Arts & Health
Vol. 3, No. 2, September 2011, 95–109

Routledge
Taylor & Francis Group

POLICY

Arts practices in unreasonable doubt? Reflections on understandings of arts practices in healthcare contexts

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(*Received 30 November 2009; final version received 14 December 2010*)

This article suggests that the discourse on arts and health encompass contemporary arts practices as an active and engaged analytical activity. Distinctions between arts therapy and arts practice are made to suggest that clinical evidence-based evaluation, while appropriate for arts therapy, is not appropriate for arts practice and in effect cast them in unreasonable doubt. Themes in current discourse on "arts" and "health" are broadly sketched to provide a context for discussion of arts practices. Approaches to knowledge validation in relation to each domain are discussed. These discourses are applied to the Irish healthcare context, offering a reading of three different art projects; it suggests a multiplicity of analyses beyond causal positive health gains. It is suggested that the social turn in medicine and the social turn in arts practices share some similar pre-occupations that warrant further attention.

Keywords: arts; health; evaluation; aesthetics; public health

Introduction

In the spirit of interdisciplinarity, which is espoused as a founding principle of this journal, this article seeks to claim a space for arts practices within the discourse on arts and health. To date, analyses of practice have largely relied on using approaches that employ methodologies originating in evidence-based medicine (EBM) to establish positive health gains; while this may be an appropriate methodology with which to validate arts therapy, it is not congruent with contemporary arts practices.

This article is necessarily a summary, as much ground needs to be covered to establish key concepts. To understand arts practices in healthcare settings, it is necessary to have an understanding of the reformulation of what is meant by health and the institutions and practice of healthcare in tandem with a nuanced awareness of the concerns of artists/art theorists and art institutions regarding arts practices in the social realm. The specific subject domains of "arts" and "health" do not exist as concrete entities, but are shifting, amorphous and contested, subject to competing knowledge claims within their own disciplines. I am adopting an approach that specifically addresses arts practices in health care settings, "not exclusively as an artistic genre but as a 'problem idea'" (Kwon, 2002), that warrants greater attention than advocacy, cooption and assimilation. I am not concerned with establishing whether there is a causal relationship between arts practices and health outcomes; rather, my focus is on how these practices can be understood.

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ISSN 1753-3015 print/ISSN 1753-3023 online

DOI: 10.1080/17533015.2010.551716
http://www.informaworld.com

In the first section, a distinction is drawn between arts therapy and arts practices based on policy, academic comment and practice-based observation. The aim is to distinguish between what on the surface appear to be similar activities, but are in effect quite different in their purposes, processes and outcomes. As intentions for arts projects differ, so too do expected outcomes; it is not a matter of privileging one approach over the other, rather it is a question of parity of esteem between disiciplines (McGonagle, 2007). I suggest that a claim for a research agenda that foregrounds arts therapy and clinical evidence-based practice does not adequately reflect all the interests of this diverse field and specifically places arts practices in a position of unreasonable doubt.

In the second section, I discuss different approaches to understanding what is meant by the concept of "health", the changing role of health services, the emergence of a social model of care in distinction from the traditional medical model and the influence of the meta narrative of the knowledge economy as it is operationalised through EBM. The *Open Window* arts project (St James Hospital, Dublin, Ireland) is discussed in light of the imperative to evaluate arts projects using the analytical framework of EBM.

In the third section, critical discourses relating to participatory arts practices are discussed in relation to two arts projects, *The Lost Children* (St Finbar's Hospital, Cork, Ireland), and *Training to be a Service User* (RehabCare, Cork, Ireland).[1] One of the primary challenges for practice is validation. As a general case, I draw on literature synthesising analyses of the social impact of the arts, followed by the particular case of subdomain analyses of the impact of arts practices on health.

Arts Practice and Arts Therapy

Putland (2008) identifies the risk of an "eclipse of art" as a consequence of different knowledge systems competing to dominate discussion of practices. The possibility of diminishing arts practices to a subservient role can be reduced if these knowledge systems and their fields of operation are recognised. As a step toward this end, a distinction is made between arts practices and arts therapy. The Arts Council of Ireland makes this distinction by indicating that arts therapies are a therapeutic intervention informed by the practice of psychology, psychotherapy and psychiatry. Arts therapists work alongside other clinical grades in the planning and delivery of patient care plans. The Arts Council of Ireland (2003, p. 113) further clarifies:

> From the perspective of a therapist, the intention is primarily therapeutic in that art is used as a means of communication and expression. Positive enjoyment of art is a bonus added to the value of their work. For artists, on the other hand, the primary intention is artistic and any therapeutic effect is seen as a bonus.

