THE ROLE OF THE MODERN CURATOR IN HOSPITAL

A research project funded by the

The Meath Foundation
Healthcare, Research and Education at the Hospital in Tallaght

INTRODUCTION

The arts play a significant role in every society and culture, from the earliest societies to modern life. However, in healthcare settings, there is often an absence of normal access to the arts and hospitals can arguably be described as aesthetically deprived environments [1, 2]. Recent studies indicate a neglect of the aesthetic environment by hospital policy makers and a lack of access to and control of aesthetic interests for patients in hospital [3-5]. The importance, or not, attached to the role of the arts in healthcare can be viewed as a split between politicians and policy makers who value the 'instrumental value' of the arts, and cultural professionals who are dedicated to the 'intrinsic value' of the arts. Hospital Curators, or Arts Managers, are a relatively recent phenomenon, whereby the arts are introduced in hospitals to address both the intrinsic value of the arts in the public space of hospital as well as to meet certain health promotion or clinical aims. The role of the curator in hospitals is a particularly complicated one, given the pressure for evidence based practice to fund any healthcare activity and the constraints on spending within tight health budgets. The subjective nature of the experience of art in hospital, and the many stakeholders, contribute to the delicate role played by hospital arts managers and curators. O'Neill proposes that the key issue for curators is not actually the conflict between instrumental and intrinsic values, but how expert arts curators make their specialist contribution while at the same time fostering the wellbeing all in the hospital [6].

Relatively sparse literature exists on the role of the curator in hospital, as well as little exploration of how patient or service user preferences are taken into account when planning and delivering arts programmes within hospital. In addition, the majority of literature in the field focuses on evaluating arts projects that are participative with scant attention given to the role of receptive arts [7].

DEFINITIONS

For this paper the terms *Arts Manager* and *Curator* are used to define the role of the professional employed within a hospital to run the arts programme and make artistic decisions about which art forms are programmed within the hospital.

Arts management is the field that concerns business operations around an arts organization. Arts managers in hospitals are responsible for facilitating the day-to-day operations of the organization and fulfilling its mission. The duties of an arts manager can include staff management, marketing, budget management, public relations, fundraising, program development and evaluation, and board relations.

The Oxford English Dictionary defines curator as *the officer in charge of a museum, gallery of art, library or the like* [8]. The word curator comes from the Latin word *curare* meaning *take care*. Curators are also defined as *guardians of our artistic heritage… making decisions which may not always serve the wider population* [9].

There are many varied definitions of the word curator, but common understanding is that curators specialise in understanding the diverse range of reasons why people view art and how they react and act as a bridge between specialised art and public audiences. The process of curating is highly significant and curation is always relational. It is also about deciding what to exclude as well as what to include. Adding the sensitive environment of a hospital and a vulnerable audience to this already complicated role demands a high level of specialisation and awareness. For example, art collected by museums and galleries, and indeed hospitals, may reflect the cultural priorities of the time as much as the quality of the art collected. The partial, subjective, individual passions of the curator (and indeed the hospital management) affect collections and there is a need to acknowledge this partiality and subjectivity. Curation is an interpretation of the world, needing judgement and understanding of social contexts [9, 10].

The curator is a term that is commonly understood to focus on visual art in museums or galleries. However for this paper the modern definition is used, understanding that curators now work with multiple art forms, for example, one who curates festivals or music programmes as well as visual art. *Curated consumption* is a modern term, developed due to the sheer quantity of arts available due to technology. There is a new business called curated consumption which concerns itself with decisions people have to make around buying art or listening to music. In a world where everyone can livestream musical events, view art from around the world and interact with film and dance, it is possible that we need this emerging class of finders and choosers more now than ever. The modern curator has moved from providing arts (as we can now access any arts want ourselves) to being a professional who can *excel at selecting and choosing exactly who and what to pay attention to… being able to make discerning choices is the key* [11].

The terms *Arts Manager* and *Curator* are used interchangeably within healthcare organisations and most arts professionals responsible for programming and selecting arts are often called arts managers, arts directors or arts coordinators. Thus the terms *Arts Manager* and *Curator* are used interchangeably within this paper to describe the *arts expert employed in the hospital*. The research focused not on purely visual art curation but rather curation of multi art form programmes. A discussion of the term used to describe the work of this professional is discussed in more detail in the results section.

For this paper, *participative arts* are defined as arts activities that involve active participation on the part of patients or service users, for example singing in a choir, painting or dancing.

Receptive arts refer to those activities where the patient is not involved in active participation, for example, listening to music, reading and looking at art.

For this paper, the term *patient* is used to describe the person (the patient, service user or client) who uses hospital services.

Wherever *arts* is used in this paper it refers to all art forms as listed by The Arts Council 2006 [12].

BACKGROUND TO THE ROLE OF THE MODERN CURATOR AND ARTS MANAGER IN HOSPITAL

Many art forms play a role in hospital life - music, film, literature and visual art being the most common - with dance and theatre increasingly finding a form within in hospital life [13]. Arts managers must curate a wide range of art forms, for a wide range of people, of all ages, varied clinical issues, length of stay and pain levels. The role of the curator in hospital is, then, a complex craft.

