrated the photographs. Dialogue flowed naturally within this group and I realised how important enthusiasm was to the development of a dialogue.

By asking the participants to select and sequence the photographs as well as justify their decisions, various kinds of dialogue emerged from this table-top art object handling exercise. For example, there was:

One-to-one dialogue: In the first session dated 15 August 2008, the surgeon and the nurse were having dialogue for every photograph they chose. They talked, listened and then agreed. The interaction between was richer than the

dialogue in the previous workshops. The surgeon and the nurse knew each other already so they worked well as co-curators. They also understood the dilemma of a curator when they themselves became involved in the decision making process.

Group dialogue: The group dynamic was rather different in the following session (22 August 2008). It set an ideal partnership for both the medical world and the art world working together towards a healing art programme. Though we did not speak much, we did pay attention to each other's selection, and anticipated which photograph to pick in order to create the best flow of a photo-story and thus an interesting exhibition as a whole. It was like having dialogue silently. Each photograph was like a word. The succeeding photograph was like a correspondence with the previous one. Freire (2004) argues that *word* is the essence of dialogue, whereas action and reflection are two inseparable elements in the word. I found that, in this session, I was integrating action and reflection. Here the difference between the curator and the audience was blurred by the impact of the table-top curatorial process. The audience became the curator while the curator became the audience. I regarded this as a significant step to bridge the two worlds.

Re-creating and re-discovery dialogue: The participants and I were discovering the numerous possibilities of exhibition making via the table-top art object handling exercise. We were creating and recreating the stories from the photographs. In the second session, the manager of the Education Centre was very inspired by this table-top exercise. At first, he expressed his respect and trust towards the artists, and suggested that it should be for the artists to decide how to display the artworks. The manager did not think he should interfere in the curating process. But when he participated, he got very engaged. He discovered

the unlimited possibilities of the grouping of the photographs and suggested that people could come back in two weeks to do the selection again.[35]

Within these three types of dialogue I found that the table-top handling exercise allowed the members of staff to confidently install exhibitions within *in situ* curatorial exercises in their actual clinical environment. Furthermore, before the August workshops, I had no idea that the stories created from the photographs would be so interesting. The overall result was very constructive and two ideas about curatorial practice emerged:

1) Curated exhibitions as shared meaning

The exhibitions were the results of the group efforts achieved in the workshops, which, in this cycle, were co-curated by the participants and myself. They were seen as the shared meaning that emerged from our curatorial dialogue. I was pleased with this exhibition making method and planned to continue in the next cycle.

2) Curated exhibitions as transformed meaning

The manager of the Education Centre and the librarian changed their attitude through the workshops. As mentioned above, the education manager admitted that in the beginning he did not have any expectation for the workshop because he disagreed with the staff intervention in the curating process. After participating in the workshop, he was delighted to find that he did make a difference and found the session surprisingly enjoyable. For the librarian, it was the third time she had attended the workshop. At first she was very silent but in the third workshop, she expressed herself more by relating her experience to the photographs, inviting

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[35] Unfortunately, the suggestion could not be realised because the charity could not afford printing new images every two weeks.

me to join their selecting process, showing confidence in the selection made by the group, moving drawings around the space and giving cogent justifications for her curatorial decision. Such transformations were encouraging because they showed the medical world was more receptive to the art world than I imagined.

Within the third Cycle I witnessed breakthroughs in the research I was undertaking through workshop and exhibition curation. In particular, by inviting hospital participants to be curators, I harmonised the power relationship between myself and the audience, which, in effect, helped strengthen the bond between the two worlds. My progress of bridging the two worlds is illustrated in the following diagram. Both the medical world and the art world were now extending the connection to each other. With the newly emerged co-curatorial practice, I found that I could extend my interactions with the hospital user groups, make more connections, and, hopefully, contribute to the healing process.

Artist   Curator   Audience
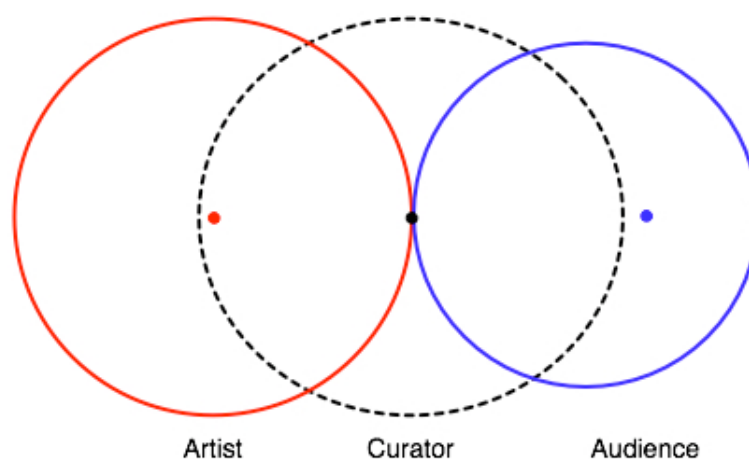
Diagram 12: Connection made in Cycle 3.

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In the table-top exercises, the artists' photographs became art objects. I observed that the actions of holding and passing around made the images generate lively dialogues with all participating groups. Once the photographs were spread out across a table, the participants became very engaged as they

used the images as windows for the imagination: a process that cross-referred to the professional life of the hospital staff, to the workspaces around us, to personal memories and interests. It was very noticeable that the participants expressed their thoughts and told stories by just looking at the photographs. In some ways, the photographs stimulated a more questioning response than the drawings and paintings. As a photographer, I was excited to see the engagement between the participants and the photographs. In the next Cycle, I became interested in experimenting with my own photographs.

I learned that as long as I planned the workshop in advance with the involvement of the members of staff, I could fit the event into the busy schedule of the medical staff. There appeared to be audiences from the medical world who were interested in art and believed in the power of art in the healing process. They would support the art workshops. For example, the senior surgeon brought his lunch to the workshop in order to have time to participate.

Through the cyclic nature of my action research approach, my curatorial dialogues were deepening my understanding of the context of my research project. These understandings enabled me to have more confidence in making curatorial decisions at HGH. The positive feedback from workshop participants, the growing popularity of the exhibitions, and the recognition of the architect[36] were satisfactory outcomes of the iterative development of my ideas for exhibitions and workshops.

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[36] Four exhibitions were created from the workshops in this cycle. No complaints were reported. The responses of these exhibitions were very encouraging. For example, *The Expedition,* a collaborative show by the artists who had formed the core participatory group in the workshops, was very well received. The architect of the hospital, Jonathan Bailey, was impressed by the interaction between the artworks and the space.

Photographic Practice

At the beginning of the research I had planned to start a new photographic project to explore the meaning of healing in North East England, but due to my curatorial responsibilities this had not happened. Now I planned to invest more time and energy on my own photographs. Following previous projects with my husband Nomis described in the Introduction, I attempted to develop a project exploring the relationship between the human body and nature. As Nomis has been taking Chinese herbs and receiving acupuncture treatments, I have become interested in the Chinese notion of healing. Much of the traditional Chinese medical philosophy believes that human beings have an intimate relationship with the environment at all levels. Traditional Chinese Medicine aims at preventing diseases by applying the *yin-yang* theory of balance. Taoist thinker Zhuang Zi interpreted the cosmic *yin* and *yang* as the greatest '*qi*' (energy flow), and wind is the *qi* of the earth (Zhuangzi, 1926). All living beings have *qi*. It was my ambition to explore the concepts of *yin-yang* and *qi* creatively in order to offer an alternative perspective on healing in a Western medical setting. I decided to create a photographic project that could express the Chinese belief in the self-healing properties of human beings, and the proximity between man and nature.

I determined to make more works for this new project, to which I gave the title *Flow*. The idea came from the Chinese notion of healing, which stresses that health is attained when there is harmony between *yin* and yang. Situated in the wilderness of the Northumbrian landscape, I was overwhelmed by the power and beauty of nature. Inspired by the philosophy of Chinese medicine, I tried to find the energy flow within myself and the environment.

Flow was a collaboration with my husband, Nomis. As a photographer, I have been documenting Nomis' chronic illness. By carrying out this art project, I hoped

we could understand the potential of our bodies and hopefully get inspiration from nature to cope with chronic illness.

I produced a triptych. This represented the elements of *yang* (left) and *yin* (right), while in the middle is the body part of a human being which unites *yin* and *yang*. I travelled the countryside to look for scenes that represented *yin* and *yang*. For example, sky, outside, light, sun, south facing and male represent *yang*, whilst earth, inside, darkness, moon, north facing and female represent *yin*. However I was not satisfied with the resulting photographs. Even though they were the best among hundreds of photographs I took in the region, I found that the images lacked the visual impact I wanted. However, I regarded this piece as the beginning of the project: I aimed to create another version before I finished my research.
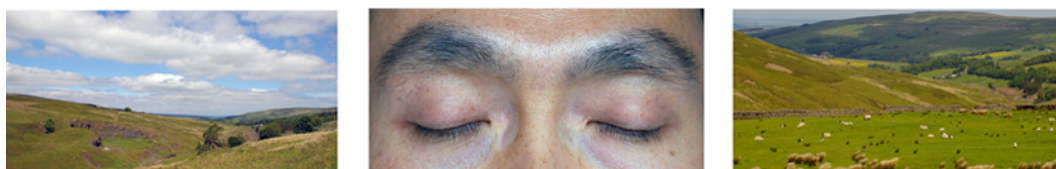
Fig. 24: *Flow.*

Meanwhile, I was very interested in the similarities between the flow of a river and the flow of energy inside our bodies. In our human bodies, *qi* flows through our meridians. I wanted to suggest that the meridians in our bodies are like rivers on our earth[37]. Therefore I visited various rivers in Northumberland to take photographs in order to find equivalents in the landscape to the internal flow of our energy. I tried to capture the state of rivers from different angles. I also experimented with underwater photography. Since I was not familiar with the geography of the region, it took me a lot of time to find a location where I could

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[37] In fact, *Huangdi Neijing* states that the twelve major meridians correspond to the twelve major rivers in China.

safely stand in the middle of the river to take photographs. Sadly, even when I found a good place to photograph, I could not work for long because the water was so cold even in the middle of summer.

Fig. 25: Experiments of underwater photo-taking in River Tyne, near Hexham (the top right and the bottom left photographs taken by Nomis Fung).

Then I remembered that rivers flow into the sea: my recurring theme. For example, *Sea Stories* had been my first curatorial project for the hospital. By focusing my lens on the Northumbrian landscape, I strived to find the flow between the universe and human beings. Still I found it difficult to get the right combination between the landscape and the human body, or the visual harmony between *yin* and *yang*. Dissatisfaction meant that I had to keep taking more photographs and think more carefully about what I was trying to achieve.

For this new photographic project, *Flow*, I still had the same challenge I faced in the previous cycles: not enough time. Since I was dissatisfied with the resulting images, I had to take more photographs. I endeavoured to produce more work,

and planned to present what I produced in the table-top handling exercises in the next cycle. I also planned to reverse the direction in which power 'flowed' from a curator to an audience by asking the participants to curate my work. Bohm (2004) said that genuine dialogue is like water flowing through people. I hope my photographs of *Flow* would prompt a dialogical 'flow' through the group.

Despite my struggles in finding the visual balance of *yin* and *yang*, I recognised that the triptych of *yin-yang* tellingly illustrated my role as the curator at the hospital. Situated in the healthcare setting of HGH, I, the artist-curator, was overwhelmed by the different modes of reception that characterized the medical world and the contemporary art world. The *yin-yang* concept seemed to represent this contrast and, as curator, I was positioned as the relational flow between these opposites. It became clear to me that a curatorial dialogue could be defined as the correlation of our bodies with our environment, which in my case meant the interaction of the medical and art worlds.

4.4 Cycle 4: bridging the gap

The last research cycle took place from October 2008 to September 2009. I worked more closely with members of staff. Two series of workshops were organised with staff of the Radiology Department and the Diabetes Team. The contents, format and aims of these two series evolved from the previous ones. I also integrated my photographic practice with my curatorial practice by presenting my work and asked the participants to curate them. I was curious to learn how the group dialogue would shape my own engagement with the creation of images.

As my research advanced, I became more focused on the sustainability of art programmes in the hospital. I wondered if the workshops could operate as a training opportunity for the staff to run their own programme of exhibitions when I had finished my research. In Cycle 3, I began to explore how the medical world could run art programmes harmoniously and creatively with the art world. Although the participation of patients had always been one of my major concerns, I now decided to concentrate on the staff, knowing that I could indirectly engage in a healing dialogue with the patients through the nurses, doctors and administrators. If the members of staff were aware of the benefits of art in the hospital, they would naturally include the patients in their healing art programmes.

Meanwhile I needed to improve my photographic practice. I took many more photographs than in the previous cycle, but still had to maintain a balance between the roles of artist and curator. I was aiming to strike a balance between the two elements of the 'artist-curator' for the rest of my research project. Since this involved the integration of my photographic and curatorial work, I planned the next cycle in such a way that the action research steps ('plan', 'action',

'documentation' and 'reflection') made no distinction between the personal and organizational aspect of my research.

The planning of new exhibitions and workshops became more integrated. Whenever there was a request for a new exhibition, I would ask myself if it was feasible to run workshops, whether the artists were willing to participate and if the hospital users would benefit from participation. There was a request from a senior manager in the Tynedale Patients Centre (TPC) who suggested I contact the Diabetes Team to create art exhibitions for the new clinic, a regional chronic diseases management centre in the new phase of the hospital.

I also had to look for a new exhibition to replace *Navigating from Newcastle to Hexham* by Jonathan Chapman, who kindly loaned his work to the hospital for six months. The exhibition space was on a corridor leading to the Radiology Department and in the patient waiting area, so I planned to invite members of staff from the Department to attend a workshop to curate new exhibitions. The involvement of this Department would mark a milestone for my research because previously there had been complaints about the display of Pholprasert's work and my *Smile* exhibition in this space. As a result, I felt that it would be very helpful if I could meet the staff in person and engage them in a conversation about art exhibitions in the hospital.