This analysis of the divergent roles of arts therapy and arts practice is shared by leading commentators in the field. Dileo and Bradt note that "arts therapies are inherently different in nature from arts in healthcare practices, therefore, each field and discipline needs to create and embrace its own body of literature" (2009, p. 177). White (2009) suggests that the confusion of arts therapy with arts practice has its origin in early hospital-based projects. He suggests that this confusion led to a burden being placed on the arts to demonstrate that they have a viable role in treatment that would require evidence of these benefits.

How these differences are made manifest in practice became the subject of attention in a collaboration between artist Marie Brett and arts therapist John McHarg, who worked together on a project over an 18-month period (at Bawnard Day Unit, St Raphael's Hospital, Youghal, Ireland, 2008/2009). One of the outcomes of this collaboration was an analysis of the role of the artist and the arts therapist (Brett & McHarg, 2010). To the

outsider their work may seem similar, but for themselves and their professional practice they adopt entirely different approaches.

Their analysis highlights important factors such as work practices, duty of care, supervision and support, and aesthetic vs. therapeutic concerns as follows. The work practices of the artist and the arts therapist differ in that an artist usually works freelance as an individual on short-term contracts, whereas the arts therapist is typically a staff member working as part of a professional team. Supervision and support differ in that artists typically work in isolation, often without collegial professional support, while the arts therapist is professionally supervised. Artists do not bear a clinical duty of care, the artist–participant relationship begins without prior knowledge, the artist has no access to confidential medical information and their relationship develops over the course of the project. An arts therapist–client relationship is defined in advance; the arts therapist is focused on the client in a "serving role". A client comes to arts therapy because of a specific concern; the arts therapist can access medical records and uses art making as a tool for recovery. For the artist, the primary concern is the artwork and the development of their own arts practice, an artist will comment on the artwork being made, making aesthetic judgements and influencing the process/outcome. An artist will push boundaries aiming for a balance between challenge and support for participants to work at the edge of their creative potential. For an artist, the artwork produced stands on its own merit. The arts therapist, on the other hand, aims to develop a therapeutic relationship and maintain a safe place for the client and the artwork. The arts therapist does not make judgements on the artwork produced by the client. Both the arts therapist and client use the artwork produced in a number of ways, interpretatively and symbolically, as a tool.

The foregoing summary of the analysis of Brett and McHarg (2010) clearly demonstrates practical differences in the art-making approaches of an artist and arts therapist. These characteristics, in conjunction with the policy frame outlined by the Arts Council of Ireland and the academic analyses previously referenced, establish a case for distinguishing arts practices and arts therapy. The clinical evaluation of arts therapy outcomes is appropriate as they have a clinical purpose. Arts practices, however, cannot be evaluated in the same way as they are concerned with different motivating forces.

How then might these arts practices be formulated? There are many possibilities, but, for example, thematically, arts practices could address disciplinary perspectives on health by opening a discursive space that can comment and critique the evolving relationship between medicine and society. These can operate at both the level of the individual and of collective experience. An individual narrative of illness is exemplified by the work of UK artist Jo Spence, who documented her experience of terminal cancer through photography, bringing her body to research "in an immediate and shocking way" (Bell, 2002, p. 23). An analytic of collective experience can be seen in the work *Cradle to Grave* at the British Museum (Pharmacopoeia, 2003).[2] The installation consists of a lifetime supply of prescription drugs based on the fictional biographical life course of a man and a woman. Over 28,000 pills are woven into fabric and displayed in a glass case 13 m in length (Mordhorst, 2009). Neither of these two artworks had the intention of seeking a therapeutic health gain, yet they can contribute to critical discourse on health and healthcare. Clearly, arts therapy and arts practice are very different in substance, yet each can undoubtedly play a different role in the context of health and healthcare.

Approaches to Health, Healthcare and Evidence-based Medicine

How we understand health is a central problem in the philosophy of medicine and the sociology of health and illness. Definitions exist on a continuum from a scientific naturalist

approach to a normative understanding with many hybrid definitions in between. The naturalist approach is exemplified in the biostatistical theory of health in which health is defined as a statistically normal function of species design, and "health" and "disease" are characterised as empirical, objective and value-free concepts (Boorse, 1997). A normative approach to the concept of health is illustrated by Nordenfelt (2001) when he argues that a healthy person is one who can satisfy "vital goals", which are necessary and sufficient for minimal happiness. Interpretations offered under the rubric of the social construction of health offer socially and culturally embedded analyses of how we understand health at a given point in time and in a given place (Berger & Luckmann, 1967), e.g. masturbation, homosexuality, drapetomania and sluggish schizophrenia were all classified as disorders at one time, but now the first two examples are understood as expressions of sexuality and the second two as expressions of a desire for freedom.[3] The above characterisations are only briefly cited as an indication of diverse approaches and understandings of what is meant by health and are the first point of entry to a discussion on arts practices in healthcare settings.