The work of curators and arts programmers in hospital is not a professional, recognised role [14]. Aston presents a comprehensive report on the role of the Hospital Arts Manager, whose job, like the curator, is to manage the arts provision within the hospital, deciding which arts are presented and how and when patients and staff may access and interact with the arts. Aston also identifies the skills of the arts manager or curator, to include (1) inspiring the institution and its members, (2) using the arts as a forum for reflection and inspiration, (3) negotiating to achieve a good result when there are a number of competing agendas, (4) being skilled in the practical aspects of project management, (5) advocating for arts in healthcare, (6) bringing people together and (7) flexibility and imagination. Hospitals can be particularly difficult settings in which to initiate arts projects and time is needed to build the broad coalition of support that is needed for such projects to succeed and flourish. The curator, in hospital, is faced with two unique issues (1) in a hospital setting, without mediation, how will people interpret the arts? And (2) how does one manage the involuntary nature of viewing arts or having arts delivered to them in hospital?

AIMS OF THE RESEARCH

This research project set out to explore of the role of the curator in the modern hospital, through an international qualitative study of ten professionals working as arts managers/curators in English speaking hospitals. The focus of the project was to explore the specialist nature of the role of the modern curator in hospital with emphasis on patient preferences, types of arts intervention (particularly the role of receptive and participative arts), the aesthetic environment and the curator's contribution to restoring aesthetic support in an arguably aesthetically deprived milieu.

This research aimed to address the gaps identified in the literature on curation and arts management in healthcare settings. It also links with previous research on the aesthetic deprivation encountered in hospitals [1, 2, 7]. The specific aims of the research were to:

a) **Expand knowledge within the health sector** regarding the role of arts managers/curators in delivering high quality arts services to patients/service users.
b) **Contribute to improving practice in arts and health** by highlighting the importance of consulting service users/patients regarding their arts preferences and by encouraging dialogue within the sector.

c) **Explore gaps identified in previous literature** on curation and arts management specifically (i) the particular issues associated with curating art in hospital contexts (ii) the role of service users in designing arts services in hospitals and (iii) the role of receptive arts in hospital arts programmes.
d) **Promote the importance of the specialised role of arts and arts managers in healthcare settings** through high quality research.

METHODOLOGY

In-depth semi-structured interviews of between 15 – 40 minutes were held with ten specialists in arts and health management/curation in hospitals across UK, Ireland, USA, Canada and Australia. Telephone or skype calls were used and all interviews were recorded for data analysis purposes.

Sampling: Non-probability purposeful sampling was used. In other words, participants were selected from well-established hospital arts programmes, from national arts and health resource websites and from their reputation for experience in the field.

Inclusion criteria: (1) Arts manager or curator in a hospital setting for at least three years; (2) The hospital arts programme must include multi-art forms (at least three); (3) Living and working in English speaking country; (4) Able and willing to undertake a 30 minute skype interview.

Interview Themes: A series of questions were designed to explore the area of enquiry (see Table 1). The researcher moved between these questions flexibly, so as to follow the interviewee's priorities. Key questions included:

- How does the curator understand Arts and Health, what are their priorities, their passions and their beliefs about the core role of their job? What is the aim of the arts programme curated in the hospital?
- How often, and in what way, are patient preferences in the arts taken into account by modern hospital curators? How are patients involved in decision making about the hospital arts programme?
- What emphasis is given to participative and receptive arts by hospital curators?
- Are arts programmes in hospital influenced by the curator's art form preferences primarily or those of patients?
- What are the main barriers or issues associated with curation in hospital?

Timeframe: Interviews were held between 1st August and 10th October 2015.

DATA ANALYSIS

Data was analysed thematically, drawing on the qualitative, phenomenological approach of Van Manen [15]. Phenomenological qualitative methodologies aim to describe, interpret and understand the meanings of experiences at both a general and unique level. The overall research question centred on *What is the role of the modern curator in hospital?* The data analysis focussed on the depth of this particular experience, aiming to describe the qualities of experiences that were lived by current arts managers and curators in the field. Thematic analysis was undertaken, moving back and forth between data and reflective notes. Previous studies indicate suitability of this approach and have been tried in both arts and health studies and commonly in health services research [16, 17]. Phenomenology was seen as especially appropriate as these interviews

sought to describe, understand and gain insight into the rich meaning of personal experiences from the arts managers interviewed.

Van Manen's approach to data analysis was followed. The steps in this process are: Open coding; creating initial themes; grouping into units of relevant meaning; developing emerging themes; validation exercises and final description of the phenomenon. Activities within data analysis included reading and transcribing text from interviews; developing initial themes and clustering smaller themes into broader groups; eliminating minor themes; writing and re-writing the themes; returning to the participants to validate the data; researcher journaling to reflect on themes and discussion with other researchers.

Validity and reliability were ensured by returning to the participants for validation of the data, as well as journal keeping and mentoring with a senior researcher.

