

## The art of medicine

### Aesthetic deprivation in clinical settings

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

In recent years medical humanities and arts programmes in health care and medical education have matured. However, many clinicians, including those favourably disposed to a greater presence of arts in health care, remain uncomfortable with the often fulsome language and somewhat uncritical stance of evangelists of the arts and health movement. Phrases such as the "healing arts" seem to overstate potential benefits and contain uneasy echoes of obscurantism and mysticism. Indeed, many of us may think of the golden age of art in hospitals with the worst forms of speculative and unscientific treatment—the four humours, purging, and blood-letting.

Equally, reviews of the efficacy of arts in health care, as opposed to professional arts and music therapy, rarely stand up to sustained academic scrutiny, with a tendency to mould weak data and speculative associations into an often less than convincing polemic. We propose that a more reflective and critical line of reasoning is needed

for the development of arts in health care. This is not a surrender to scientism, rather, it is the need to develop a common language and intellectual framework between medicine and the humanities.

A helpful insight comes from research on the effect of music on recovery after stroke. For example, one study by Sarkamo and colleagues purported to show that listening to music had a positive impact on cognitive recovery and mood after stroke in the intervention group compared with the control group. However, the intervention consisted of access to the patients' five favourite CDs and a CD player. This finding prompted us to question why it is that patients recovering from stroke do not routinely have access to their favourite music? Surely aesthetic deprivation—denying patients access to usual sources of aesthetic support, such as the deeply personal choice of music to which we turn in times of stress and difficulty—might impair cognitive recovery and depresses mood in patients recovering from stroke? Reorienting the debate in this way allows us to reconsider the importance of aesthetics in health and sickness, the aesthetic impoverishment of most health-care environments, and the role of arts and aesthetics in private and public life in a way that is accessible to clinicians.

The notion of aesthetic deprivation reflects a continuum of philosophical thought on the importance of art and aesthetics in human existence. From Plato through Aristotle, Immanuel Kant, and, more recently Roger Scruton and Anne Sheppard, philosophers have identified aesthetics as markers of human identity, pathways for exploration of the human condition, and key elements of personal self-expression.

Art and aesthetics also matter in everyday life. Many people engage with the arts and believe that they have a valuable role in a modern society. Indeed, one Norwegian study suggested a positive association between receptive participation in the arts and wellbeing. There is an emerging interest in the impact of aesthetic deprivation in everyday life. The philosopher Yuriko Saito has been a leader in philosophical and practical approaches to everyday aesthetics, and suggests that seemingly insignificant everyday aesthetic preferences and decisions are more significant than experiences of high art in forming and informing one's identity and view of the world. Saito argues that more attention to the beauty of everyday objects can enhance our appreciation of them and our environment. Thus, attention to everyday aesthetics, such as food, the texture of bed sheets, crockery, and interior design, could be more important to patients than introducing the fine arts to the health-

#### Further reading

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The premiere of *Bewitched* by Ian Wilson, composer in residence to the stroke unit at Tallaght Hospital, Dublin, Ireland

care setting. A series of studies by Caspari and colleagues in Norway highlighted that there were few concrete guidelines or directions for the aesthetic aspects of hospitals, whilst another survey suggested that many patients were dissatisfied with the provision for choosing different kinds of aesthetic input in hospitals.

Yet it seems limiting to generate an artificially dichotomous choice between two manifestations of aesthetics—fine arts and everyday—and we suspect that a combined approach would be preferable, particularly since arts and health programmes are likely to provide the nexus for reflection and action in implementing a range of aesthetic enrichment in health-care settings. In turn, such programmes need to engage in a more sustained way with clinical and humanities research programmes to investigate the relation between aesthetics and wellbeing. Formal academic linkage between arts and health programmes and university departments of medical humanities is clearly a logical development, and we have found much interest among a range of clinical and humanities disciplines in practical and academic aspects of our arts and health activities. The research opportunities and the potential to impact on health are tantalising.

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

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

Of course, health-care professionals also suffer from aesthetic deprivation. If the health-care settings in which they practise are poorly designed, aesthetically barren, and polluted by noise it is not surprising that such an environment may have a negative influence. Aesthetic enrichment is likely to have an impact on staff wellbeing and empowerment, and might also promote a clinical framework that rises above task and technique-oriented



Sir James Galway performing in the geriatric medicine unit of Tallaght Hospital, Dublin, Ireland, during a residency with the Irish Chamber Orchestra

health care. Our own experiences with a programme of live music in our hospital have been striking in this regard, with equally positive responses from patients, visitors, and staff. The active involvement and enthusiastic participation of health-care staff in supporting such arts and health projects might be an indicator of unrecognised need and demand.

If aesthetic deprivation can be seen as an important factor in wellbeing, it might also liberate arts and health initiatives from disproportionate constraint over issues such as funding. A better understanding of aesthetic deprivation and enrichment in clinical settings would allow for a more considered approach to the design of aesthetically pleasing and supportive health-care environments, including arts programmes. Such insights might also prompt a reconsideration of how we prioritise arts and health initiatives by adding a welcome articulacy and focus to tackling aesthetic deprivation across a range of health-care settings. Instead of wearisome recourse to the increasingly tired trope of C P Snow's two cultures, we might find that unpicking the elements of aesthetic deprivation and enrichment not only supports good biopsychosocial care, but also a more robust model of interdisciplinarity between the life sciences and the humanities.

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This work was supported by a research grant from the Meath Foundation, Dublin to HM.

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