Secondly, the role of healthcare institutions has changed rapidly consequent to the demographic transition which has led to a change in the pattern of disease characterised as the epidemiological transition[4] (Jamison, Creese & Prentice, 1999). Health services are no longer predominantly providing interventions to acute episodes and infectious diseases; rather, they concern the provision of services for people with chronic and degenerative illnesses. Prolonged longevity as a result of improved medical interventions and increased affluence has changed the balance of service delivery. As chronic and degenerative diseases have replaced infectious disease, life expectancy has increased and a greater emphasis is being placed on prolonging active life expectancy. From a health services perspective this is about maintaining individual independence, for the individual it is more about autonomy, especially because as one ages, health gains are likely to be proportionately greater from improvements in quality of life rather than length of survival (Evans, 1993).

The changing character of healthcare services has had a consequent change on the model of healthcare provided. Emergent themes in healthcare research point toward a social model of medicine in distinction to the interventions of the medical model (Blaxter, 2010). The medical model of health focused on the eradication of illness through diagnosis and effective treatment. Its origins are found in germ theory, which gave rise to the doctrine of specific aetiology: for every disease there is a single and observable cause that can be isolated. In contrast, the social model emphasises multiple and interrelated factors that influence health and points to changes that can be made in society to make a population healthier. Public health advocates have established a body of literature which emphasises the lifelong importance of the social deteminants of health on health outcomes.[5] One of the key determinants of health is equality: the more equal a society is, the better are its health outcomes; the more unequal a society is, the poorer health outcomes will be for all citizens independent of individual affluence (Wilkinson & Pickett, 2009). The benefits of investment into particular pathologies have been shown to be less effective than investment in improving the determinants of health, thus health has become less a corporeal concern, and more a social issue.

Thirdly, the hegemony of the knowledge economy has had a particular inflection on the domain of healthcare. In addressing the context for arts practices in healthcare settings, consider what are the accepted modes of acquiring and arranging knowledge within the medical domain? These can be characterised by the umbrella term evidence-based medicine (EBM), which describes the explicit process of applying research evidence to medical practice in an attempt to standardise practices and manage uncertainty (Timmermans & Angell, 2001). Research practices that generate income skew the

knowledge base and the application of that knowledge through practices and products. This approach to the practice of medicine can be seen in contrast to experiential approaches where decision-making is based on the experience of the practitioner relative to the particular patient and pathology. EBM has become the dominant frame in which medicine is researched, discussed and practiced and has a significant role to play in understanding how arts practices in health care settings have been interpreted.

Although EBM is the dominant form of knowledge validation, it is not without its critics even within the medical domain itself. According to Cohen in an analysis of criticisms of EBM, five critical themes emerge: (1) it has a poor philosophic basis for medicine; (2) the definition of evidence is too narrow; (3) it does not meet its own empirical tests for efficacy; (4) its utility in individual cases is limited; and (5) it threatens the autonomy of the doctor–patient relationship (Cohen, 2004, p. 37). A social movement perspective is offered by Pope (2003), who analyses the rise of EBM disclosing power struggles between different factions within the medical profession and beyond. She suggests that resistance to the EBM movement was related to how evidence was specified as rational/technical rather than contingent/experiential. Denny (1999) provides a different reading of the rise of EBM. He suggests that EBM operates as a discourse responding to specific contemporary challenges to medical authority. It can be understood as an attempt to re-establish medical dominance in relation to patients, other health professions and practitioners of complementary therapies as well as maintaining status of privilege and authority in society at large.

Medical humanities has emerged as a countermovement to the dominance of EBM by advocates of patient-centred practice, "to encourage curiosity about the human condition and healthy skepticism about the nature of medical 'truth' and to model acceptable moral behaviour" (Kidd & Connor, 2008, p. 51). Other commentators suggest that medical humanities can be formulated as additive or integrative. Additive refers to the practice of medical humanities where the objective is to produce more empathetic doctors, whereas integrative suggests encounters with the knowledge base of medicine itself (Greaves & Evans, 2000).