Table 1: Interview questions (based on Patton 1990[18])

Theme	Draft questions
Background questions that aim to understand the respondent's previous experience	Tell me about your own arts interests outside of work? What arts, leisure pursuits, interests, or hobbies do you enjoy and engage in normally at home or in your community?
Questions about knowledge and factual information	Tell me about your hospital arts programme, what art forms, what major projects do you have happening at the moment? Please describe some of the receptive arts activities and participative arts activities you have programmed recently.
Questions to elicit descriptions of behaviour, experiences, actions and activities	What are the main aims of your arts programme? How do you consult patients/service users to find out their musical preferences or artistic preferences? What emphasis is given to receptive and participative arts in your programme?
Questions about feelings/emotions in order to obtain an understanding of emotional responses	Can you tell me of a curatorial project that in your opinion really worked and made you feel passionate about arts in hospital?
Opinions or value questions to inform about people's goals, intentions, desires and values	What, in your opinion, are the priorities of a curator in hospital? What do you feel is the strongest influence on the make-up of the programme? - Patients/service user preferences? Your own arts interests and knowledge? Staff interests? Other issues? What are the main barriers and issues for curating arts in hospitals?

RESULTS

Participants

Ten participants were interviewed for the research:

1. Michelle Cassavant, Manager, Artists on the Wards, Friends of University Hospitals, Alberta Health Services, Edmonton, Canada.
   http://www.friendsofuah.org/

2. Guy Eades, Director Healing Arts, Isle of Wight, UK. **www.iow.nhs.uk/healingarts**

3. Sally Francis, Arts Co-ordinator, Arts in Health at Flinders Medical Centre, Adelaide, Australia.
   http://www.flinders.sa.gov.au/artsinhealth/pages/intro/

4. Damian Hebron, Head of Arts, Addenbrooke's Arts, Cambridge University Hospitals NHS Foundation Trust, UK.
   www.cuh.org.uk

5. Mary Grehan, Director, Waterford Healing Arts Trust, Waterford, Ireland.
   www.waterfordhealingarts.com

6. Dr Jenny McFarlane, Curator, Arts in Health, Health Service Planning, Canberra, Australia.
   http://acthealth/c/HealthIntranet?a=da&did=5392537&pid=1365122981

7. Christina Mullen, Director, Shands Arts in Medicine, Florida, USA.
   http://artsinmedicine.ufhealth.org

8. Edelle Nolan, Arts Co-ordinator, Cork University Hospital, Cork, Ireland.
   www.cuh.ie

9. Katherine Trapanovski, Program Director, Arts in Healthcare Initiative, Center for the Arts, Buffalo, New York, USA.
   www.ubcfa.org

10. Laura Waters, Arts Programme Manager, Derby Teaching Hospital, Derby, UK.
    www.airarts.net

Themes

Five themes were identified (see Table 2):

Table 2: Results of interviews - five themes

Theme 1: **Patient involvement and influence on the arts programme in hospital**	**Theme 2:** **Understanding the role of the curator in hospital**	**Theme 3:** **Influences on arts programming in hospitals**	**Theme 4:** **Types of arts programmes in hospital**	**Theme 5:** **Limitations to effective curation in hospital**
• Informal feedback and input from patients • Strong emphasis on evaluation • Patient driven programme • Flexible arts programmes is important to respond to individual patient needs • Scarce formal involvement of patients in programme planning and development	• Arts manager or curator? The hospital *arts expert* • Undefined role; localised understanding of role • Combining management and curatorial functions in one role • Shared core values amongst arts managers in hospital • Background in arts or arts management • Curator not a term people routinely use or understand • Responsible for both curatorial issues/artistic direction and general management	• Staff as gatekeepers of programme and patient advocates • Artists and staff as key decision makers • Flexibility of artists is important so that patient can influence programme at bedside • Patient evaluation	• Participative arts • Receptive arts • Environmental arts • Arts have a predominantly instrumental role in hospital • Important to link arts programming to health policies and priorities	• Finance • Bureaucracy • Ethical issues surround short term funding of arts programmes • Clinical staff lack of awareness of scope of arts programme and potential benefits for patients • Lack of adequate staffing and resources • Isolated nature of the arts manager/curator • Physical space available for curation • Perception of arts by clinical staff and competing demands for time and funding

THEME 1:

Patient involvement and influence on the arts programme in hospital

Patients influence the hospital arts programme primarily through feedback at the point of contact. It was common across all ten hospitals that patient involvement in programme delivery happened most when individual artists visit patients at the bedside, at which time the artist tailors the arts intervention to the individual preferences of the patient. For example, in one service a team of artists are employed, with varying art form skills. Multiple offerings of arts are made but the patient drives the direction of the arts session.

Whilst involvement with patients is often informal and within art sessions - through feedback or through expressing preferences within individual art making sessions - relatively little involvement or attention was noted towards ensuring patient representation in selection processes, arts committees or design committees. Only two interviewees named formal feedback mechanisms or representation of patients at planning and development level of the arts programme. One site noted that no patient consultation was sought for the art programme development at management level and the arts programme was developed through trial and error on the part of artists and arts managers. Patient evaluation and feedback was in evidence in all programmes and widely used. It was noted that patient involvement tended to be after the arts event or activity by way of feedback rather than in planning stages. Very little evidence existed across the hospital arts programmes of formal involvement of patients in decision making about which arts progammes are planned and funded. Decisions were made by artists, mainly in consultation with staff. Notable exceptions include one curator who approached the 'Children's Board' of their hospital, to consult them on proposed plans for environmental art for the paediatric wards in the hospital. This curator also involves patients in the strategic development of the hospital arts programme. In this hospital, there were three patient/public governors on the eight-strong arts committee which approves the arts strategy and scrutinise the progress of the curator. In addition, the curator engages in focus groups on art and the environment for members of the funding foundation and guarantee to have patient representation on selection and commissioning panels for any commission worth over €5000. Another curator cited patient involvement in the form of engaging with a local arts organisation whose director was a former hospital patient, as well as engaging with artists who have been patients. However, in other hospitals evidence was limited as to how actively such representation is sought by arts managers or whether informal chance representation happens if a former patient becomes involved in the arts programme. Nonetheless, every curator interviewed engages in extensive evaluation of services which then feeds back into future arts programme.