Therefore I invited key members of the Radiology Department and the Diabetes Team to plan the workshops with me. We set the dates and venues. I explained to them the aims and objectives of the workshops. They invited colleagues and patients to the sessions we were planning. The key people involved were the Head of the Radiology Department, as well as the secretary and the consultant doctor of the Diabetes Team. Longstaff was also invited. My hope was that,

having had first-hand experience of my workshop methodology, these people would keep supporting the workshop as part of the future range of social activities of the hospital.
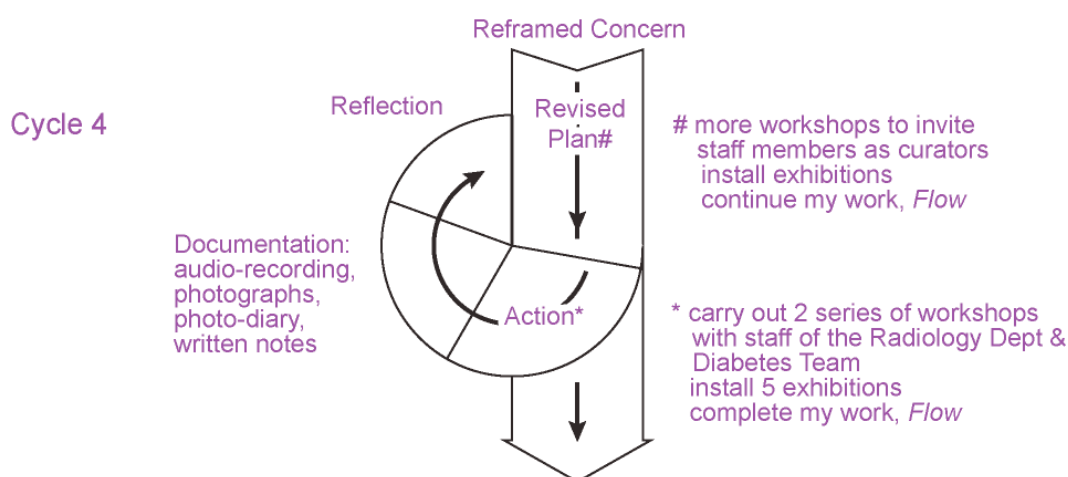
Diagram 13: My action research Cycle 4.

Workshops for Radiology Department

The guest artist who had been invited to lead the workshop had a foot injury and so I had to make a drastic change the night before, and decided that I myself would have to be the guest artist. Although I had no new works to show, I resolved to present an archive of my photographs as a catalyst for curatorial dialogue. The sudden withdrawal of the guest artist offered me an opportunity to take a new approach that built on the experience of the November workshop (see Cycle 2). In the past, my approach to the concept of a curatorial dialogue was that, in the workshops, the artists presented artworks and the participants responded to their ideas. This time I arranged the session the other way round: instead of the participants following the instructions of the artists, it was time for the curator and the artists to follow the participants. The hospital staff were invited to decide what kind of exhibition they would like to see for their clinical environment and the art world side of the dialogue would respond accordingly. This approach would be more risky because I did not know what the participants

would say, but it could enrich the visual dialogue I developed.

As a result, two versions of the workshop were held on 23 January and 6 March 2009 with the members of staff at the Radiology Department. In the first workshop, four radiologists attended. One participant withdrew because there were going to be no paintings in the exhibition. Despite my agreement with the Head of the Department on the length of the workshop beforehand, it had to be shortened from two hours to half an hour because of the pressure of work. I was shocked by their 'unfriendly' attitude but managed to sustain my composure. I conducted the table-top art object handling exercise by showing them my archive of photographs.[38] I asked the participants to choose their favourite images for the display that they would curate in their workspace.

Fig. 26: Radiologists in the January (left) and March (right) workshops.

The participants worked together by eliminating the photographs they did not like. The remaining images had natural or landscape subject matter. By grouping and playing around with the photographs, the participants came up with various ideas for a small exhibition in the patient waiting area. They articulated reasons for their selections and expressed their concerns for their patients in the area. They said that most of their patients were very old people, so it was not easy for them to

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[38] This archive is made of 59 photographs. Among them, 24 are works of landscapes; 15 of artworks / museums; 6 about city life; 3 cityscapes; 2 buildings; 3 portraits; and 6 miscellaneous.

appreciate modern art or contemporary art. The radiologists were certain that people loved to see the countryside. In the end, they agreed that the theme of the new exhibition would be 'Northumbrian nature through the seasons'.

I promised that in the next workshop I would present a new body of work in response to the discussion we had had about the patient waiting area. Meanwhile I looked for a local artist whose works might suit the vision of the radiologists in order to extend the visual dialogue that was beginning to emerge. I also responded with a new series of photographs of my own, which I entitled *Ode to Light*. I was curious to see what these nature photographs looked like as X-ray images and used Photoshop to replicate the visual qualities we associate with this medical photographic process. The results were like film negatives which I found interesting and beautiful. But I was not sure if the radiologists would accept the idea.

Fig. 27: Examples of negative images of Northumbrian nature in four seasons.

I rehearsed the curating session in my mind, anticipating three options for the participants to choose. First, it was the positive images of the four seasons. Second, it was the negative version of the same set. Third, it was the pairs of positive-plus-negative images. From the positive-plus-negative arrangement one more option was also possible: a mirror image. Therefore, I created another set of negative images but flipped them horizontally so that they worked perfectly with the corresponding positive image. I preferred this option to the other

versions described above and hoped that the radiologists would also like this proposal.

In the second workshop on 6 March 2009, I presented 24 images and asked the radiologists to select 8 images to make the exhibition. Three radiologists, Longstaff and the guest artist, Penny Grennan, attended. The radiologists were all delighted with my presentation. They were not only impressed that I had listened to what they had said in the previous workshop, they were also delighted that I had responded 'creatively and beautifully' [39] through my work. They liked all the images I presented, and loved the idea of the mirror image. Because of the limited number of frames installed in the area, the participants could only choose 8 images. However, the Head of the Radiology Department suggested that we have two exhibitions. She thought that it was a pity not to show all the work I had done. As a result, the participants selected four pairs (8 images) for the first exhibition, and another four pairs for the second exhibition. We scheduled each exhibition to last four months: *Ode to Light (I)* was displayed from March to August 2009 and *Ode to Light (II)* from August to December 2009.
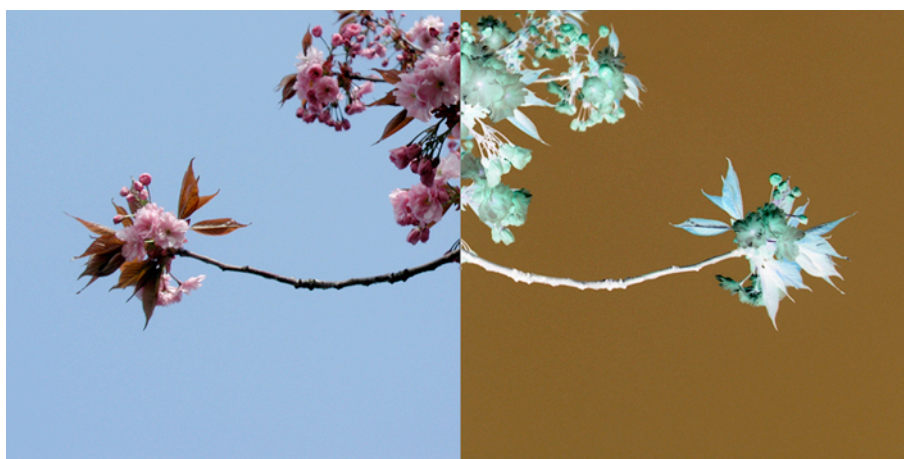
Fig. 28: *Spring* from the *Ode to Light* series.

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[39] Comment from the Senior Radiologist during the workshop.

In the second workshop on 6 March, we also discussed the coming exhibition for the corridor area. Local artist Penny Grennan was invited to present a series of paintings entitled *Looking Down*. The works were about nature, sometimes viewed in an unusual way. Grennan has a congenital sight defect – she has no depth of field and no three-dimensional vision – and so makes paintings about the difficulty of judging distance, speed or changes in her field of perception. The painting in the *Looking Down* series reflect the fact that Grennan spends a lot of time looking at the ground; hence her view of the world is often of the things that position around her at a low level.

Listening to the story told by Grennan, the participants expressed their sympathy and admiration for her as an artist. They said that the background knowledge helped them to look at the paintings from a perspective beyond their imagination. This conversation led to the group discussing the function of exhibition labels and the role of artists' statements in the appreciation of artworks.

Given the long history of resistance and criticism in the Radiology Department, I was relieved to find that the participants welcomed Grennan's paintings. When the workshop moved to the corridor to begin arranging the paintings as an exhibition there was a great deal of dialogue about how each piece worked with the series as a whole. By walking back and forth, moving around the paintings and talking to each other, the group were able to finalize both the sequence of the paintings and the location in which the series was to be installed. Most of the time, Grennan and I remained observers. When the participants made a decision, they asked our opinions. Grennan and I either accepted their proposals or voiced alternative suggestions. They were surprised to find that we listened to them and seriously considered their ideas. This curating process was lively and joyful.
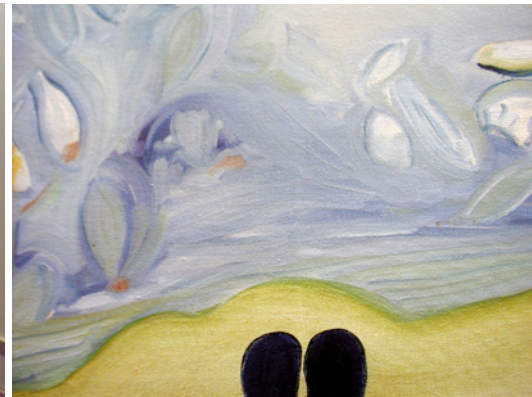
Figs. 29 & 30: Curating exercise in the second workshop (top); *Looking Down* exhibition by Penny Grennan (bottom).
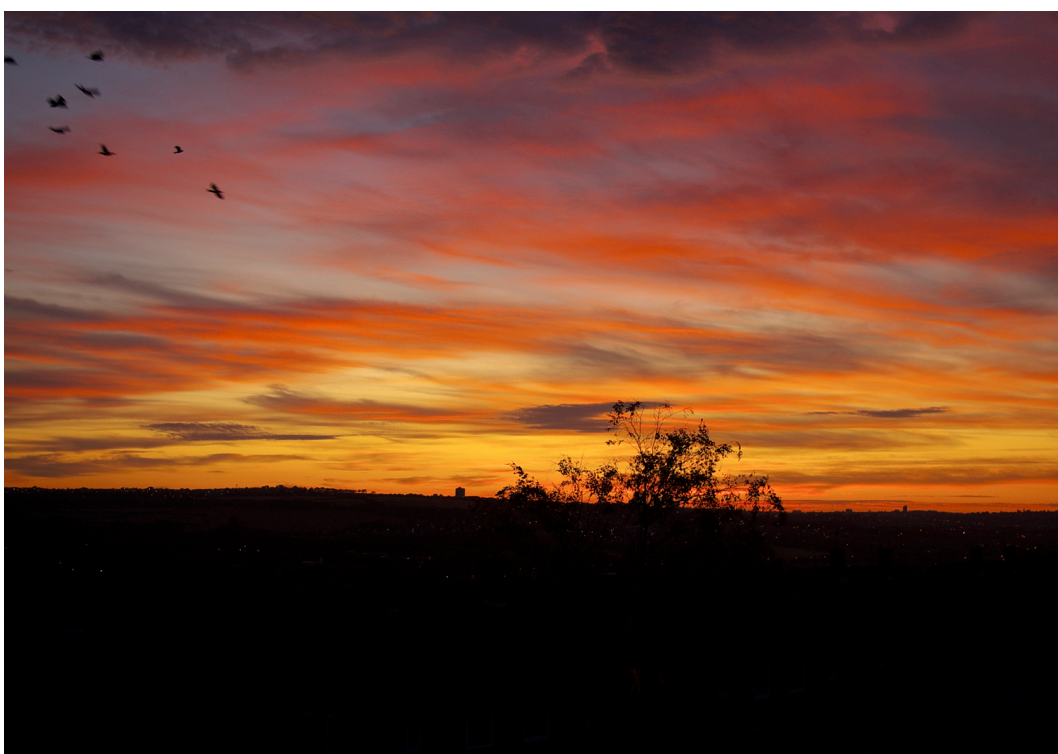
Workshops for Diabetes Team

From January to May 2009, a series of five workshops was held at the TPC with participation of the Diabetes Team (comprising both members of staff and patient representatives). This was the first time I worked with a team of people for a long period on the theme of chronic diseases. We scheduled to meet on Tuesday afternoons every three to four weeks. The first session of this series lasted for two hours but I then shortened the meeting to one hour to fit with the busy clinic schedule at the TPC.

The consultant doctor of the Diabetes Team is also the Clinic Lead of the Long Term Conditions North East (an NHS regional health programme). Acknowledging the limit of orthodox medicine to cure chronic diseases for many patients, the consultant doctor was curious to know if art could play a role to help the patients to live with chronic health conditions. I met with the consultant doctor and told him about my husband Nomis coping with Myalgic Encephalopathy (ME) for twenty years. Therefore, our shared experience of chronic conditions helped us share a vision of the healing potential of art.

The TPC workshops[40] started with 9 participants: 7 medical staff members (the consultant doctor, nurses, dietitians and a podiatrist), 1 secretary and 1 patient representative. During the process, though some of the staff members could not attend due to work commitments, there were new people joining at each session. For example, the patient representative brought two guests, while a cancer group support leader came along after reading a poster in the hospital. Longstaff came to one of the workshops. I also invited my colleague, artist-researcher Alex Rowe, and my supervisor Dorsett to join us. A student at Northumbria University

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[40] For details of this series, see Appendix 3.

who was interested in my research project volunteered to assist me for two workshops. On average, there were 6 participants in every workshop. The number of participants exceeded that of the previous workshops.

To achieve the aim of enriching the patients' and the staff's experience in dealing with chronic illness I designed and developed the following workshop activities:

(1) table-top photograph handling exercise

(2) presentation of art projects on illness and healing

(3) curating exercise

The table-top photograph handling exercise derived from the experience in the previous workshops. In this series, I used an archive of my photographs[41] to invite people to talk about themselves, to share their hospital experiences as well as their preferred photographs for exhibitions in the hospital.