I cite these critical perspectives of knowledge claims within the sphere of medicine, as an insight to the internal discourses that take place within the domain of "health". When understood as a practice of power, it is easy to understand why EBM gives rise to a tension in the articulation of arts practices in healthcare settings. This tension is discussed in relation to arts practices in community healthcare settings by Putland (2008), who highlights the pre-occupation by health advocates with establishing evidence based research and arts advocates that are concerned with the encroachment of reductive measures and narrowly defined objectives for arts practice.

The radicant[6] advance of arts practices to healthcare settings presents a challenge to prevailing clinical orthodoxy. In order to remedy this situation, the discourse on arts and health is required to conform to that of the medical establishment, with the compliance of artists and arts institutions, to embrace the vocabulary of evidence-based clinical practice. This positivistic approach to activities that take place within clinical settings places an obligation on arts and health practices to conform to a clinical standard of evaluation. Thus we find, when reflecting on arts and health practices, the discourse is dominated by claims for positive clinical outcomes for patients.

For example, the arts project, *Open Window* (Roche, Napier, Maguire & McCann, 2008) at the National Bone Marrow Transplant Unit in St. James Hospital, Dublin brought together members of the National College of Art and Design, Trinity College Dublin and St James Hospital, to create arts-centred research to help patients deal with being in protective isolation. The *Open Window* project was subject to a randomised control trial

whose central research question was to assess whether the artworks had an impact on the recovery of patients, even though the original specification for the commission did not include this element. Randomised control trials are the basis for validating medical knowledge and rank highly in the hierarchy of evidence based medicine.

The artist noted that when creating an artwork that was accountable concurrently within the medical and artistic community, not only did he have to contend with the functional physical architecture of the hospital building, but also a second architecture composed of staff protocols and management structures. However, Roche was able to make a conceit on this idea of architecture when he created an inflatable sculpture, which doubled as a meeting room, in which the review committee discussed submitted artworks. Roche's purpose for the sculpture was to provide a space that could suspend the influence of the prevailing physical and psychological architectures in the application of normative criteria to the process of selection of artworks. Pressure to present positive evidence-based clinical outcomes is critical to sustain funding and to legitimate arts and health projects. In order to normalise this encroachment into the medical domain, projects are given legitimacy through clinical discourse. The key question asked of this artwork was whether it was clinically useful and indeed during the Vital Signs 2009 conference exhibition, a core element of the project was exhibited as *A Clinically Useful Artwork? Part 1 & 2*.[7] This succinctly illustrates how biomedical discourse becomes the dominant mode of understanding arts practices in healthcare settings.

The discussion in this section broadly introduces themes from philosophy and sociology that indicate that the domain of health is an arena of complex contested claims to knowledge, regarding concepts of health, models of health care and validation of practices. I have offered a reading of an artwork that suggests that arts practices are subject to clinical knowledge claims through EBM, as a practice of power. My intent in this article is to divert attention from this dominant approach to claims for individual health gains, to an approach that can address the complexity of health and healthcare on the basis of an aesthetic.

The Social Turn in Contemporary Arts Practices

This section considers contemporary participatory arts practices in the social realm in general and in healthcare settings in particular in light of critical discourse on these practices. I am foregrounding these practices over and above other practices because the Arts Council of Ireland has singled out participatory arts practices as the predominant artform adopted in healthcare settings (Arts Council of Ireland, 2003). The discussion highlights the highly contested nature of the field. Validation of these arts practices has presented both a philosophical and methodological challenge that remains unresolved, particularly when value is deemed to be analogous with economic value.

The prevalence of participatory arts practices is not a phenomenon peculiar to healthcare settings, it is indicative of a widespread shift in artistic practice in general. These changes, in becoming increasingly participatory, have given artistic practices a new identity and character and represent a notable change from the artistic practices of previous decades in which the artist was studio based and audience engagement was mediated solely through the artwork itself. This shift in arts practices has been conceptualised in a number of different ways. Nicholas Bourriaud, Grant Kester and Claire Bishop are leading theorists in this field.

Bourriaud (2002), reflecting on the changing arts practices of the 1990s proposes that artworks are judged based upon the inter-human relations that they represent, produce

or prompt. Bishop (2004), reflecting on these ideas challenges the significance of the relations formed in the process, while Kester (2004) proposes a dialogical aesthetic, a performative, process-based approach in which artists become context providers not content providers.