Participants cited the following examples of ways in which patients opinions might feed into hospital art programmes: (1) A support committee made up of staff, artists and representatives of hospital patients who feed ideas into the arts programme; (2) Patient groups as a reference group for arts manager to consult about programme ideas; (3) Informal feedback from users of the hospital arts programme; (4) Expressed preferences of patients using the hospital arts programme (5) Research and evaluation of the programme (6) Conversations with individual patients referred to the programme.

THEME 2:

Understanding the role of the curator in hospital

A wide variety of terms were used to identify the arts expert in hospital. Arts Manager, Arts Co-ordinator, Director of Arts and Curator were all terms used. Five participants identified themselves as an arts manager

and one specifically as a curator. However, four described their role as both, juggling the management activities inherent in any programme director's role with the artistic direction and decision-making inherent in curation. Many said the role of arts manager is to manage the arts rather than create work; however nearly all were involved in the artistic direction of the programme. All but one of the participants had a professional artistic background and only one had a purely business background with an amateur love of arts. One said she didn't use the word curator as she felt busy hospital staff wouldn't understand the term and it added a pretentiousness to the role. Within the research group, misunderstandings and varied meanings were attached to the term 'curator' indicating confusion about the nature of the role. Many associated curator with purely visual art.

I can't pretend to know what sort of art people need. But if they tell me what they want I can find it as I'm strongly inserted into the arts community. My practice as a curator does look at quite challenging art ... but it's difficult to imagine how to include some artists' work in healthcare. I get a sense from staff (and consumer representatives) of what they want to achieve, but staff aren't (always) good at identifying quality art. So I never ask which artist or what image they want, rather what they want to communicate. My expertise is to identify the right art to meet the need/brief [19].

Nine of the ten professionals had a professional arts background prior to taking the role of arts manager or curator in hospital. One had no arts background at all. Four participants said they were definitely not a curator but instead an arts manager.

The term curator was met with confusion, even amongst hospital arts managers. One participant saw curation as purely visual arts based. One of the interviewees has a background as a nurse and an artist so was very comfortable in both healthcare and arts worlds, while another had an art history background and fifteen years' experience of curating in museums.

Three participants felt that their role was both curator and arts manager. The role requires active knowledge of arts practice, for example debriefing artists, shortlisting artists, curational work, mentoring clinical staff about what art will work in the environment and acting as an editor or curator of the art in hospital. However, these participants also carried out generic management duties such as overseeing finance, governance, human resource activities and general staff management. Overall, participants might not identify themselves as curators but they did identify themselves as having a very specialised role.

However, titles aside, all participants expressed similar aims and core reasons for their role and their values which drive their service. One participant summed up a common aim: *My role is to be a conduit, a facilitator of less rigid arts practice with the rigid health service… to be a filter for some of the bureaucracy… to ensure best quality and service to meet users' needs… for art to support people in hospital*.

One participant summed up an acute hospital arts programme as *creating space for aesthetic reverie.* Another participant described their programme as having two strands, a 'Welcome' strand and an 'Engage' strand, which incorporate both environmental art and participatory arts into the hospital. Another aimed to *embed arts in clinical services, to offer enhanced therapy through clinical staff.* Another aimed to *enhance the aesthetic environment, engage staff and patients and support them in transitions within the hospital.* A useful model was one UK hospital arts manager who identified four aims of the arts programme, namely to distract, amuse, enlighten and engage patients. The idea of positive health through arts engagement was important for many participants: *Positive health is more than freedom from disease or illness… it is awareness and involvement in the joy of living.* In addition, many cited policy documents on arts and health, notably the UK

Department of Health report 2007 *…arts are, and should be, fully recognised as being integral to health, healthcare provision and healthcare environments, including supporting staff* [20].

THEME 3:
Influences on arts programming in hospital

Many stakeholders influence the development of an arts programme in hospital. In five cases a legacy of a visual arts collection influenced the nature of the current role. The personality and artistic experience of the curator employed was acknowledged as having a large bearing on the programme, however most were adamant that their own artistic practice had nothing to do with their hospital role. All but one claimed that they try to set aside their own arts preferences when engaging in hospital arts programming. One participant acknowledged that a lack of experience of one art form made it difficult for her to imagine that art form working in a hospital context and that you tend to programme arts you have experience of. Others indicated that they had seen evidence of benefit for art forms with which they were unfamiliar and thus had developed the programme to respond to this.