Figs. 31 & 32: An archive of photographs acted as a catalyst for curatorial dialogue in the workshops (left). As a result, photographs were selected by the participants to represent their vision for an ideal exhibition in the TPC (right).

The table-top exercise helped us to achieve a better understanding of each other. Despite the fact that the team knew each other already, they were inspired by the communal effect of handling and laying out the images on the table. Participants

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[41] The same set of photographs I used for the workshop at the Radiology Department (pp. 112-113).

told very interesting, sometimes moving, stories about the visual materials before them. Everyone was immersed in the process and attentive to the dialogue that was emerging within the group. The doctor found that the table-top exercise helped build a team spirit. Dietitian J was inspired and said she would 'pinch' this idea because it was a very good 'ice-breaker'.[42]

With the table-top activities, I wanted to explore how people made aesthetic choices with my photographs. The pictures were of various sizes on various kinds of paper: photographic paper, digital print paper, and A4 plain paper. There were contact sheets as well as final prints and I was eager to know if people would accept and respond to these test strips. Among the chosen photographs, 13 of them were landscapes, 6 scenes from previous exhibitions, 4 miscellaneous views, 1 portrait, 2 cityscapes, and 1 of a building with a rainbow. Among the photographs on the table there was an image of a dead moth and a withering tulip. Although these subjects were not positive ones, the participants told intriguing stories and provided interesting reasons for including these photographs in their exhibition. A collection of working titles were generated: for example, 'good days and bad days' and 'window of hope in the dark world'. The participants related their own experiences to the images and felt that their ideas would be conveyed, through the vehicle of the exhibition, to the patients that attended the TPC.

These workshops explored the experience of dealing with a chronic illness. In the first workshop, I presented my work about Nomis coping with ME. The presentation provoked a lot of questions and Nomis was able to respond to at the workshop. For example, 'what do you feel when you see the photographs

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[42] Email correspondence dated 22 January 2009.

again?', 'do you feel better now?', 'can you find the pattern of good days and bad days?' The doctor wanted to know if we had documented Nomis' life on good days as well as bad days. The expressions of 'good days' and 'bad days' were frequently used in the discussion. I asked the group if this kind of work would be suitable for an exhibition. They said the art project should not focus on one person but feature 'good days' and 'bad days' in terms that related to all patients.

Fig. 33: A documentary project on Nomis living with ME.

In the second workshop, I presented my work *Flow* to the group and asked them to curate an exhibition in the centre. I explained the concept of *Flow*. Since I had not finished the project, I presented them with work in progress, hoping that the participants would understand what I wanted to achieve. There were images of Northumbrian landscapes as well as various body parts (eyes, ears, nose, and mouth) to represent our senses connecting with the external world. Even though I emphasised that the images were not finalised, one of the participants strongly disapproved of some of my images. The doctor was very reserved about the Chinese notion of healing, and worried that the *yin-yang* concept would confuse patients. He stated clearly that he did not like the images of the pulse taking and

the body parts because they were medical. However the secretary disagreed, saying that she appreciated the pulse taking and the *yin-yang* concept.

Fig. 34: *Flow*-in-progress.

Nevertheless I had to accept that photographs of body parts were not welcome. The participants suggested I took photographs of babies, old people or a woman to represent the senses, instead of using Nomis as my subject. I understood their suggestions but could not change the fact that this project was about Nomis coping with his ME. Despite this disagreement, my unfinished images engendered dialogue and it became clear that the TPC group were now very interested in using art to explore the experience of chronic illness. As a resut, the group was concerned about what would happen when I had finished my PhD. They wanted to keep the healing art programmes running. I explained that this was why I had got them involved in this kind of workshop so that members of staff and the patient representative could run sustainable art programmes when I left.

Fig. 35: The unfinished project evoked heated discussion.

In another workshop, Rowe was invited to share with the group the experience of pain that had prompted her to create artworks. The practice-led research project that Rowe was conducting explored the difficulty of communicating the subjective experience of pain to others, both to family members and health professionals. Moved by the story behind Rowe's research, the group was keen to learn if art helped her to cope with pain. Not unexpectedly, Rowe said that it was the most important tool for coping with her chronic condition. In asking these kinds of question, this particular hospital audience was revealing that they knew how to reach out to the art world for alternative ideas about the healing process. In turn, Rowe was encouraged by the response of the group. She was surprised to discover that hospital staff had an interest in the subjective experience of illness represented in her artworks. Here a platform had been established that brought together the two worlds in a single dialogic exchange.

Fig. 36: Rowe presented her artwork, *Red Mirror*.

Meanwhile I used a form of action research methodology called Appreciative Inquiry (AI) (Ludema, et al., 2001). It seemed that this approach was suited to generating curatorial ideas for the TPC environment. AI is about asking:

> the unconditional positive question to ignite transformative dialogue and action…appreciative inquiry is a way of organizational life - an intentional posture of continuous discovery, search and inquiry into conceptions of life, joy, beauty, excellence, innovation and freedom (Ludema, et al., 2001: 191).

Although AI was originally used for organisation development within the business sector, its ideology echoes Buddhist teachings for it teaches us how to bring out the goodness of life and the environment. Aspects of the method also relate to Chinese medical philosophy, for they seek to enhance the energy and harmony of our bodies and enable us to enjoy health and longevity. Moreover, there are people using AI in the field of healthcare. For example, nurses at DuBois Regional Medical Center in Pennsylvania were able to provide better care with AI (Cooperrider & Whitney, 2005) and Reed (2007) employed the method to examine the lives of elderly patients discharged from hospitals in Northeast England. Therefore, I began to reframe my methodology in accordance with the sequence of five phases of inquiry used by AI researchers: (1) positive topic choice, (2) discover, (3) dream, (4) design, (5) destiny (Ludema, et al., 2001). For the topic choice of this series of workshops, I asked myself how I could create art and exhibitions that would unfold in the positive manner described above.

If the table-top workshops had established artworks that were considered by both the medical and the art worlds as a positive topic choice, then, in the 'discover' phase, my inquiry would have to seek 'the "best of what is" in any given situation' (Ludema, et al., 2001: 191). It follows that, in the 'dream' phase, the curatorial dialogue would have to envision 'what could be' (Ludema, et al., 2001: 191). In AI research, 'dreaming' opens the door for alternative voices, unfolding new ways of seeing and understanding the situation. This phase in the inquiry aims to liberate the research, empowering our ability to dream of a positive vision for the future. In my situation, I invited participants to walk around the TPC and search for the factors that gave life to the centre, the 'best of what is', and envisage what could be the best healing art for the TPC.

To facilitate the 'discover' and 'dream' steps in the AI process, I put paintings, prints, photographs, screen installation and books of art throughout the TPC. The displaying of those artworks also had the purpose of testing people's responses to various kinds of art medium and artworks. Participants did 'discover' and 'dream' around the artworks. Some jotted down discoveries and thoughts in notebooks whilst others discussed their ideas openly. Everyone looked very absorbed. They stopped, contemplated and wrote. They explored the space as if they had never been there before.

Fig. 37: Participants used AI to plan exhibitions for the TPC.

Within the sequence of AI phases, researchers have to 'design the future through dialogue' (Ludema, et al., 2001: 192). It is a crucial stage, in which people share their discoveries and dreams, and then discuss and find common ground with each other. Nurse K remarked that the 'discover' and 'dream' processes were a very fresh experience for her. Although she worked in the TPC, she had suddenly seen the centre as a visitor might as they first walk through the door. She noticed the many curves in the space in a new way, and saw that the space could be utilised well with art installation.

Everyone shared his/her discoveries and dreams in turn. Most of them articulated a wish to see artworks that depicted the expressive aspects of the human face. It

was recognised that different people like different things. Thus they expected to see various kinds of art and different types of exhibition themes. They 'complained' about the bright colours of the chairs because such colours could 'compete' with artworks on display. The doctor asked the workshop group to sit in a second waiting area to experience how uncomfortable it could be for the patients using such a narrow space.

Fig. 38: The group experienced how the patients felt if they had to wait here.

I summarised the group's discoveries and dreams in two mind maps before the group proceeded to the phase of 'destiny' in which 5 exhibition plans were proposed as part of my last workshop at the hospital.

Some of the proposals were approved by the group, whilst others were rejected because the group did not find the proposed art projects related to the theme of coping with chronic illness. I did not find this a problem because what mattered was the flow of dialogue that now characterized my curatorial research.
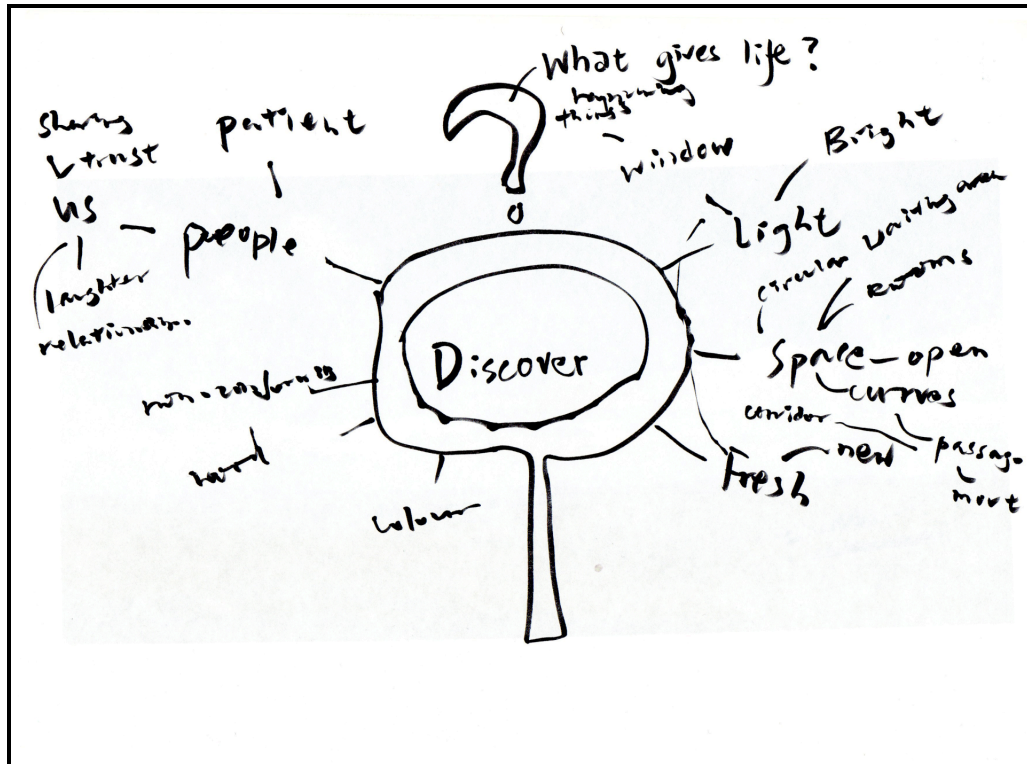
Fig. 39: A mind map shows the group's discoveries of what gives life to the TPC.
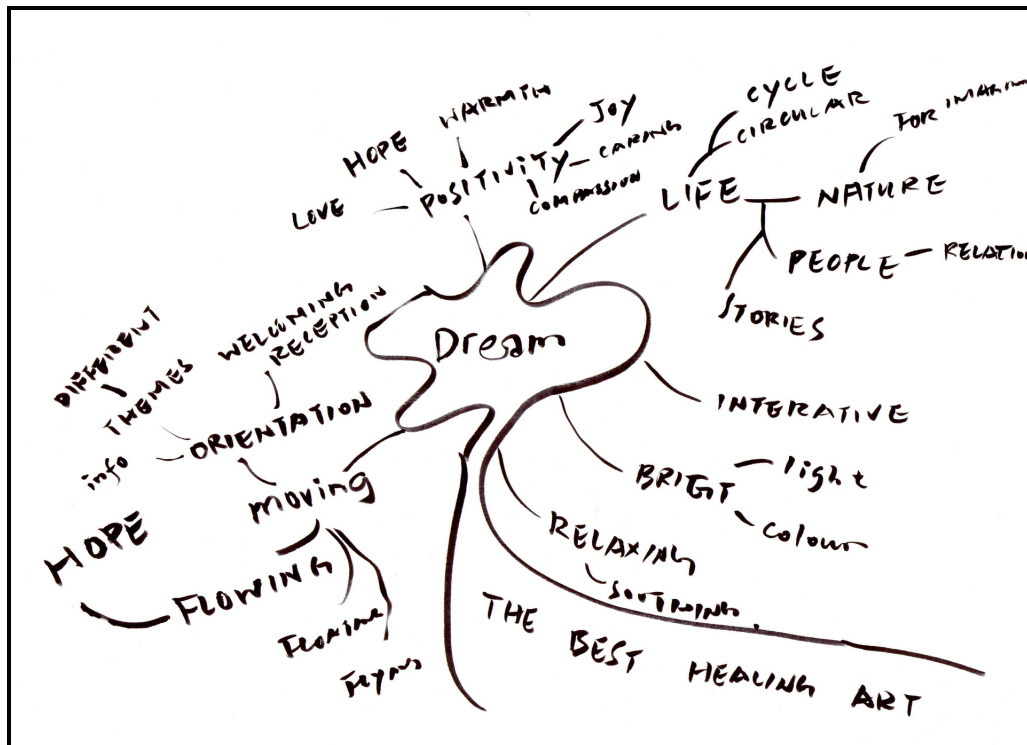
Fig. 40: A mind map shows the group's dreams of their vision for the TPC.

I also presented the latest version of my *Flow* project. As with *Ode to Light* in the Radiology Department, *Flow* was shaped by ideas originating in the table-top dialogues that were now a feature of all my workshops at HGH. I described once again the meridians of the human body that had inspired *Flow*. My new photographs not only showed cycles of water and seasons, but also cycles of life. I was responding to a theme that had arisen in the earlier session: good days and bad days. Here I was exploring the idea that 'come rain or shine, life goes on'. I found myself expanding this theme with the group and, from their points of view, I had successfully extended the *Flow* idea beyond the immediate concern of Nomis' illness.

I arranged the photographs in a grid. These were all finished images that I felt fully represented what I wanted to communicate. This presentation seemed very harmonious because there were no negative comments. The conversation 'flowed' freely in a very friendly and supportive fashion. We talked about how to curate the photographs in the Centre and considered the size of the images, the labels accompanying the works, as well as the significance of the metaphors I had used in some images.