In describing his conceptualisation of relational aesthetics, Bourriaud contextualises arts practices in a historical context. He eschews conceptions of artistic activity as an "immutable essence"; rather, he views it as "a game whose forms, patterns and functions develop according to periods and social contexts" (Bourriaud, 2002, p. 11). Relational art reflects the concerns unique to this period in time and may be described as a set of artistic practices, which theoretically and practically originate in human relations and their social context. Bishop suggests that aesthetics can offer the ability to think contradiction and negotiate the social constructs of our time (Bishop, 2006), but nonetheless retains a sceptical outlook. She decodes the conviviality of socially engaged practices as the imposed consensus of an authoritarian order, sheathed beneath recurring ethical themes in critical discourse. Bishop describes these as "well intentioned homilies espousing Christian ideals of self-sacrifice and 'good souls', in contrast to the contradictions that naturally arise from the artist's intentions" (Roche, 2006).

The Lost Children *by Marie Brett (Figure 1)*

The Lost Children (Brett, 2007) took place with artist Charlotte Donovan, patients, staff and visitors at St Finbar's Hospital, Cork. Participation was not predicated on an easy and relaxed subject matter. The artwork was a response to an embedded social memory. It uncompromisingly addressed the terrible legacy of Magdalene Laundries. Sculptural

Figure 1. *The Lost Children*.

artworks composed of plaster of paris moulds of children's dresses were created in response to the memory of unmarried pregnant girls, abandoned by their shamed families, their babies taken at birth to be sold or given away. This was at a time in Irish history when the authority of the Catholic Church was beginning to crumble under the weight of its hidden history of institutional abuse. The artwork proposed a medium of expression for those who had been shunned and forgotten and contributed to a new narrative that challenged institutional authority, enfranchising the disenfranchised. This project, although convivial in nature, did not suffer the "imposed consensus of authoritarian order" as Bishop feared; rather, it revealed an uncomfortable truth.

Bishop (2010) offers a reading of the social turn in contemporary art practices, describing how "the project" became the descriptor for the kind of artistic practices that engage with the social after the 1990s. It is an umbrella term for describing arts practice in relation to society through various modes, through elective practice, self-organised activities, documentaries, transdisciplinary research practices and participatory and socially engaged art. She notes that the paradox of participatory art in general is that the more participatory the artwork, the more it forecloses spectatorship and the less open it is to future audiences. This is a particular challenge for arts practices that take place in healthcare settings, as in addition to the process-oriented nature of practice, projects usually take place in contexts far from public gaze.

Training to be a Service User *by Colette Lewis (Figure 2)*

In July 2001, the management of a number of sheltered workshops for people with disabilities moved from a model of supported work practices to a model with a developmental and therapeutic focus. At the initial stage of this transition, people in the

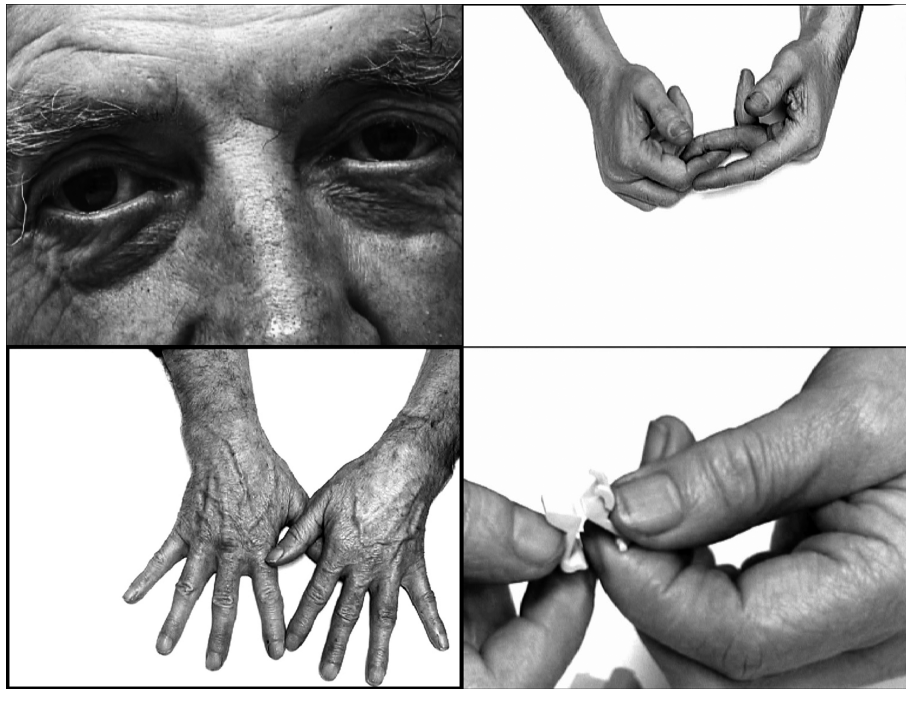

Figure 2. *Training to be a Service User.*

workshops were concerned about what the changes in management would bring. In *Training to be a Service User* (Lewis, 2004), dialogue was recorded based around the changeover relating to identity and work. Ambiguities about the terms "trainee" and "service user" were teased out. Using the hand as a symbol of the relationship between physical ability and work, each participant explored their hands on video in terms of the shape, form, mobility, improvised movement and stories remembered about their hands. Using a camera connected to a TV monitor, participants could interact with their own image-making process. The outcome of the project claims as much for the process as the final artwork.