Clinical staff were perceived by arts managers as a strong influence on the arts programme, possibly more so than patients. Staff act as gatekeepers of the arts, having strong input about what art is allowed and/or requesting art programmes for their patients, as well as being advocates for patients. Arts managers often see staff as representing the needs of patients in their care and clinical staff were seen as the group having the strongest influence on the nature and development of the arts programme. This had both positive and negative influence, both restricting artistic intervention and making the arts possible.

One curator noted that staff would not always select quality art so the curator has to look after this aspect for them. Another contributor noted that in the really successful programmes, the staff and artists work together to bring a programme to patients. For example, in one hospital expressions of interest were sent to staff to become involved in offering an arts programme to patients. The staff in the falls prevention programme came forward and suggested an interest in dance for their patients and a successful programme developed.

The priorities of the hospital's executive management team, along with local and national health policy, also shape the arts programme. For example, in one hospital the executive management team wanted arts to be part of the new health environment and so funded the arts programme significantly. Policies that focus on building local community involvement in a hospital can, for example, influence collection management and donations policies. For example, in one Australian hospital, a policy of reconciliation means that artworks by selected indigenous artists must be displayed in public areas to reflect this hospital priority.

Current priorities in the health service have an enormous influence on the arts programmes researched. For example, in Australia one participant stated that improving the patient journey and building trust in the health service are the current priorities, and so arts are supported as they are part of the desire to care for the whole person. In other cultures where the current climate is cuts and efficiencies, it is difficult to secure resources for arts programmes.

Seven of the participants cited short stays and acutely ill patients as the main reason for consulting staff and artists more actively than patients. Participants all commented that clinical staff often control access to patients which can be both positive and negative influence.

THEME 4:
Types of arts programmes in hospital

Arts programmes in hospitals are diverse, including adult education, medical humanities, participative arts and environmental work. All curators consulted engaged in a mixture of participative and receptive art but they were wide variations in approaches to what constitutes arts and health programming.

The type of art forms and models of arts and health practice used in hospitals were influenced by the priorities of those who established the programme as well as the interests and understanding of the arts manager. For example, UK and Irish hospitals had no arts therapies as part of the arts and health programme, whilst Australian and Canadian hospitals tended to have arts therapists working alongside arts and health practitioners. Four of the ten programmes featured arts therapies and arts and health programmes under the umbrella of their service. Arts therapies were identified as clinical, another level or sphere of arts practice in hospitals and outside the remit of some arts and health programmes.

All programmes featured an environmental art programme (i.e. artwork on the walls and installations) and eight featured some participative arts. There was more focus on participative arts than receptive. Interestingly, although all programmers identified viewing visual art on hospital walls as part of their programme, three managers said that listening to music and access to reading material was outside the remit of the arts programme. Only one of the ten hospital arts managers had a music listening service, with a CD library, CD players for patients and MP3s with relevant playlists for patients. Eight had some form of live music performance programme available for patients.

Three hospitals employed collection managers, thus focussing on the receptive nature of visual art and environmental art programmes. One hospital noted their programme was 50/50 balance between visual gallery style art and participative arts. An American hospital had a nearly 100% participative programme with an ultimate goal being to encourage patients or carers to engage in the creative process to reduce stress and aid relaxation. Reading was not seen as part of the programme by any of the participants, however creative writing programmes were part of many hospital programmes. Similarly live music was part of many programmes but holding a CD collection for patients was not. There was a sense that ‘anyone could manage a music or reading library’ but the arts manager focussed on more specialised arts programming and management.

It was also acknowledged that many people in acute hospital were too ill to engage in participatory arts. One participant also identified that participative arts are cost intensive – a purchase of one artwork can benefit generations of patients but the same funding for a participatory project will reach very few patients, albeit in an intense manner. It was also noted that arts programmes were voluntary and this is an important aspect of arts in hospital. Patients can say no to arts whereas everything else that happens in hospital is outside of their control and often done to them.

The arts were felt to have a predominantly instrumental, functional role in healthcare settings. All art programmes, for example, focussed on improving the aesthetic environment through visual art which aims to reduce the anxiety for patients attending the hospital. Music programmes were often described as acting as a social activity, which could aid relationships between patient and staff. Non-medical conversations between patients and staff could take place and music reduced isolation and helped patients to make meaningful connections. As an arts manager, it was felt important to tap into the latest health service

priorities or rationale and justify the arts in hospitals using the current criteria. For many of the participants, the primary purpose of the hospital arts policy is to service therapeutic goals for the patient.

There was agreement, nonetheless, among all participants as to their priorities as a curator or arts manager, with similar missions and values across services:

The arts programme aims to be as effective and helpful as possible in health outcomes for participants....(to assist) the treatment and management of their condition – that's the purpose of it. That's my objective and (I) work with clinical practitioners and artists to achieve that.

Imagine a gallery with 6 floors and 12 public exhibition spaces; a gallery that showcases installations; musicians and theatrical performances; employs more than 7500 staff and welcome over 1.5 million people through its door each year… you're probably not picturing your local hospital but (our) arts programme has been taking visual art, dance, drama, poetry and music into corridors, waiting rooms and wards.

The primary aim of the programme is distraction, soothing, relaxation, supporting emotional expressions, passing time and sometimes deep transformative experiences.