In particular, the doctor responded to the many narratives that were implied by the sequence of photographs. The open-ended nature of the images meant that different people could create different meanings. My favourite photograph, the image of a bridge over River Allen,[43] seem to symbolise the artist-curator bridging the medical world and the art world. I told the group that I wanted to put this image at the end of a passage as suggested by Dietitian J, who was very pleased to know that I had taken her suggestion seriously. Even though the

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[43] A river west of Hexham in Northumberland, River Allen is a tributary of River Tyne.

image was only printed on a piece of A4 paper, the group was impressed by the effect. Nurse K found that the curating process was helping her envisage what was 'right' for the space. The doctor admitted that looking at the 'bridge' photograph on a wall was a revealing experience. 'By seeing a photograph there today, I start to experience what's actually there and what could be there.'

Fig. 41: *Bridge*, from the *Flow* series (the right one taken by Alex Rowe).

Dorsett interpreted these 'revealing experiences' as an important by-product of the collaborative art-and-healthcare project that makes it possible to re-envision the familiar:

> an artist comes to intervene and put something onto the wall. Everybody suddenly looks into the space differently. I would say it's one of the gains for the staff and the patients.[44]

Dorsett said that this kind of curatorial dialogue is an ongoing experiment in which both the art world and the medical world can learn from each other. Lastly, the doctor and the secretary (on behalf of the group) said that I had gained their trust and so I could make curatorial decisions for the TPC. They added that they would let me know if they saw anything inappropriate.

In the description above of my use of the unfolding phases of the AI sequence, it is clear that each step was a learning experience for the TPC workshop

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[44] Dorsett shared his view on the 5 May workshop with the group.

members. The positive nature of handling photographic material and narrating the images once they had been laid out on a table or a floor generated the following ideas for particular environments used by the TPC staff and patients:

1. art can be used to explore and understand the meaning of a long-term health condition;

2. art can be used to uplift the feelings of those who visit or work in the TPC.

We also agreed on the following exhibition proposals:

(1) *Tree of Hope*: an out-reach project with local school students, to transform a small waiting area into an interactive space for the users and the community to share their stories on coping with long-term health conditions and their wishes.

(2) *Wishes*: developed from the first table-top photograph handling exercise in which participants selected photographs to represent their vision of a healing art exhibition for the TPC.

(3) *Flow*: the final version of my photographic work on the meridians of the human body.

After the successful dialogue that had occurred with the TPC group of participants, I was able to execute the approved proposals within the 'destiny' phase of the AI method. The term 'destiny' describes the point in an inquiry where the researcher can construct a sustainable future through innovative actions. My final exhibitions – *Tree of Hope, Wishes,* and *Flow* – were installed in September 2009.

Composed of three wooden panels, *Tree of Hope* was designed for the narrow waiting area with the aim of making this part of the TPC a space filled with

interesting stories. Created by sixth form students from the Queen Elizabeth High School, Hexham, *Tree of Hope* was led by student W who hopes to study medicine after finishing her A-levels. I gave the students complete freedom to create this piece of work but shared with them the various ideas that had emerged within my dialogue experience with the Diabetes Team. Over the summer of 2009, I worked closely with student W, whose mother and father helped produce and transport the wooden panels that formed the base of the piece. Since W's family live in Hexham, it was very promising to see a local family contribute to the development of an artwork in their local hospital.

Figs. 42 & 43: *Tree of Hope* (left) and *Wishes* (right).

The second project, entitled *Wishes*, was a collage of 17 colour photographs developed after the first table-top handling exercise of the workshop series. Here the participants were asked to select from a collection of my photographs to form an exhibition which they thought would be appropriate to the environment of the TPC. This photo-selecting exercise was not meant to result in an exhibition but, after I presented to the group a collage of their selected images, it was agreed that the collage should be displayed in the Centre. *Wishes* is currently installed near the TPC entrance corridor where it bears witness to the importance of group

dialogue in the curatorial relationship that developed between myself and the workshop participants.

The third project was *Flow*, the exhibition that I developed over the entire period of the workshops. It was divided into two parts. The first part included the bridge photograph and a triptych of a river, which was installed in a corridor leading to the TPC office. The second part included a series of 9 photographs on a curving wall, and another series of 5 photographs on a similar wall nearby. Both walls faced consultation rooms.

The second part of the *Flow* exhibition was called *Horizon*. I had many photographs of the sea and was drawn to images that included a horizon. Mention was made of the relationship between horizons and dialogue as suggested by Gadamer (1979), who uses the notion of a horizon-like limit to the standpoints taken in a conversation in order to suggest that dialogue requires a 'fusion of horizons' on which people can reach an understanding:

> The horizon is the range of vision that includes everything that can be seen from a particular vantage point. Applying this to the thinking mind, we speak of narrowness of horizon, of the possible expansion of horizon, of the opening up of new horizons etc (Gadamer, 1979: 269).

Gadamer deems that understanding does not necessarily mean that the partners have to agree with each other. Rather they need to understand each other's horizon (standpoint). Since a horizon is not rigid but fluid, it is something into which people move and that moves with them. Those who are willing to understand will have wider and superior vision of horizons (Gadamer, 1979). This horizon concept helps us to recognise what makes a successful dialogue. If we keep open-minded to seek the truth of the object, we can reach an understanding and develop a bond with each other. The *Horizon* exhibition symbolises the 'fusion of horizons' resulting from the dialogue in the series of workshops

between groups of participants and myself.

Fig. 44: *Horizon*, from the *Flow* series.

Reflections

In this final cycle, as I have said above, my main concern was the future of the art programmes in the hospital because I thought it was important to train key members of staff and committed local artists to run sustainable art programmes. Key people in the development of my research project such as Longstaff and Dorsett participated in the workshops.[45] I regarded their participation as crucial because they represented the NHS Trust and Northumbria University respectively and would be considering the future of the curatorial programme at HGH when my project was concluded. From December 2009, the consultant doctor has worked with my PhD colleague Rowe to run art workshops for the patients in North Tyneside Hospital. Nurse K has joined the Healing Arts Committee at HGH and local artist Penny Grennan was taking the role of artist-curator at HGH in order to explore the potential of objects and healing as part of her master's studies in fine art at Northumbria University. As a result, it seemed

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[45] Longstaff attended two workshops, having dialogues with the staff of the Radiology Department as well as the Diabetes Team; while Dorsett joined the last workshop with the Diabetes Team.

that the curatorial dialogue was expanding. More people in the hospital were becoming involved. The Matron has written that:

> Poyan has not only engaged with the patients and staff but over the three years had set up a good basis for future university students wanting to research and explore the use of art in an acute health care setting. The process takes time and patience by both, and what might seem a minor milestone to Poyan is actually a major move in such a large bureaucratic organisation such as the NHS.[46]

Thus, in the workshops, the artworks had acted as a catalyst for dialogue and the participants had found ways to bring both their feelings and their diverse views to the idea of exhibiting artworks in a hospital setting. A vision for the ideal healing environment had emerged. New understandings were forged, and the bonds between the art world and the medical world grew stronger as the workshops progressed. Shared meanings emerged from the dialogue, and I responded to them with my photographs and exhibition plans. The *Ode to Light* series in the Radiology Department and the *Wishes* collage in the TPC were the outcomes of what I considered to be a genuine dialogue in the terms used by Bohm and Gadamer. In particular, what had taken shape was as visual as it was verbal.

Buddhism teaches that everyone has Buddhahood and my interest in dialogue reflects that way in which I practise to respect people and connect with everyone even when views conflict. Action research is a method of undertaking investigations for the people, not 'on' the people. Therefore, any comments made by the participants are always considered and appreciated. Bohm proposes that, in a dialogue, it is better to suspend disagreement or judgement, and just listen. I followed this approach and was not defensive when workshop participants criticised my unfinished images of *Flow*. The many criticisms and comments offered valuable data for further reflection. During the development of my

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[46] Email from the Matron to Longstaff, dated 21 January 2010.

curatorial dialogue, there were tense moments but my Buddhist background, and the philosophy of action research, helped me to overcome conflict and transform my investigation into a curatorial dialogue.

To begin with, I treated conflict as a responsive issue. For example, the doctor responded differently to the photographs of *Flow* in two workshops. In the February workshop (pp.121-122), he disapproved, but in the last workshop in May, when he saw the project again (pp.128-129), he was appreciative and asked which images were important to me. At this point he became interested in the way in which working with the group was helpful to my research. At the end, he thanked me for inviting him to be part of the research and I felt that I had learned from, and enjoyed, the process in which the group was exploring many aspects of art and healing. The doctor had said that he came to every session because of the debate about healing and I realized that I too looked forward to the workshops because they challenged me to engage fully with health as a general issue, not just as a subjective response.

In the TPC sessions, the patient representative had identified himself as a 'non-art' person. He made a very clear statement that he would be put off if the group did any art-making activity. However, he enjoyed the table-top handling exercises, telling many interesting stories about his experiences with the photograph. He became very engaged with the idea of curating exhibitions and was particularly enthusiastic about the development of the *Flow* photographs. His input was important as well as valuable because he spoke for the patients. I found that both the doctor and the patient representative became more open to the suggestions as they extended their connections to the art world.

Another important factor was the transformation of existing relationships in which curatorial dialogue was sadly lacking. The most outstanding example was the negative attitude of the Radiology Department to the art world. I believed it was a considerable achievement on my part to get the radiologists involved in the two workshops. A much higher level of mutual understanding followed and, together, we created two exhibitions for their Department. In the end, the radiologists were encouraged when their opinions had impact on the exhibition arrangements and they became more enthusiastic about the healing role of art in hospitals.

There were also transformations within my own attitudes. I began with a perception that the medical world was not in a position to understand artists, and I thought that they did not know how to appreciate art. Before the development of the workshops and the table-top handling exercises, I did not have any ideas about how to make interesting or relevant exhibitions for a world that seemed to have no investment in the subjective and experimental world of contemporary art. As a result I doubted the viability of my role in the hospital. Now I can see that my understanding of the target audiences at HGH had expanded and, in my own small way, I felt that I had begun to map out the legacy of the community arts movement,[47] a set of ideas that were implicit in the partnership between Northumbria University and NHCT. Here I would cite my work, *Horizon*, as both a representation of, and embodiment of, a 'fusion of horizons', in which the will and ability to move and expand our understanding takes the researcher beyond communal boundaries: in this way, I engaged with my 'post-community arts' situation at the University.[48]

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[47] With the formation of the Association of Community Artists in 1972, the community arts movement began in England and Wales, aiming to bring waves of cultural change to society (Morgan, 1995).
[48] Dorsett describes Northumbria's arts and health partnership as being focused on a 'post-community arts' situation in the University.

Through the transformation of my standpoint as a member of the art world, I had been strengthening my connections with the medical world. In the TPC workshops, the number of participants exceeded most of the previous series of the workshops[49] and, as a result, my dialogue with healthcare professionals, such as the Diabetes Team, had become richer. Nevertheless, the task had been challenging. I had to start the exhibition plan from scratch at the TPC. It was like a blank canvas without any history of art exhibitions. However, two working themes emerged quickly from our dialogue: 1) we wanted to explore a range of feelings about long-term health conditions; 2) we wanted to enhance the environment of the TPC. Actually these themes echoed my plans at the beginning of the fourth Cycle but without the curatorial dialogue, I would not have been able to know if it was the right direction for the clinic users. I was glad to know that the group and I shared a similar vision for the TPC. More importantly, I gained the trust of the workshop participants and was able to be more confident about creating exhibitions for the centre.

During my research, the intersecting relationship between the part of Diagram 4 (p.68) I had named the medical world and the part I called the art world had improved a great deal. In relation to the medical world (as I encountered it at HGH), this improvement had seemed to need the power of the curator to be reduced, or even removed, by the table-top handling exercises. This enabled the medical world to explore, in a direct manner, different perspectives of the task of placing art in hospitals. Here the hospital audience found their own voice in relation to the curatorial process. Instead of complaining about exhibitions after the installation had taken place, the medical world was now taking responsibility for the pre-exhibition process. For the artists too, this pre-exhibition stage was

[49] Except the third workshop in the first series in November 2007, in which there were 13 participants.

enhanced by the participation of staff and patients from HGH. Therefore my curatorial dialogue had extended and strengthened the connections between the two worlds I encountered at HGH.

The following diagram illustrates the connections I achieved in the final Cycle. At this point I had integrated my photographic practice into my curatorial projects and the workshop participants had extended the horizon of my role as an artist-curator. The ultimate proof of the success of this dialogue would be the hospital reaching the point where it no longer needed a curator from the art world because the community of local artists and the medical world at the hospital connected with each other without the need for an intermediary.
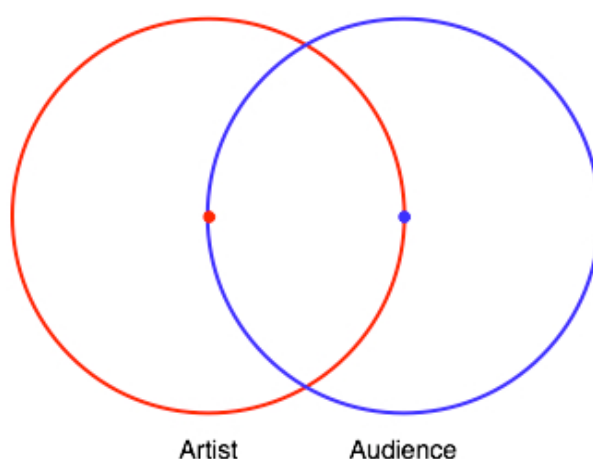
Diagram 14: Connection achieved in Cycle 4.

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In Chapter 3 I suggested that the need to improve my photographic practice forced me into a more dialogic relationship with the workshop participants. One aspect of this interaction was insights offered during my sessions with the Radiology Department and the TPC. In both workshops I used the same collection of photographs. As is clear from the discussion above, the former group used my images to create exhibitions about the Northumbrian landscape and the TPC group were more interested in the human dimension of chronic

healthcare. As a result I learnt to create and recreate exhibition themes using the same imagery. This suggested to me that artists have a lot to gain in collaborative projects that take the creative practitioner beyond the art world.

Fig. 45: Same set of photographs but different themes and results. Top: workshop in the Radiology Department. Bottom: workshop in the TPC.