Training to be a Service User provided a safe space in which questions could be asked and criticisms made, that would not have been possible in another context; but clearly a collaborative encounter or conversation does not necessarily constitute an artwork or art practice. Kester (2004) proposes a dialogical aesthetic by declaring that it is not the dialogue but the degree to which emancipatory insights can be catalysed through dialogue that distinguishes a project as a work of art. His starting point lies in the assumption that aesthetic experience can challenge conventional perceptions and systems of knowledge. Artistic practices incorporate provocative assumptions about the relationship between art and the broader social and political world and about the kind of knowledge that aesthetic experience is capable of producing. The artist's role in catalysing emancipatory insights is critical in this process. Contemporary artists and art collectives can be "context providers" rather than "content providers" located outside the institutional confines of the gallery or museum and separate from a tradition of object making, to carve out a new role in the facilitation of dialogue among diverse communities.

Beech (2008) is critical of the participatory project claiming that it is doomed by virtue of the inherent contradiction of participation. The price of participation is the neutralisation of difference and the diminution of the power of subversion; he further maintains that although Bourriaud's conceptualisation of relational aesthetics includes a critique of the commodified art object, the practice of relational art is in fact extending the commodification of art by incorporating social events and exchanges into the field of art's commodities. In a similar vein, Fraser (as cited in McIntyre, 2007, p. 38) notes the increasing tendency of arts practices to incorporate some aspect of service provision. These criticisms are cautionary for artists working in healthcare settings.

McGonagle (2009) reflects on the social turn in arts practice, in an analysis of the work of Canadian artists, Condé and Beveridge,[8] whose work is an exemplar of the reconfiguration of arts practices, being both participatory and collaborative, reconnecting aesthetic values and ethical responsibilities to lived experience, "These are artists who engage in social processes and see no contradiction in their practice being validated as art" (2009, p. 35). This social turn requires a reconsideration of arts practices in relation to a repositioned understanding of art and its functions in the human project over the longer term. It differs radically from conventional understandings of arts practices in which the validation of artworks is mediated through the market, the academy or peer recognition. Much of this work is process led with a lesser emphasis on specific material outputs. As a result, they are not easily validated in an environment where merit is primarily accorded to artworks that have commercial value. Condé and Beveridge have succeeded in securing validation for their work by positioning it within the distribution zone where validation is conferred and using dissemination strategies beyond that of the exhibition. McGonagle proposes "A New Deal" for models of art and institutional practice that "foreground participation, engagement and commonality" (McGonagle, 2007). Nevertheless, participatory arts practices are not universally met with enthusiasm. Antagonisms emerge regarding conceptualisations of practices as socially useful rather than emancipatory in intent (Meade & Shaw, 2007).

These antagonisms can be seen in the literature on the social impact of the arts. The advent of New Labour in the UK inaugurated a period of commissioning policy reports that sought to validate investment in the arts on the basis of desired social outcomes (Landry, 1993; Matarasso, 1997). Much research attempted to address the impact of social arts practices and debates surrounding appropriate and rigorous methodologies abounded. Many journal articles synthesise and review this research (Merli, 2002; Mirza, 2006; Reeves, 2002; White & Rentschler, 2005). White and Hede (2008) suggest that research has been reoriented over the past 30 years, from an empirical emphasis on positive economic impacts during the 1980s, followed in the 1990s by trends in more socially oriented government policy leading to evaluation of positive social impacts which was subsequently replaced by a current pre-occupation with establishing *a posteriori* knowledge of the relationship between the individual's definition, experience, and impact of art.

Rather than focusing on methodological issues, Belfiore and Bennett (2008) have addressed the social impact of the arts in an intellectual history of claims regarding debates about the value, function and impact of the arts and by examining the many different ways in which the social impact of the arts have been articulated. They conclude that this is a dialectic that has existed as long as Western civilisation. From Aristotle and Plato through to contemporary censorship boards, the "good" and "evil" influence of the arts has been a source of debate in society. They suggest that an approach informed by advocacy is futile; rather, an active and sustained engagement with the history of ideas is necessary to gain any real understanding of the value of the arts.