Finally, it was noted that all ten hospitals had active visual art programmes and eight had live music available to patients. These were the predominant art forms used in the ten hospitals. Other art forms tended to be engaged as special projects rather than ongoing programmes.

THEME 5: Limitations to effective curation in hospital

Money was cited as a major limitation. Project funding limits outcomes and lack of sustained funding was raised by many participants as an ethically questionable way to deliver a service. Discontinuing a service which is of benefit to patients is inappropriate and there is an inordinate pressure on arts managers to prove the value of arts programmes in a way that is uncommon for other healthcare practitioners. Funding is often provided by charitable donations and grants, which often seek to improve the quality of life of patients' experience in hospital. More evidence of benefit of arts would assist in gaining extended funding for arts programmes.

Issues such as infection control, health and safety and ethics were cited as reasonable and important limitations of the arts programme. Understanding and skills in this area were cited as important for any arts manager or artist working in healthcare environments.

At least half the participants noted that making staff aware of the arts programme was difficult and some staff were still unaware of the hospital arts service despite many years in the organisation.

Lack of staffing and limited resources in staffing and funding reduced how much could be offered to patients. Many managers rely on the good will and volunteerism of some artists and many worked alone trying to manage a diverse programme single handedly. This limits how much they can commission and offer. The isolated role of arts manager and the need to continually be energetic and enthusiastic in order to persuade people to fund projects was noted.

Navigating the bureaucracy of hospital was a primary issue for arts managers in every country. For example, organisational issues such as installing art work onto the walls and levels of approval needed in management

are important factors. Staff relationships are key to successful curatorship; support is needed to implement any arts project in a hospital. A perception issue was also raised as a problem for arts. For example, if hospital management are reducing costs and services then it is difficult for clinical staff to understand how the hospital can afford a new artwork.

The physical space allocated to some arts programmes was limited. The physical space available determines how a curator can work. For example, some hospitals have art studios on site whereas others work at the bedside. There is no common expectation of what space an arts programme will need in a hospital.

RECOMMENDATIONS

As a result of this research, a series of recommendations have been produced (See Table 3). These are discussed below.

Table 3: Recommendations arising from the research

	Recommendation
1	**The arts expert in hospital increase recognition -** within arts councils and health services of the specialised role of the hospital arts manager/curator as the arts expert in hospital.
2	**Engage and build effective and positive relationships with hospital staff.** For example, provide experiential creative workshops for staff, presentations at clinical team meetings and consulting staff about all aspects of the programme. Produce guidelines for staff to assist them in understanding the role the arts can play in the organisation and maintain ongoing communication with management and at all levels of the organisation. Attend staff meetings and clinical forums within the institution.
3	**Increase patient involvement in decision making about the hospital arts programme.** Increase patient representation on arts committees, steering groups and advisory groups and engage patients formally in programme planning and design. Link in to hospital patient advocacy groups, establish patient consultation and advisory steering committee for the arts programme, survey patients regarding arts interests prior to and during hospital stay and continue feedback and evaluation processes.
4	**Consider art forms and modalities that are currently underrepresented in hospital settings.** Look beyond visual art as environment enhancement to performance arts and literature, for example.
5	**Consider all arts activities, art forms and potential arts engagement.** Look beyond participative arts activity only. Be open to all modes of arts engagement within a hospital setting. Consider increasing access to receptive arts for patients who can't cater for themselves in terms of access to reading, listening or viewing material.
6	**Continuing professional development.** Extend your own knowledge as a curator/arts manager, especially with art forms you are not familiar with. Training, development and courses needed for arts managers in healthcare settings. Maintain your own creative practices and/or experiences.
7	**Engage artists who are flexible and adaptable in how they use their art form, to be as responsive as possible to patient preferences.** Identify and develop training for artists to equip them to work in health settings.
8	**Engage in reflective practice, mentoring or supervision** - to better understand the restrictions, barriers and limitations of the role and to counter the isolation of the arts manager position. Develop links with other arts managers in hospitals to share experiences.
9	**Be cognisant of current health service priorities** - and be sure that hospital arts policy is linked to local and national priorities and health policies.
10	**Strive for best practice** - regarding arts in health, based on models of excellence in the field and evidence of benefit.
11	**Embrace technology** - and the changing nature of bedside engagement in the arts.
12	**Build links with national cultural institutions.** Draw on their expertise and resources and use these as a resource and support.

DISCUSSION

This research has explored, in depth, the role of the arts manager/curator in hospitals. The role of the arts manager is not a clearly defined role. Curators in healthcare contexts arguably have a delicate role in balancing support for the intrinsic value of the arts with meeting both patients' preferences and health service aims for improved well-being through the arts. Clearly articulated aims are paramount in this emerging field. *Curatorial knowledge does not exist in a vacuum; it is a social construct* [21]. Debates about the term curator and arts manager are common across the field. However, the role of the curator or arts manager in hospitals emerged as that of an *arts specialist* or *arts expert in hospital*. Curators must guide inexperienced staff and patients to realise the potential of the arts as well as brokering relationships between artists and clinical staff. One participant summed up her approach as follows:

I seek advice from staff, consumers, service users, carers, managers and architects about what art they want. I do this not by asking which art they like, but by asking 'What message do you want to communicate through the art we install here'. Then the arts manager's job is to identify the artwork to meet that brief. This moves away from asking staff to identify art, which can become tricky if conservative ideas or lack of experience lead to poor quality art choices. Instead, the stakeholders are asked to identify what the work or activity is to communicate within the environment (for example warmth, welcome, comfort). These higher level objectives, partnered with lower level limitations (for example health and safety, infection control) lead to certain art being chosen by the curator, in consultation with stakeholders. The role of a hospital curator is an inversion of so many standard tropes associated with arts management that it is has been worthy of detailed exploration For example, in a gallery a visitor will view a video artwork for 1 minute 20 seconds on average yet in a hospital, a video is designed to be viewed for 40 minutes in a waiting room. Hospitals are a time rich environment, so work needs to reveal itself gradually in waiting rooms. In hospitals, the primary reason for being there is not to view art, you are often too sick to look at art, but need to be absorbed by it somehow. Many patients do not have the physical or psychological resources to participate in the arts and may only be able to receive accessible art [19]. In hospitals a curator must also accept community work and donations that are perhaps less important artistically. A curator is normally a representative for the artist; however in hospitals the curator represents the voice of the audience (i.e. the patient) [19].

A key recommendation arising from this research is that arts managers and curators seek to involve patient representatives more formally in programme planning and design. Informal feedback and detailed evaluation was apparent in all programmes but more involvement of patients regarding arts preferences is important. This may also help to begin to break down elite notions about arts and artists, as well as challenging the notion that staff can plan for their patients without their involvement.

Guidelines for clinical staff regarding arts programmes as well as training and experiential arts opportunities for them are important if they are to continue acting as gatekeepers to patients' arts opportunities. One hospital has introduced lunchtime creative workshops for staff, offering short, forty minute experiential art or music making sessions to engage staff in creative activity.

It became apparent during the research that the flexibility of artists is paramount when providing patient driven programmes. Appropriate training and development for artists is important to equip them with the skills required in this specialised environment. Arts managers in hospital can be advocate for high quality arts practice and patient needs across both the arts, and health, sectors.

Arts participation was seen as important by all arts managers, however a focus on receptive arts other than visual art is recommended as an addition to hospital arts programmes. The modern curator may need to involve themselves in how they curate live streamed performance arts within hospital and make these available to patients as well as offering a curatorial expertise regarding which arts accessed through technology might be beneficial to patients in hospital.

It was difficult, from the data, to conclude the extent to which curators in hospitals influence the programme and prefer their own art forms; however there was evidence that most arts managers seek to include art forms other than their own preferences and all programmes are multi art form. Developing relationships with clinical staff is a key task of the hospital arts director and needs to be given time and attention. This research arose from concerns that arts managers and staff interests drive a hospital arts programme more than patients' preferences. Making arts available for patients who wish to wear headphones and create *aesthetic asylum* for themselves, for example, is arguably as important as participative arts activity [22].

Social, political and economic contexts affect how the arts are received and perceived as well as decisions regarding selection and commissioning of arts. Rather than art always being the work of a genius, the creation of art can be greatly affected by the social positioning of gatekeepers [10]. In healthcare settings the dominant focus of the institution is not engagement in arts and therefore high levels of concern about risk, infection control and health and safety can affect what art is possible in this setting [23]. The prevailing fashions of the time affect the role of arts in the hospital context as much as in art galleries or museums [24]. The priorities of the modern healthcare setting include cost effectiveness, efficiency and elimination of risk. Health and safety concerns often outweigh aesthetic concerns. In all contexts, from art in galleries to public spaces to healthcare settings, there are conventions that can either constrain art or make art possible. A common issue arising in this field is what kind of provocation is acceptable in health-care contexts? If intrinsically good art challenges some people, how do we manage this result, especially when focusing on the needs of vulnerable people? [19].

Whilst a curator in a museum or gallery should arguably be curating for their wide public community, in reality it can be argued that the curation is normally for their peers who use these arts spaces [10]. The work of hospital curators, however, is embedded in 'real life', in a community of staff and patients who may never access the arts in traditional concert halls and other venues.

In a gallery, the curator is expected to push the boundaries – it's a relatively safe space where people are expecting to encounter art, and they've always got the option of saying, "Oh, this isn't for us, let's go." If you do something way out in a hospital, in some ways it's easy – the patients aren't expecting to engage with art – you go further each time as you gain confidence. You get more honest feedback, as well – "That's stupid", "That's noisy", "That shouldn't be here." [14].

Hospital curators need to draw on the expertise already existing in museums, galleries and arts councils regarding the role of public art. Curators in hospitals have possibly developed their role in quite an ad hoc way, with arts programmes often reflecting the strengths of the individual arts managers. Perhaps hospitals need to move from simplistic evaluations of the arts such as 'Did patients notice the art?' and 'Did they like it'? to questions such as politically motivated ones: 'What message is this art giving about the hospital you are visiting?' 'What health promotion message does it carry, if any?' and questions that concern art and its interplay with health and well-being: 'In what way does the art contribute to the sense of a therapeutic environment?'[9].