With these creative dialogues developing between myself and the workshop participants, my understanding of the hospital audience began to deepen. I became aware of the rhythm of their working lives. Moreover, I learned many personal stories as well as a great deal about the healthcare profession through the table-top handling exercises. For me this was a matter of personal growth as well as an evolution of my ideas as an artist. Therefore, it is important to keep in mind that a curator (or any other kind of art facilitator) can connect with people in an institutional space in very personal terms. Once again, this is probably a core research idea in my project. The notion of 'healing artworks', and the enhancement of the hospital environment through the curating of those artworks,

is perhaps not as obvious as the concomitant effect of using curatorial practice to relate to the people who inhabit the healthcare environment, either because of illness, or because they work there. Having participated in the workshops, Longstaff made the following observation:

> They (staff members and patients) were reluctant, at first, to take a chance on actively being involved in the formation of artwork and exhibitions, as they did not have prior training or specialist knowledge. Art was an unknown quantity to many of the participants, whose prior exposure to the arts had purely been limited to images they liked or disliked, rather than studied and appreciated.
>
> At the workshops, the artists explained their art medium to the groups, enabling the participant's eyes to observe with new knowledge and appreciation. This was, of course, not without controversy and many artists were besieged with questions about interpretation of abstract art in particular. It seems that the emotional reaction engendered by a piece of art has the ability to divide opinion but also promote fascinating debate… Somehow, Poyan had managed to dismantle the boundaries between the scientific and artistic minds, between logic and the emotions, enabling healthcare professionals to put aside their inner doubts and uncertainties and take part in the creation of something which invested their own energy to enhance the working environment.[50]

However, one needs to qualify the scope of this statement. Many of the staff members who participated in my workshops were already very enthusiastic about the aims and objectives of my research and were thus very keen to engage with me. I was aware that the participants only represented a small proportion of the potential audience that visits HGH. Apart from one diabetic patient, the voices of non-staff hospital users were not heard.

By adapting the action research cycle of Kemmis and McTaggart (1988), I developed my research in four distinct research cycles running from January 2007 to September 2009. This enabled me to respond to my research question: how can exhibition curation form effective dialogue between patients, doctors and the healthcare staff as well as the local community, and thus enhance the healing

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[50] Email dated 5 January 2010.

process? The four steps of plan, action, documentation and reflection helped me to improve my practice and deepen my understanding of the context of my practice. In order to reflect on the cyclical method I used in my research, and the impact it had on my research ideas, I will first consider the points of good curatorial practice in healthcare environments that have merged during my investigation. These points are markers against which I will later evaluate my research outcomes as they developed within the 4 research cycles.

Point 1: face-to-face meetings

Of the 18 workshops, a breakthrough happened in Cycle 3 when I made face-to-face connections with key members of staff before running the sessions. Though the meetings might have been short, they were important as they provided both the medical and the art worlds with an opportunity to understand each other. I was able to explain the aims and objectives of my research as well as of the workshops directly to them, while they in turn helped me to deliver my message to their colleagues and recruit people to participate in the workshops.

Through setting up the dates and times for the workshops, I learned about the work rhythms of various departments. For instance, the Radiology Department usually has a quiet Friday afternoon so a workshop during lunch hours is good for the staff members; while the members of the Diabetes Team work in various hospitals within the Trust and they meet at HGH for a departmental meeting every Tuesday, thus Tuesday afternoon is good for their workshops.

This was a very different situation compared to the early stage of my project, when I recruited participants through the help of Longstaff. I did not have personal contact with the members of staff, and consequently the attendance was poor. Only local artists came.

Point 2: be flexible and considerate

The members of staff were always very busy with their work. In order not to disturb their work routine and encourage them to participate in art programmes, I shortened the time of the workshops from two hours in Cycle 2 to an hour in Cycle 4.

Point 3: artworks and flow of dialogue

Artworks, especially photographs, proved to be good catalysts for group dialogue in the workshops. By looking at, touching, holding or moving around the artworks, the participants expressed their views in the sessions. Because of the subjective nature of art, stories told around it were personal. There was no right or wrong. Everyone responded to his or her own feelings. No judgment was made. The will to listen and be open-minded was important to encourage the flow of dialogue. It was found that understanding was reached and relationship was established through the curatorial dialogue. A bond between the participants and myself was strengthened throughout the process. I believe the good relationship we cultivated helped us to make the curatorial decisions together.

Point 4: risk and trust

A certain degree of risk was associated with the workshop participants curating exhibitions in their own hospital spaces. However, I believe that everybody has a Buddha nature and so invested a great deal of trust to the participatory spirit of action research and, ultimately, discovered the power of dialogue. The interrelationship between risk and trust enables us to transform and bring out the goodness of this healing art project. Because of my trust in the participants with curation, I gained their trust in return.

4.5 Reflecting on the research cycles

My research project consisted of four series of workshops (18 events in all), which were carried out as the core practical component of my practice-led research. Apart from the twelve artists who led the workshops, 62 people were involved as participants in my action research journey. In Cycle 1, there was a gap between the medical world and the art world in terms of perception and reception of contemporary art. I aimed to improve this situation in Cycle 2. As a result, I set up a series of workshops for patients, members of staff and local artists as a platform for the development of dialogue and understanding. During the course of the second research Cycle, the table-top handling exercise emerged as an important tool in my workshop practice. However, I found that these workshops, even though the table-top work was starting to bridge the differences, were limited in their scope because the medical world participated in much smaller numbers than the art world. I also noticed that I sacrificed my photographic practice.

As Cycle 3 progressed, I changed my recruitment strategy by approaching key members of staff and inviting them to participate in my workshops. Here I saw the benefits of working closely with the staff rather than the patients. Although the participation rate from the medical world was still not high, their input was valuable because they were more engaged in the healing potential of art than anyone I had worked with before. As a result, the gap between the medical world and the art world at HGH became smaller. In addition, photographs became the principal type of art object used in the table-top exercises which helped stimulate dialogue, story-telling and exhibition ideas.

In Cycle 3 participants explored curatorial ideas, not only on the workshop table, but also in the actual spaces of the hospital building. By taking curatorial

responsibility for exhibitions in their own clinical environment, the hospital audience demonstrated both their vision of a healing environment and their concerns for the feelings of hospital users. The participants also revealed that they understood how to operate as curators. Unexpected talents came into view. The workshops evolved from a 'round-the-table-dialogue' to a 'table-top handling exercise'. By the time the workshops had transformed themselves with 'table-top photograph handling', it was possible to transfer my curatorial dialogue to *in situ* curatorial debates within the corridors or waiting areas of the relevant hospital departments.

In the concluding Cycle 4, I ran two series of workshops within two HGH Departments. The workshops in the Radiology Department taught me that it was not necessarily problematic if an artist-curator followed the aesthetic preferences of the audience. The participation of, and support from, the Radiology Department was significant because in the past this department had been noted for making complaints about the art exhibitions. Later, when I began running workshops with the Diabetes Team at the TPC, I developed a bond with the participants based on our shared interest in using art to explore the issues of coping with long-term health condition. My photographs were used in table-top handling exercises that facilitated new and unexpected dialogues within the group. Despite some tense moments all the participants were honest with each other and shared enough common ground to move forward. I treasured the interactions we all experienced in these workshops and, at the conclusion of my doctoral project, will build on the spirit of dialogue I discovered in the TPC sessions where everyone was equal and everyone's voice was heard.

Gradually I learned that the key to healing lies in supportive relationships in which everyone is willing to listen to each other and is committed to working together

towards the goal of healing. It became far more important to make curatorial decisions with the staff rather than on my own. As a result, every decision I made involved listening, discussion, respect, understanding and trust within the group. Through this discourse, I slowly began to understand how to create art and exhibitions to enhance the healing process. The methodology that allowed me to transform these experiences into a viable research project was based on Kemmis and McTaggart (1988) who had, as we saw above, devised an action research cycle protocol for educators undertaking research in school classrooms. I modified their approach in an attempt to develop a model of practice-led research that would extend my photographic practice to a curatorial project that promoted the healing potential of exhibitions in hospitals. When I reflect on my ambitions as a practice-led researcher, the most important goal was probably my attempt to create a harmonious relationship between the art world and the medical world (as defined above). I will elaborate this ambition in the following chapter.

Cycle 1

Concern

Reflection

Plan#

plan for hospital visits
& install two exhibitions
of my own artworks

Documentation:
audio-recording,
photographs,
photo-diary,
written notes

Action*

* visit hospital &
put up two exhibitions:
Smile & Sea Stories

Reframed Concern

Cycle 2

Reflection

Revised
Plan#

a series of workshops
install exhibitions

Documentation:
audio-recording,
photographs,
photo-diary,
written notes

Action*

* carry out a series of workshops
& curate 5 exhibitions from the
workshops

Reframed Concern

Cycle 3

Reflection

Revised
Plan#

more workshops to explore
table-top object handling exercise
install exhibitions
make my own new work

Documentation:
audio-recording,
photographs,
photo-diary,
written notes

Action*

* carry out 5 workshops
curate 4 exhibitions
start my project, *Flow*

Reframed Concern

Cycle 4

Reflection

Revised
Plan#

more workshops to invite
staff members as curators
install exhibitions
continue my work, *Flow*

Documentation:
audio-recording,
photographs,
photo-diary,
written notes

Action*

* carry out 2 series of workshops
with staff of the Radiology Dept &
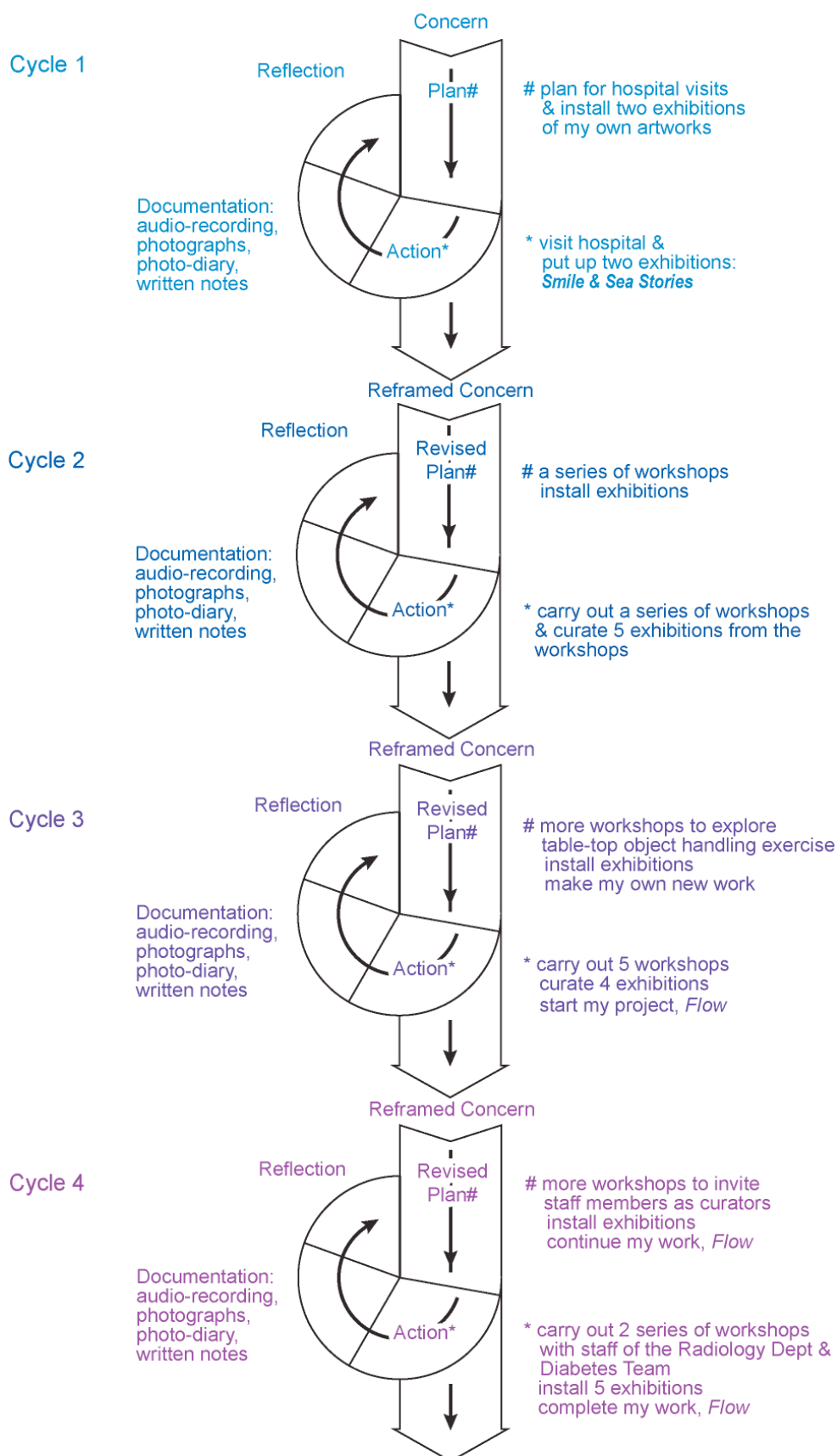Diabetes Team
install 5 exhibitions
complete my work, *Flow*

Diagram 15: My four research cycles from January 2007 to September 2009.

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Chapter 5

The End is a Beginning

5.1 A contribution

This chapter discusses my contribution to the concept of art and healthcare research and the impact of my doctoral project on the partnership between Northumbria Healthcare NHS Foundation Trust and Northumbria University. In this last chapter I will comment on the new insights I gain into my practice, the limitations of the research I have just completed and the opportunities afforded by the work I have done.

In seeking to re-envision the role of art in healthcare for hospital users at Hexham General Hospital (HGH), *Healing Through Curatorial Dialogue* has been an exploration of the way that contemporary art practitioners seem to facilitate healing through a range of practices that include art production, organizing exhibitions and outreach work within the communities that are likely to form an audience for those exhibits. As an artist-photographer who took on the role of an artist-curator for this research project, I recognize that the core idea that allowed me to complete my research and understand the healing potential of curatorial dialogue was the discovery of workshop techniques that engaged patients, members of staff and the local community in a debate about the meaning of healing. Through the cyclic nature of inquiry, I was able to define a research model for art practitioners doing research in the healthcare context. I demonstrated the positive impact of contemporary art practice by bridging the medical world and the art community with the mediating role of an exhibition curator.