Much of the early literature in relation to arts and health practices was similarly concerned with establishing an evidential base to state the health benefits of arts practices (Clift, 2005; Macnaughton, White & Stacy, 2005; White, 2006a, 2006b). In a guest editorial of the Journal *Health Education*, Clift (2005, p. 330) expresses sentiments widely held regarding the issue of evidence, but frames it within the context of individual health benefits:

> Everyone with an interest in arts and health is exercised by the issue of "evidence" and the need both to demonstrate the effectiveness of arts-based interventions for health and to understand the processes by which engagement in the arts and creative activity can be beneficial for health.

Typically, research was framed to prove the health benefits of arts activity with the aim of becoming part of health service delivery (Eades & Ager, 2008). Attention focused significantly on methodological issues of measurement with a wide variety of scales used. The World Health Organisation Quality of Life Index (WHOQOL) was suggested as an international reference to establish common ground between projects across borders (White, 2006b). Mental health services in particular are singled out as key beneficiaries of the potent power of the arts as they provide an antidote to increasing alienation in the workplace and in the community (Camic, 2008), and can contribute to social inclusion measures (Hacking, 2006).

Dileo and Bradt (2009), writing on the nascent steps to establish a discipline and profession in the field of arts and health, claim that when providing evidence for health professionals, evidence-based practice should be adopted. Particular attention is accorded to Cochrane meta-analyses and randomised control trials as formulations for evidence-based practice. They argue that for arts practices in healthcare settings to be taken seriously within the medical domain, evidence must be provided in ways acceptable to the medical establishment.

Similarly, in an attempt to provide an evidential base for arts and health practices, Arts Council England commissioned a review of medical literature published between 1990 and 2004 demonstrating the impact that the arts can have on health (Staricoff, 2004).

The review explored the relationship of arts and humanities with healthcare, and the influence and effects of the arts on health. In total, 385 papers were reviewed. The findings highlighted the importance of the arts and humanities on: clinical outcomes, mental healthcare, practitioners and staff morale and job satisfaction.

Mirza (2006) adopts a critical perspective, caustically characterising arts and health practices as an anaesthetic instrumental intervention. She challenges the notion that social problems can be dealt with through therapeutic arts projects which in effect medicalise social issues. Her analysis would bracket claims for medical benefit within a health agency research agenda and replace the array of impact reports with a discussion about the "value" of the arts and why they should be subsidised.

O'Carroll (2009) suggests that seeking to validate arts practices and impacts using the dominant evidence-based model is futile. He suggests that artists who choose to seek integration within the boundaries of the medico-scientific discourse face a difficult challenge, because within the domain of health, the medical profession are the "arbiters of truth". The impulse to establish a link between arts practices and health is based on two false assumptions: firstly that research can "prove" that arts are good, and secondly as a consequence more funding will accrue. Neither of these assumptions is likely to hold true. "The notion of evidence based art is as absurd as an impressionist school of science" (Baum, 2001, p. 306), but relinquishing the holy grail of clinical evidence-based outcomes (Hamilton, Hinks & Petticrew, 2003) does not necessarily infer that evaluation of arts practice should fall into the dominion of anecdote and opinion.

Mike White is a leading exponent for and researcher of arts and health practices. Despite, or perhaps as result of, having spent many years grappling with the methodological challenges of evaluation, he has changed his position on "proving the practice" in his most recent book (White, 2009). He historicises the emergence of arts and health practices in hospital programmes, which consequently left a legacy of confusion regarding art therapies and a burden of proof regarding evidence-based benefit. According to White, research has been limited by a focus on the individual rather than on the social and by poorly developed research methods. He suggests that a shift to social medicine is prompting a new research agenda. He suggests arts and health and its ally medical humanities can contribute to the dialogue in medicine concerning the complexity of extra physiological factors, by negotiating a philosophical space of creative inquiry rather than clinical evidence-based benefit. He suggests that these practices might be best understood using an anthropological approach informed by medical humanities. Putland (2008) asks what we want from evidence. She claims that we are looking for evidence that will not surprise us, to confirm what we already know, and suggests an alternate philosophical and interdisciplinary approach that can reconceptualise questions to create new knowledge.

In this section I have described critical discourses concerning participatory arts practices, discussing arts projects and artists in light of the social turn in contemporary arts practices. I have addressed the literature on the social impact of the arts in general and the sub domain of arts and health in particular. Dissatisfaction with the current approach of EBM has lead to a rethinking of what is wanted from evidence prompting a new philosophical research agenda.