Gadamer (1996) remarks that the state of health is an inner accord of harmony and equilibrium, which can be subjective. Everyone can have his or her own measurement of health. Therefore it is difficult to have an objective measurement of what it is to contribute to the healing process. From the perspective of the art

world, an artist who has ambitions to achieve this goal should not worry if their practice is measurable or proved statistically. Art, like virtue, is its own reward. However, I hope that my research has shed some light on the work of clinicians who support the idea that art has an impact on our capacity to get well (Staricoff & Loppert, 2003; Ulrich & Gilpin, 2003; Staricoff, 2004; Macnaughton, 2007). The above authors have researched the effects of displays of artworks in hospitals, and their investigations have generated interesting data with diverse interpretations. My own efforts as a researcher are different from those above, since the outcomes I have achieved are the hospital exhibitions themselves, the healing connections achieved, and the hospital audience's transformation.

As a practice-led researcher, I did not conduct systematic interviews that would have provided the evaluation of the healing connections the participants achieved outside of the workshops. Moreover, even though my reflections suggest that the healing process was enhanced at HGH, my theatre of action was limited to those who participated in the workshops. The countless people who come and go at HGH must be aware that there are artworks in different parts of the building but I have no way of representing this general level of appreciation (or displeasure).

However, during my research project, there has been a transfer of authority from the art world to the medical world. In the beginning I made all the decisions. Changes speeded up when I asked participants to curate exhibitions for their own clinical domains. Compared to the workshops in Cycle 2, where participants followed a guest artist's instruction and created artwork to order for the 'visual dialogue' exhibitions, the participants in Cycle 3 selected works by themselves, constructed personal justifications for their choices, and articulated interpretative meanings for the displays that addressed the people who routinely used those hospital corridors and waiting rooms.

In the last Cycle, workshop participants co-generated ideas for exhibitions and the input of the TPC group was so effective that the number of participants, as well as the frequency of meetings, exceeded the amount of workshops I had organized in the rest of the project. The active participation of the workshop participants not only led to the enrichment of my curatorial dialogue, but also gave rise to understandings in which the two worlds connected with each other in creative ways. As a result, new skills emerged through the table-top handling exercises and I learned to accommodate the different perspectives of the hospital staff as they gained a wider knowledge of my culture, my vision of healing art, and the dilemmas of being a curator. Through the curatorial dialogue both parties understood each other's standpoint, or in Gadamer's word, 'horizon'. Each of us was able to expand our horizon, open up new horizons, and reach a 'fusion of horizons'. Here we did not necessarily reach agreement, but we did, as said above, become familiar with each other's limitations: as we moved backwards or forwards, left or right, we gradually learnt to bond together – this was Gadamer's point.

The shared meanings that emerged from my curatorial dialogue gave rise to transformations in the attitude of the hospital staff towards contemporary art practice: indeed, Gadamer (1979) has said that people no longer remain what they are when they have been transformed by the *communion* of dialogue. In the early stages of my research, I was frustrated by the poor level of participation in the workshops, but the Matron encouraged me by sharing her particular enjoyment of art. As described in Cycle 4, I successfully recruited the Diabetes Team to participate in the 5 sessions of the last series of workshops. In the final stage of my research, I did not worry about the participation rate anymore.

From Cycle 3 onwards there were no complaints about the exhibitions and my

work as a curator was recognized when I was requested by the Matron to run two Christmas workshops for junior staff and ward managers. When a renovation project was planned in the A&E Department, the manager consulted me about the implications for the rolling programme of exhibitions. In addition, a ward manager emailed to ask where a donated artwork should be exhibited so that it did not disturb the current exhibition in her ward.[51] In January 2010, Longstaff and the Matron initiated a farewell party for me at HGH to thank me for my work, an honour that marked the level of acceptance my curatorial dialogue had gained (Appendix 8).

Dialogue is important in the healing process. Gadamer refers to the difficult levels of communication that occur at various stages in a doctor-patient relationship. Many healthcare practitioners and researchers have already emphasised the role of building interpersonal connections in the healing process (Carlson & Shield, 1989; Egnew, 2005; Hsu, et al., 2008; Scott, et al., 2008). In my practice, I created an equitable balance of power between a curator and artists / the audience. Instead of me making all the decisions for the healthcare environment, I collaborated with the artists and the audience (members of staff, patients and visitors) to create art and exhibitions together. The curatorial dialogue we developed established a good and strong relationship, which can be seen as the healing relationship between the curator and her audience. Gablik (1991, 2000) even argues that relationship between artists and the audience is the artwork. "The work becomes a metaphor for relationship – which has a healing power' (Gablik, 2000).

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[51] Email correspondence between August and October 2009.

Artist Penny Grennan[52] has described my approach as democratic because she felt that everyone involved in the research project was equal. I believe that this perception was created by the success we achieved in the workshops. As Gadamer (1996) says, dialogue can humanise the prevailing inequality of relationships. A hierarchy of power not only exists between a doctor and a patient (Widdershoven, 2000), but also between hospital staff and doctors (who usually have more authority), and so I am delighted to know that my curatorial approach has had a positive impact on the hospital staff. The secretary of the Diabetes Team told me that the workshops have been beneficial because:

> Everyone is equal around the table. I find I am an intellectual woman but I don't have the opportunity to express myself in my workplace. But your workshops offer everyone opportunity to say what he/she thinks about the artworks. I am sure the doctor and the nurse feel the same. They came to your workshops every time.[53]

My curatorial practice balanced the power relationship between the artists and the audience within the framework of action research, which values the participation and contribution of everyone. I found that not only were the participants empowered by the curatorial practice, but I was also empowered by the trust from the participants. My relationship with my audience (the physicians, members of staff, patients and other hospital users) improved tremendously once the workshops had reached the third Cycle. My research has brought a more harmonious relationship between the art world and the medical world although it is important to keep in sight the fact that the number of people who attended my sessions only represented a very small amount of hospital users. There is a methodological dimension to this discussion of democratic harmony. Reason and Bradbury (2008: 4) define action research as:

> a participatory process concerned with developing practical knowing in the pursuit of worthwhile human purposes. It seeks to bring together action and

---

[52] In a discussion with me and another local artist Cathy Duncan on 18 April 2008.
[53] Face-to-face conversation on 3 November 2009.

reflection, theory and practice, in participation with others, in the pursuit of practical solutions to issues of pressing concern to people, and more generally the flourishing of individual persons and their communities.

To paraphrase, my research was a participatory process concerned with developing curatorial knowing in the pursuit of creating art and exhibitions with the purpose of enhancing the healing process. Reason (1994: 10) argues that 'making whole necessarily implies participation' because a participative worldview stresses the importance of the reunion of an individual person with the circle of human community. With the participation of local artists, members of staff and patients in the pursuit of making connections between the medical world and the contemporary art world, my research project brought together action and reflection, theory and practice. The inquiry process was collaborative and communicative, and the contribution of both myself and the participants were equally important. The participants and I became co-learners, co-researchers and co-curators. Thus knowledge may be said to be 'co-generated' (Levin & Greenwood, 2001).

5.2 The validity of my research

In my research, actions determined the validity of my action research approach. If actions solve the problems, or help participants gain control over their own situation, then the research is valid (Levin & Greenwood, 2001). I think that the actions of the workshops, especially the table-top handling exercises and the *in situ* curatorial decision making process have answered my research questions. These creative actions have bridged the gap between the medical world and the art world, as well as enabled the participants to have more control over the art exhibitions in their clinical environment. However, the bridging only applied to those who attended the workshops. Nor did the participants gain full control over every stage of exhibition making. I was the one who invited the artists and

selected the artworks presented in the workshops. Nevertheless, I tried my best to be as transparent as possible by giving reasons for my choice of artists and the artworks. As discussed in Chapter 4, I would consult artists and members of the Healing Art Committee regarding my curatorial decisions. Since the launch of the workshops, I was able to explain and express my decision-making process directly to participants who were staff members, patients and local artists. The workshops generated a lot of data for my reflections. At the end of each series of workshops, I disseminated the research progress as exhibitions (Appendix 5) so that all the hospital users including the participants could monitor and give feedback on the research project. Having supported art projects in the Trust and participated in my workshops, Longstaff remarked:

> Poyan Yee has succeeded in providing a new medium for engagement between healthcare staff and patients…Although at first it was difficult to get this process moving, it has been very encouraging to witness the change of mindset of staff towards the validity, and indeed benefit, of a non clinical intervention as part of the healing process. Poyan has been an extremely competent interpreter, moving the separate worlds of science and arts towards transformational change.[54]

Ian McMinn, Non Executive Director of NHCT as well as the Chairman of Charitable Funds Committee for the Trust, also made similar positive comments:

> For many years, the Trust has actively supported arts in healthcare research projects which have provided an interesting insight into the affects of artworks on the patient environment. Your recent work with patients and staff groups attending the art workshops has helped to break down barriers of misunderstanding about the arts and foster increased awareness and understanding of the impact that art can have.
>
> Working within a healthcare environment can be challenging and you have demonstrated a wonderful ability to communicate often complex concepts to the art workshops, and convincingly win over Trust staff and support. You have provided a number of exciting and stimulating exhibitions throughout the hospital and your work in curating the atrium exhibition space was highly regarded by all visitors to the official opening of the hospital, including Her Grace, the Duchess of Northumberland.[55]

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[54] Email dated 5 January 2010.
[55] Letter dated 29 July 2009.

Despite this official level of recognition, it has to be stated that my research plan, process, data and outcome were shaped by my personal experience and worldview. My research can be criticised as being subjective. Certainly, if the project had been undertaken by another practitioner, different outcomes would have been achieved. However, because art practice is subjective in its nature (Barrett, 2007), I learned from my practice and contributed knowledge to art and healthcare studies through the inquiry of actions and reflections. Here the limitations of my research have paved the way for further research. It would be desirable if my workshop experiments could take place in other hospitals, and in other departments within HGH.

In the latter stage of my research, photographs became the dominant art objects at the table-top art object handling exercises. This happened because I am a photographer who was able to provide many photographs as the catalyst for curatorial dialogue in the workshops. It would be interesting to see what will happen with other art mediums, such as paintings, drawings, sculptures or even ready found objects. This will enrich the curatorial dialogue that I developed.

As my research concludes, I am still trying to create a more harmonious relationship between the medical world and the contemporary art world. I would suggest the workshop methodology can work in contexts wherever there is a gap between groups of people. That is exactly what I want to do in the future. Throughout the action research journey, I have been inspired by many examples of action research practice across the globe. I have been very excited by my potential to contribute to a better world with this PhD training and with my practice as a photographer and a curator. Wang and Burris' *PhotoVoice* (1997) in Yunnan, China and Lykes' photo project (2001) in Guatemala have proved the positive impacts of photography on local communities. It would be my aspiration

to integrate photography with action research to address issues of conflict or promote better understanding between people.

At the end of my writing-up stage, I had a very hard time within my domestic life but a difficult episode forced me to think about how I can use my research training to contribute to greater levels of social and cultural wellbeing. Here is my story:

Starting from a September night in 2009, some teenagers on bikes started throwing pebbles, sweets and wooden planks at our house for several nights. My husband was so frightened that in the end he could not stay at home. We reported the incidents to the police and informed our neighbours. The police and our neighbours reckoned it was because we were Chinese. They explained that this kind of anti-social behaviour happens when the economy is bad. I was outraged. I wanted to know why these teenagers did this to harmless ordinary people like us. I also wanted to have dialogue with them. The more I thought about it the more I felt sorry for those young people. I wondered if they were happy. I felt that these young people had a lot of energy but just did not know how to channel their abundant energy into something constructive.

All my mixed feelings and questions prompted me to think of the positive effects of my art workshops at HGH. From my experience, I know that artworks can generate dialogue, and thus pave the way for understandings and connections. I realised that I wanted to have understandings and connections with those teenagers. Therefore, an idea to run art workshops in a local comprehensive school to address the issue of racist attacks sprang up. I hope that I can realise this idea after I finish this thesis so that I can have communication with and understanding of the British teenagers in the village in which I lived.

This episode sets the direction and potential for my future research and career development. Looking back, this new plan corresponds to the title and theme of my first solo exhibition: *P.E.A.C.E.*

Appendices

Appendix 1: My Criminal Record Bureau Clearance

Standard Disclosure
Page 1 of 2

disclosure

Disclosure Number: 001188893577

Date of Issue: 21 FEBRUARY 2008

Applicant Personal Details

Surname: YEE

Forename(s): PO YAN

Other Names: YEE, PO YAN

Date of Birth: 26 MARCH 1972

Place of Birth: HONG KONG HONG KONG

Gender: FEMALE

Employment Details

Position applied for:
ARTS CURATOR

Name of Employer:
NORTHUMBRIAHEALTHCARE NHSTRUST

Countersignatory Details

Registered Person/Body:
NORTHUMBRIA HEALTHCARE NHS TRUST

Countersignatory:
JANET HENDERSON

Police Records of Convictions, Cautions, Reprimands and Final Warnings

NONE RECORDED

Information from the list held under Section 142 of the Education Act 2002

NOT REQUESTED

Protection of Children Act List information

NOT REQUESTED

Protection of Vulnerable Adults List information

NOT REQUESTED

Standard Disclosure

This document is a Criminal Record Certificate within the meaning of sections 113A and 114 of the Police Act 1997.

Use of Disclosure information

This Disclosure must be used in accordance with the Code of Practice and any other guidance issued by the Criminal Records Bureau (CRB). Particular attention must be paid to the guidance on the fair use of information in respect of those whose Disclosures reveal a conviction or similar matter.

This Disclosure is issued in accordance with part V of the Police Act 1997, which creates a number of criminal offences. These offences include forgery or alteration of Disclosures, obtaining Disclosures under false pretences and using a Disclosure issued to another person as if it were one's own.

THIS DISCLOSURE IS NOT EVIDENCE OF IDENTITY

CRB Criminal Records Bureau, PO Box 165, Liverpool, L69 3JD Helpline: 0870 90 90 844

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Appendix 2: Invitation Letter

The Contemporary Arts Research Group
School of Arts and Social Sciences
Northumbria University
Newcastle upon Tyne
NE1 8ST

8 August 2007

Dear

Re: Invitation to a Research Project – Healing Through Curatorial Dialogue

I am writing to invite you to participate in my PhD research, *Healing Through Curatorial Dialogue*, in a series of art and curatorial workshops in Hexham General Hospital.

My research is to investigate how to create arts and exhibitions to enhance the healing process in a healthcare setting. The central aim of this workshop is to discuss and create artworks and exhibitions for the Hexham General Hospital. This workshop will, in particular, examine how exhibition curation can form effective dialogues between the artists, the communities and hospital users. It is planned that the workshop will take place once a month. The first series of the workshop will run from September 2007 to February 2008. For the objectives and details of the workshop, please refer to the attached document.

Your participation is highly appreciated and will benefit the advancement of arts and healthcare in the Northumbria NHS Healthcare Trust, as well as academic research in the field. Should you have any inquiries, please feel free to contact me at 0787 2142 363 or email me at poyan.yee@unn.ac.uk .

Looking forward to hearing from you.

Thank you very much.

Yours faithfully,

Poyan Yee

—

Reply Slip

I, _____, confirm that I can / cannot* participate in your research project via a series of arts and curatorial workshops in Hexham General Hospital from September 2007 to February 2008. (*please circle your option)

_____   _____
Signature   Date

Appendix 3: Details of Art Workshops

Cycle 2

Workshop 1: 6 September 2007		
	Participants:	1 local art manager
		1 patient representative
	Artist:	Poyan Yee
	Content:	Introduction and a curatorial exercise
	Exhibition:	Nil

Workshop 2: 3 October 2007		
	Participants:	The Matron
		2 local artists
	Artists:	Adam Thompson
		Pippa Armstrong
	Content:	Student artists presented their art works
	Exhibitions:	*Limbo* & *Untitled* on 1/F & G/F

Workshop 3: 6 November 2007		
	Participants:	6 patients
		1 carer
		1 local art manager
		1 patient representative
		2 local artists
		The Matron
		1 project officer
	Artist:	Tuesday Nesbitt
	Content:	Nesbitt presented her work which was going to be exhibited; she then led the group to mix the colour and paint

	Exhibitions:	Nesbitt's exhibition; and *Colour Cards* in the Radiology Dept

Workshop 4: 3 December 2007

Participants:	1 local art manager
	1 local artist
Artist:	Ashley Hipkin
Content:	Hipkin presented his works and led the group to explore non-visual qualities of art
Exhibition:	See Workshop 5

Workshop 5: 7 January 2008

Participants:	The Matron
	1 occupational therapist
	4 local artists
	1 art student
Artist:	Poyan Yee
Content:	I developed Hipkin's idea and integrated Chinese medicine elements in the face drawing
Exhibition:	*Watch This Face I, II, III* in the Out Patient Waiting Area

Workshop 6: 23 January 2008

Participants:	2 local artists
Artist:	Ashley Hipkin
Content:	Hipkin continued to explore the non-visual qualities of art with clay
Exhibition:	Nil

Cycle 3

Workshop 7: 18 April 2008		
 	Participants:	Brenda Longstaff 1 librarian 2 local artists
	Artists:	Ashley Hipkin Cathy Duncan Penny Grennan Poyan Yee Teresa Toms Yang Yang
	Content:	Artists presented their artworks for the new atrium of the hospital
	Exhibition:	Group exhibition *The Expedition* in the new atrium

Workshop 8: 03 June 2008		
	Participants:	1 librarian 2 local artists
	Artist:	Jonathan Chapman
	Content:	Chapman presented his paintings and led the group to do postcard paintings
	Exhibition:	*Navigation from Newcastle to Hexham* by Chapman, and postcards by the participants

Workshop 9: 13 June 2008		
	Participants:	2 local artists
	Artist:	Poyan Yee (on behalf of Ernest Cheng)
	Content:	I presented photographs by Cheng, & invited participants to do the table-top photo handling exercise
	Exhibition:	*From an Eye of a Child* in the Women's Health Suite

Workshop 10: 15 August 2008		
	Participants:	1 senior surgeon
		1 nurse
	Artist:	Teresa Toms
	Content:	Toms presented her drawings & her husband's photographs. Participants participated in the table-top photo-handling and *in situ* curatorial exercises
	Exhibition:	See Workshop 11

Workshop 11: 22 August 2008		
	Participants:	1 librarian
		1 manager
		1 local artist
	Artist:	Teresa Toms
	Content:	Same as Workshop 10
	Exhibition:	*Untitled* and *Middle Kingdom* in the Education Centre

Cycle 4

Radiology Series

Workshop 12: 23 January 2009

Participants: 4 Radiologists

Artist: Poyan Yee

Content: Table-top photo handling exercise to decide the theme of the new coming exhibitions for the department

Exhibition: See Workshop 13

Workshop 13: 6 March 2009

Participants: 3 Radiologists
Brenda Longstaff

Artist: Penny Grennan
Poyan Yee

Content: Yee and Grennan presented *Ode to Light* photographs and *Looking Down* paintings in response to the exhibition theme agreed in the previous workshop; and *in situ* curatorial exercise for Grennan's work

Exhibition: *Ode to Light I & II* at the waiting area; *Looking Down* at the corridor leading to the Department

Diabetes Series

Workshop 14: 20 January 2009

Participants:	Consultant doctor
	Dietitian D
	Dietitian J
	Nurse J
	Nurse K
	Podiatrist
	Patient representative
	Secretary
	Nomis Fung
Artist:	Poyan Yee
Content:	Table-top photo handling exercise
Exhibition:	Nil

Workshop 15: 10 February 2009

Participants:	Consultant doctor
	Dietitian J
	Nurse J
	2 patient representatives
	Secretary
	Student C
Artist:	Poyan Yee
Content:	Table-top photo handling exercise & presentation of *Flow*-in-progress images
Exhibition:	Nil

Workshop 16: 3 March 2009		
	Participants:	Consultant doctor
		Dietitian J
		Nurse J
		Nurse K
		2 patient representatives
		Secretary
		Student C
		Nomis Fung
	Artist:	Poyan Yee
	Content:	Curating exercise with Appreciative Inquiry
	Exhibition:	Nil

Workshop 17: 24 March 2009		
	Participants:	Brenda Longstaff
		Consultant doctor
		Nurse J
		Nurse K
		Podiatrist
		Patient representative
		Cancer volunteer
		Secretary
	Artist:	Alex Rowe
		Poyan Yee
	Content:	Experience illness through art
	Exhibition:	Nil

Workshop 18: 5 May 2009

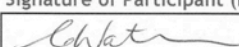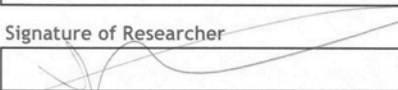|	
Participants:	Alex Rowe
	Chris Dorsett
	Consultant doctor
	Dietitian J
	Nurse J
	Nurse K
	Secretary
Artist:	Poyan Yee
Content:	Exhibition proposals after the Appreciative Inquiry & conclusion of the series
Exhibition:	*Wishes*
	Tree of Hope
	Flow

Appendix 4: Samples of Consent Forms

School of Arts and Social Sciences - Research Ethics Framework

Participant Consent Form

To be completed by both participant and researcher before research commences

Name of project

Healing Through Curatorial Dialogue

Organisation(s) initiating research

Northumbria University & Northumbria Healthcare NHS Foundation Trust

Researcher's name

Poyan Yee

Research Organisation

Northumbria University

Participant's name

Catherine Watson

I confirm that I have been supplied with and have read and understood an Information Sheet (ASS-RE5) for the research project and have had time to decide whether or not I want to participate

I understand that my taking part is voluntary and that I am free to withdraw at any time, without giving a reason.

I agree with Northumbria University recording and processing this information about me

I understand that this information will only be used for the purposes set out in the information sheet

I have been told that any data generated by the research will be securely managed and disposed of in accordance with Northumbria University's guidelines

I am aware that all tapes and documents will remain confidential with only the research team having access to them

My consent is conditional upon the University complying with its duties and oblagations under the Data Protection Act

Signature of Participant (Even if below 18 years old)) | Date

06-Sep-07

Signature of parent / guardian / representative
(if participant is under 18 years old) | Date

I can confirm that I have explained the nature of the research to the above named participant and have given adequate time to answer any questions concerning it.

Signature of Researcher | Date

06-Sep-07

School of Arts and Social Sciences - Research Ethics Framework

Participant Consent Form

To be completed by both participant and researcher before research commences

Name of project

Healing Through Curatorial Dialogue

Organisation(s) initiating research

Northumbria University & Northumbria Healthcare NHS Foundation Trust

Researcher's name

Poyan Yee

Research Organisation

Northumbria University

Participant's name

Helen Maughan

I confirm that I have been supplied with and have read and understood an Information Sheet (ASS-RE5) for the research project and have had time to decide whether or not I want to participate

I understand that my taking part is voluntary and that I am free to withdraw at any time, without giving a reason.

I agree with Northumbria University recording and processing this information about me

I understand that this information will only be used for the purposes set out in the information sheet

I have been told that any data generated by the research will be securely managed and disposed of in accordance with Northumbria University's guidelines

I am aware that all tapes and documents will remain confidential with only the research team having access to them

My consent is conditional upon the University complying with its duties and obligations under the Data Protection Act

Signature of Participant (Even if below 18 years old))   **Date**

H J Maughan   03-Oct-07

Signature of parent / guardian / representative
(if participant is under 18 years old)   **Date**

I can confirm that I have explained the nature of the research to the above named participant and have given adequate time to answer any questions concerning it.

Signature of Researcher   **Date**

                                                                     03-Oct-07

School of Arts and Social Sciences - Research Ethics Framework

Participant Consent Form

To be completed by both participant and researcher before research commences

Name of project

Healing Through Curatorial Dialogue

Organisation(s) initiating research

Northumbria University & Northumbria Healthcare NHS Foundation Trust

Researcher's name

Poyan Yee

Research Organisation

Northumbria University

Participant's name

CATHY DUNCAN

I confirm that I have been supplied with and have read and understood an Information Sheet (ASS-RE5) for the research project and have had time to decide whether or not I want to participate

I understand that my taking part is voluntary and that I am free to withdraw at any time, without giving a reason.

I agree with Northumbria University recording and processing this information about me

I understand that this information will only be used for the purposes set out in the information sheet

I have been told that any data generated by the research will be securely managed and disposed of in accordance with Northumbria University's guidelines

I am aware that all tapes and documents will remain confidential with only the research team having access to them

My consent is conditional upon the University complying with its duties and oblagations under the Data Protection Act

Signature of Participant (Even if below 18 years old))   Date

Cathy Duncan.   3 Oct 07

Signature of parent / guardian / representative   (if
participant is under 18 years old)   Date

I can confirm that I have explained the nature of the research to the above named participant and have given adequate time to answer any questions concerning it.

Signature of Researcher   Date

                                                            3 Oct 07

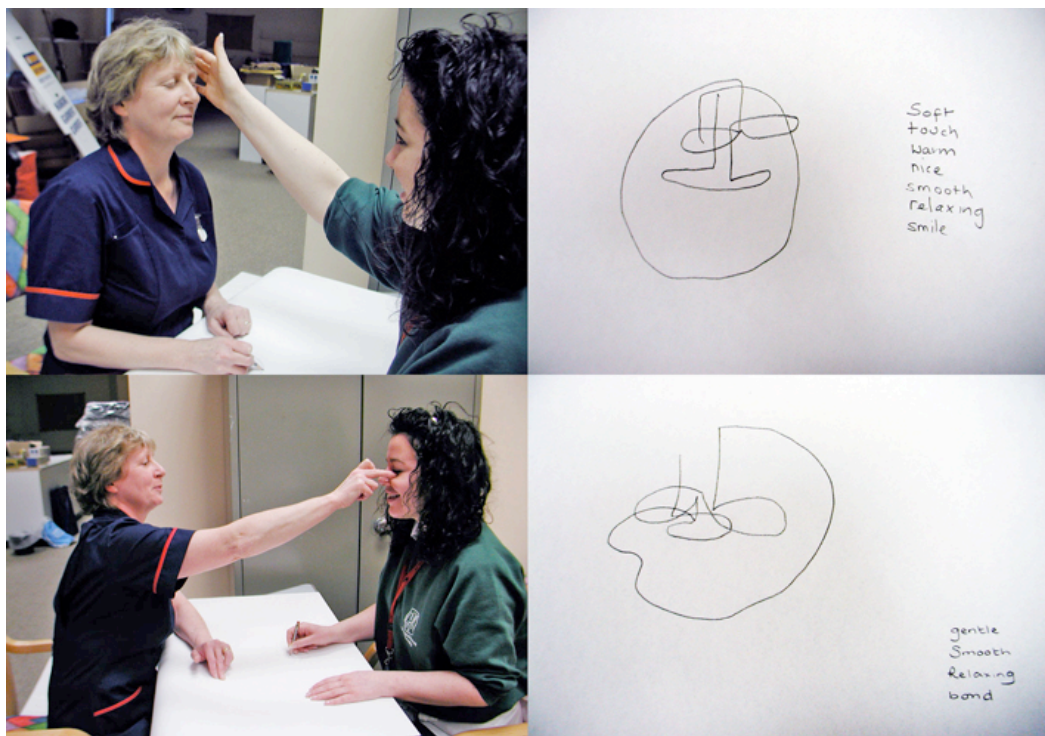**Appendix 5: Exhibitions on Research Progress**

A wall in the Out Patient Unit was designated as exhibition area on the progress of my research on the art workshops. It was also used to acknowledge the support of members of staff, patients, local artists and visitors to participate in my project. Three exhibition reports are featured here, namely, *Watch This Face*, *In Search of Healing Art*, and *Healing Through Dialogue*.

WATCH THIS FACE

WATCH THIS FACE is an ongoing art project created and curated by the Artist-in-residence Ashley Hipkin, artist-curator Poyan Yee as well as participants of the *Healing Through Curatorial Dialogue Workshop*. With a strong interest in the non-visual qualities of art, Ashley led the group to start an unexpected yet intimate journey to our faces and heads. The adventure resulted in very intriguing and imaginative visual images.

This exhibition is updated in rhythm with the workshop. You are cordially invited to join us to create art and exhibitions to enhance the healing process in Hexham General Hospital. For inquries, please contact Poyan at 07872 142363 or poyan.yee@unn.ac.uk.