Conclusion

In this article, I have distinguished between arts practice and arts therapy, to create a space for considering how arts practices might be understood within the domain of health.

A brief introduction to some of the contested knowledge claims within this domain shows that there is considerable divergence of opinion on how health might be defined, how the practice of healthcare has changed from a medical model to a social model of care and how social factors influence knowledge validation. Health as a construct is not fixed, measurable or contained; rather, it is a nebulous complex. I suggest that although the dominant theme in arts and health discourse concerning validation has been characterised by clinical evidence-based practice, this mode of analysis is not congruent with contemporary arts practice, nor indeed universally accepted within the domain of health. The *Open Window* project provided a practical example of how clinical discourse can colonise an arts project by subjecting it to a randomised control trial. Theoretical concepts concerning the social turn in contemporary arts practice were introduced providing analytical reference points for discussion of *The Lost Dress* and *Training to be a Service User* arts projects. Literature evaluating the social impacts and health impacts of the arts were discussed, which in their separate disciplinary fields have moved to a position considering philosophy as an appropriate mode of inquiry.

From this discussion, it is evident that when the arts sector and health sector meet, there remains a considerable level of ambiguity about what arts practices might mean for the artist, patient and healthcare professional; indeed, each may have very different interpretations. The artist may be seeking an aesthetic objective, the service user an opportunity for conviviality and the healthcare professional may seek evidence-based positive clinical outcomes. While this ambiguity may have been tolerable, even useful, during the establishment of arts practices in healthcare settings, it is necessary now to reflect on whether any or all of these expectations are achievable or desirable.

Contemporary analyses in public health discourse claim that, in developed societies, post-epidemiological transition, what matters is the social environment. Improving the quality of social relations can lead to improvements in the quality of our lives. Such an approach encompasses the revolutionary ideals of liberty, equality and fraternity that suggest self-determination and risk (Wilkinson, 2005). Arts practices that offer dynamic engagement offer neither a solution nor a panacea to our ills, but can offer sustained critical reflection. It is at this point that the analyses of the social model of medicine meet the social turn in arts practice, sharing a critical engagement with structures that maintain and reproduce systems of inequality in local, regional and global contexts. Understanding arts practices in health care contexts in this way might lead to a more engaged deliberation on global health inequalities as was called for in a previous editorial of this journal (Clift, Camic & Daykin, 2010).

It is important that the ineffable character of arts and health projects is not lost in clinical service provision. Further research on arts and health as a field of practice is necessary to provide a conceptual frame as an alternative to the hegemony of the clinic. Equally research into pedagogies of practice, support and mentoring of artist practitioners would clarify the divergence between arts practices and arts therapy. All research should be informed by an analysis of the specific normative culture of healthcare settings and conceptualisations of arts practices from an interdisciplinary perspective and supported by an inter-sectoral dialogue based on parity of esteem.

Acknowledgements

The author would like to thank the artists Marie Brett and Colette Lewis for permission to reproduce images, the anonymous reviewers for their comments, the Dublin Institute of Technology for the award of an ABBEST scholarship and the Arts Council of Ireland for the Connect Mentoring Award managed by Create and Common Ground.

Notes

1. Both arts projects were funded by the Arts Council of Ireland through the Artist in the Community scheme managed by Create.
2. Susie Freeman, Liz Lee and David Critchley are the collaborators in Pharmacopoeia artworks. A detailed representation of the artwork can be found on-line, www.cradletograve.org.
3. Both drapetomania and sluggish schizophrenia were supposed mental illnesses that led slaves to flee captivity in search of freedom and dissidents to "pathologically" deploy freedom of thought to question the social order of repressive regimes.
4. Epidemiological transition refers to the phenomenon in developed countries whereby increasing affluence and advances in healthcare reduce the mortality rate due to infectious and communicable diseases giving way to degenerative diseases such as heart disease and cancer (Wilkinson, 2005).
5. Social determinants of health include factors such as poverty, working conditions, unemployment, social support, good food and transport policy. The WHO Commission on the Social Determinants of Health includes a commitment to tackle inequitable distribution of power, money and resources (CSDH, 2008).
6. Radicant here refers to Bourriaud's (2009) characterisation of arts practices, using a metaphor from botany of a creeping surface root, to describe the way in which arts practices insinuate themselves in social and cultural contexts.
7. See www.vitalsigns.artscouncil.ie for the programme of arts and health events.
8. Condé and Beveridge artworks: *Not a Care: A Short History of Healthcare* 1999–2000, *Theatre of Operations* 2000, *Ill Wind* 2001.

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