Watch This Face, the first exhibition report on the research progress after the first series of art workshops. Featured here were parts 1 and 2 of the exhibition.

In Search of Healing Art

It's been two years since I first came to this hospital as artist-curator. My focus is to carry out a doctoral research, *Healing Through Curatorial Dialogue*. I have asked myself: how to create art and exhibitions to enhance the healing process in a healthcare setting?

To search for the answer(s), I have set up a series of art workshops and focus groups, in which staff members, patients, and local artists have engaged actively to create art and exhibitions for their healthcare environments. During the course, artworks have prompted interesting dialogue among the participants, bridging both the medical world and the artworld. Through handling, selecting and grouping of the artworks, the artistic and curating potential of the staff members were revealed while a sense of empowerment was developed. As a result, eight exhibitions have been installed. This exhibition particularly features the making of *The Expedition* in phase III.

More focus groups will be run within Hexham General Hospital to better understand the potential of healing art. A series of focus group is planned for the users and staff of the Tynedale Centre from January 2009. Anyone interested in the role of art in healthcare is welcome to join us.

Last but not least, I would like to thank the artists for lending us their artworks and participating in my art workshops and focus groups. These research activities would become meaningless without the support of staff members, namely, Brenda Longstaff, Helen Maughan, Anne Boulton, Louise Hawes, Katharine Jepson, Dr. Dorothy Dickinson, Dr. Stephen Attwood, Susan Colley, Tony Aspinall and Susanne Ellingham. Also my heartfelt thank you to my supervisor Chris Dorsett.

Healing Through Curatorial Dialogue is a collaborative project between Northumbria University and Northumbria NHS Healthcare Foundation Trust. All inquiries go to Poyan Yee: 0787 2142363 or Brenda Longstaff:: 0191 2031351.
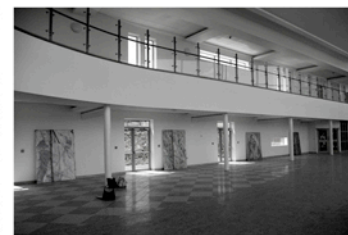
Poyan Yee, Artist-Curator

In Search of Healing Art, exhibition report after series 2 of art workshops.

Healing Through Dialogue

This exhibition features the final stage of the research project, *Healing Through Curatorial Dialogue*. From January to May 2009, a new series of workshops was launched in the Tynedale Patients Centre (TPC), a brand new national centre for chronic diseases management. Two working themes were generated from the workshops: (1) to explore the meaning of chronic health condition through art; and (2) to enhance the healing environment of the TPC through exhibiting art.

The working themes could not have been developed without the active participation and tremendous support of the Diabetes Team. Special thanks go to David Bumby, Debra Stone, Guitty Bonner, Karen Jones, Jackie Rollingson, Jessica Outhwaite, Margaret Stewart, Melaine Taylor and Simon Eaton.

Healing Through Curatorial Dialogue is a collaborative project between Northumbria University and Northumbria NHS Healthcare Foundation Trust. Since September 2007, a series of art workshops has investigated how art and making exhibitions can enhance the healing process in the healthcare environment.
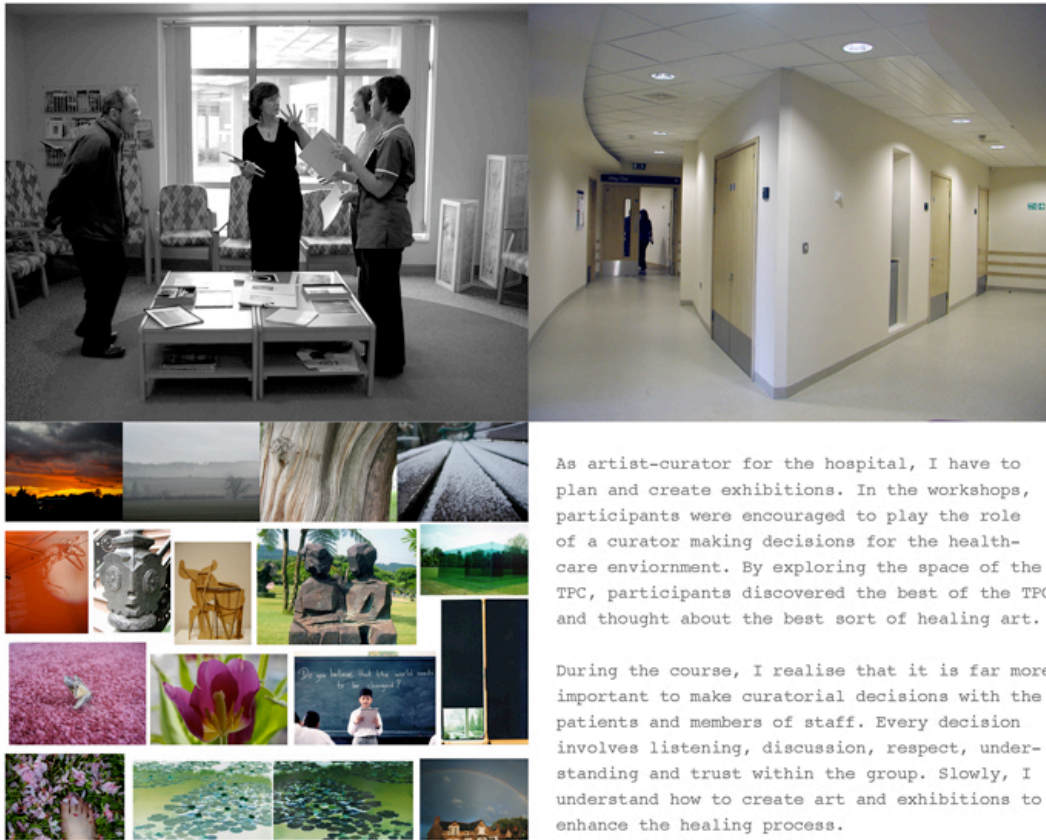
Poyan Yee, Artist-Curator

In the workshops, participants were regarded as co-researchers to explore the meaning of chronic health condition through art. Artworks acted as a catalyst for dialogue, in which people freely communicated their feelings, experiences and views on coping with chronic illness, and shared their visions for the ideal healing partnership and environment. Understanding was forged and the bond within the group grew stronger as workshops developed.

By working with the group, I learn that healing lies in a supportive relationship where everyone is willing to listen to each other and committed to work together towards the goal of healing.

Captions (top left clockwise): *Flow* by Poyan Yee; Participants shared their hospital experiences; *Red Mirror series* by Alex Rowe.

As artist-curator for the hospital, I have to plan and create exhibitions. In the workshops, participants were encouraged to play the role of a curator making decisions for the health-care enviornment. By exploring the space of the TPC, participants discovered the best of the TPC and thought about the best sort of healing art.

During the course, I realise that it is far more important to make curatorial decisions with the patients and members of staff. Every decision involves listening, discussion, respect, under-standing and trust within the group. Slowly, I understand how to create art and exhibitions to enhance the healing process.

Captions (top left clockwise): Participants explored the space to plan for dream exhibitions; Space of TPC; The first group work to illustrate their visions for healing art.

Healing Through Dialogue, the last exhibition report on my research.

Appendix 6: Samples of Liability Forms

Northumbria Healthcare NHS Trust   Date : November 2007
Hexham General Hospital

Healing Arts Group

ARTWORK INSTALLATION FORM (DEPARTMENTS):

Dear Colleague,

You are asked to read and sign the following form on pre-installation of your artwork piece, as part of a rotating exhibition, within Ward /Departmental areas at the new hospital in Hexham.

Northumbria Healthcare NHS Trust does not accept insurance liability for any individual pieces of artwork. Insurance of each individual piece is to be arranged by the relevant artist against; fire, theft, deliberate and accidental damage for the period it will be displayed on the hospital property.

The general buildings insurance for the hospital details that the first £500 will be charged as an excess on the insurance, so this means any artwork valued less that this figure will not be covered.

All artwork will be fitted onto the hospital property in accordance with an agreed method statement with the Artist and use of the agreed security fixings, this will also be done following all appropriate Health & Safety procedures.
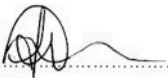
During the period when the artwork is within the building ; it will also be wiped clean (damp dusted) for Health & Safety reasons by Domestic Services staff and the method and frequency of doing this will be agreed in advance with the Artist.

The Artist is to agree "a period of exhibition" with the Curator, for their particular artwork(s).

Please sign below to acknowledge that you accept these terms of the pre-installation of YOUR art work and on behalf of Northumbria Healthcare Trust, I thank you for choosing to display your work within the hospital at Hexham which will assist in creating a pleasant environment for both patients and staff who use the building.

With kind Regards,

Ian McMinn
Chairman of the Healing Arts Group

TUESDAY NESBITT   7th Nov 2007
Artist's Signature and Printed Name   **Date of Signing**

Northumbria Healthcare NHS Trust　　　　　　　**Date : July 2008**
Hexham General Hospital

Healing Arts Group

ATRIUM ARTWORK INSTALLATION FORM:

Dear Colleague,

You are asked to read and sign the following form on pre-installation of your artwork piece, as part of a rotating exhibition, within the Atrium space at the new hospital in Hexham.

Northumbria Healthcare NHS Foundation Trust does not accept insurance liability for any individual pieces of artwork. Insurance of each individual piece is to be arranged by the relevant artist against; fire, theft, deliberate and accidental damage for the period it will be displayed on the hospital property.

The general buildings insurance for the hospital details that the first £500 will be charged as an excess on the insurance, so this means any artwork valued less that this figure will not be covered.
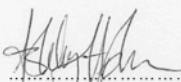
All artwork will be fitted onto the hospital property in accordance with an agreed method statement with the Artist and use of the agreed security fixings, this will also be done following all appropriate Health & Safety procedures.

The Artist is to agree "a period of exhibition" with the Curator, for their particular artwork(s).

Please sign below to acknowledge that you accept these terms of the pre-installation of YOUR art work and on behalf of Northumbria Healthcare NHS Foundation Trust, I thank you for choosing to display your work within the hospital at Hexham which will assist in creating a pleasant environment for both patients and staff who use the building.
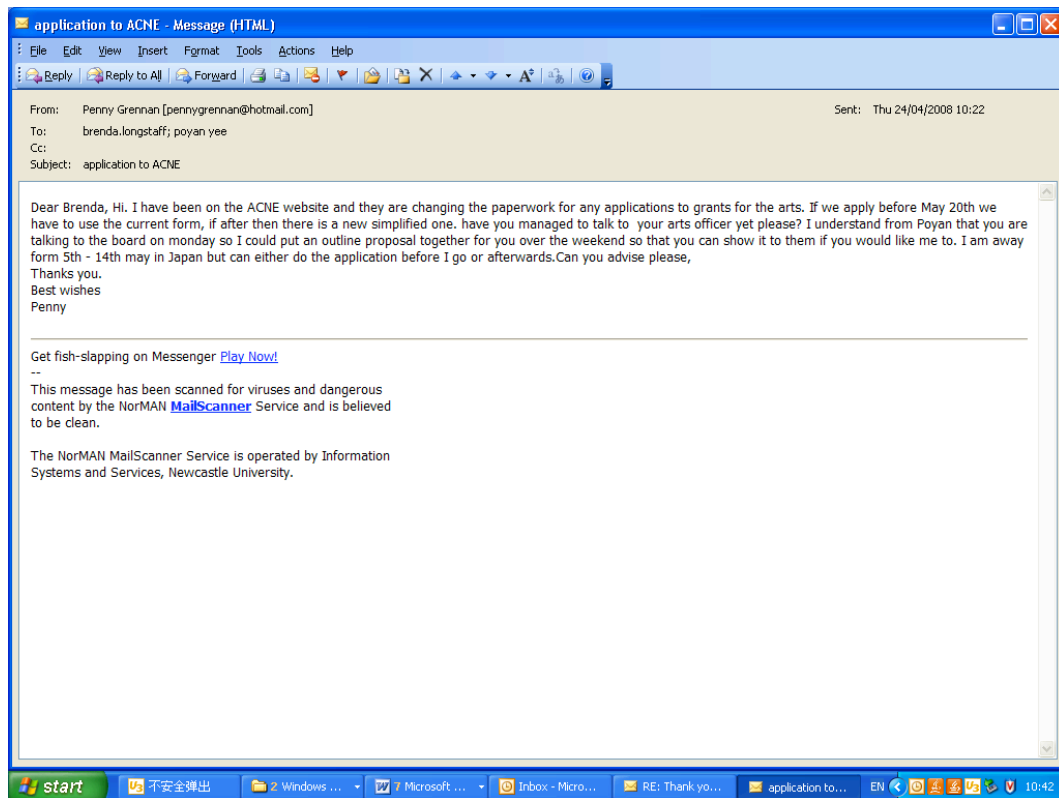
With kind Regards,

Ian McMinn
Chairman of the Healing Arts Group

ASHLEY HIPKIN
Artist's Signature and Printed Name

14/07/08
Date of Signing

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Appendix 7: E-correspondence between Artist & Longstaff

This email shows local artist Penny Grennan offering to help Longstaff to apply funding from the Arts Council England to develop curatorial projects for HGH.

Appendix 8: Recognition from the Trust

Invitation to the opening of the Tree of Life exhibition in the Tynedale Patient Centre, Hexham General Hospital

A celebration of the work of artist-curator Poyan Yee, Northumbria University Ph.D student who has completed her thesis on the subject of *Healing Through Curatorial Dialogue* and will shortly be returning to Hong Kong in January 2010. Northumbria Healthcare NHS Foundation Trust is grateful to Poyan for her groundbreaking work with patients, staff and local schools to encourage their participation in the Healing Arts programme. Also her invaluable work with local artists and community groups to enable the hospital environment to be transformed through the rich diversity of art mediums on display. Our thanks and good wishes go with her.

Invitation card on the reception ceremony by Longstaff and her assistant. There is a typo for the title of the exhibition, which should be *Tree of Hope*.

Photograph with students and teachers of Queen Elizabeth High School, Hexham, at the reception ceremony (left, photo by Katharine Jepson), attended by over 20 guests, and reported by local newspapers*, The Journal* (14 Jan 10) and *Hexham Courant* (22 Jan 10). Present from the Trust (right).

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