MacNaughton's comprehensive paper on curation in healthcare argues that hospitals have moved from providing art purely to comfort and soothe, to acting as a cultural resource for the wider local community. In other words, hospital curators have become people who curate shows, performances and art that invite the general public into the hospital to view the art. Hospitals have become more conscious of their role as public, civic spaces [25]. Once the public are invited in to a hospital to view the arts, the space becomes a nature of viewers in a hospital gallery? For example in one hospital an interesting photography exhibition was refused as it documented the journey of one woman's breast cancer journey. Despite being a beautiful, hopeful exhibition it was rejected for the hospital gallery as it was deemed too explicit in terms of dealing with each stage of cancer treatment, as well being inappropriate for vulnerable patients at an early stage of diagnosis.

MacNaughton states that philosophers (such as Hume, Burke, Rousseau and later Kant) regarded aesthetic experience as a *state of withdrawal from the everyday world, a passage into a time or space in which the normal business of life is suspended.* Hospitals, however, are 'real life' environments, in which the arts can exist alongside critical life and death experiences and are thus exciting environments to curate.

MacNaughton cites the following aims for curating art in hospitals: (1) to create a sense of quality care (2) to provide a soothing, relaxing and calming environment (3) to create a positive and lasting impression of high quality and (4) to assist orientation and way finding [25]. However, art selected also has to fit in with the ideals of the organisation and its vision and so artists must understand that their creations must meet, to a certain extent, a preordained message, for example health promotion or welcome for patients. This can be antithetical to the freedom of intent required for the creation of art. Artists working in a hospital must understand and embrace the mission, of the arts programme. Clearly the main focus for art and design in hospital must therefore be their beneficial impact upon patients. Cost efficiency in public hospitals, however, may also be an important concern.

A link between museums and health has become fashionable and cultural institutions are increasingly engaging in accessibility and outreach programmes to attract new audiences. Books are now dedicated to the evidence base of museums, health and well-being and there is growing concern about the museums role in health and well-being, perhaps leaning towards modern concerns with cost effectiveness and return on investment[26]. Partnerships between hospital curators and national cultural institutions are thus recommended. Hospitals are sometimes viewed with caution by galleries, for example one hospital cited problems when a gallery loaned art to a hospital, showing a lack of trust that adequate installation expertise existed in the hospital. However, mutually beneficial relationships between cultural organisations such as concert halls, museums and galleries, and hospital arts managers, can be developed to serve the needs and priorities of both institutions.

An interesting example of specialist curation is the Smithsonian Folk Life Festival which was conceived as giving voice to unknown and under-represented music. The festival sat within a culture at the museum that reflected that visiting museums was essentially very dull. This ground breaking event was seen as lacking seriousness by some museum curators. The organisers took criticism from some Smithsonian museum directors and curators for demeaning museological practice; the Festival was seen as *the curatorial equivalent of turning hospital patients loose to make the diagnoses and offer the treatments rather than leaving it all in the hands of the well-trained, experienced, and rational physicians.* After initial shock, the Smithsonian became used to the annual festival as a kind of people-messy, once a year, topsy-turvy ritual that happened outside—not within—the carefully curated and scripted halls of the museums. The Festival was, in many ways, *counter to the self-absorbed seriousness and power suffusing the nation's capital* [24]. The work of a hospital curator is similarly involved with bringing the arts to new audiences and venues and

moving out of the traditional culture of galleries and museums to an arguably more experimental and challenging venue.

CONCLUSION: THE MODERN CURATOR IN HOSPITAL

Curation comes from the Latin root *curare – to take care of*. In healthcare the curator/arts manager needs to take care of artworks that others do not value and to take care of patients' quality of life by making a wide variety of arts experiences available to patients. As a curator in hospitals it is easy to become institutionalised, to accept the limitations and conservatism of the sector. Creative thinkers and artists are needed to turn the 'norm' upside down, to comment on the everyday such as long waiting times or patients on trolleys.

A recent overview by the widely respected curator, Hans Ulrich Obrist, gives a helpful insight into the role of the modern curator. Curating *at its most basic is simply about connecting cultures… to make junctions… a form of map making that opens new routes through a city, a people or a world* [27]. Obrist gives much food for thought regarding the role of the curator; much is applicable to arts and health contexts. It is important to be an expert in the field, but not to be elitist and to consult clients about their preferences.
Curating is about *asking artists what projects they could not realize under existing conditions… making impossible things possible*. In healthcare settings the curator brokers agreements between artists and healthcare staff, speaking both languages and making possible what might originally seem impossible.

Obrist cites five key tasks for professional curators: (1) preservation/safe guarding of artworks (2) selection of new work (3) contribution to art history/scholarly research (4) displaying and arranging art and (5) mediating between art and the public. He describes museums as *cemeteries of culture* and describes curating as *experimenting* and *demystifying*. For many patients, bedside art making *demystifies* art making, sometimes for the first time in their life and opens up a possibility that everyone can be creative. Art is constantly changing and can act as a catalyst for change in hospitals by developing and pushing institutional boundaries.

A modern curator James Foley (curator of live stream online music) identifies the role of the modern curator as (1) being able to understand the customer and their preferences (2) identifying new and original music that will suit existing tastes of your client group (3) discovering new talent and pointing clients to this work (4) inviting new musicians to perform (5) using data to understand what users are doing and (6) understanding what is popular and thus adapting to listeners' tastes [28].

Hospital curation can be a vibrant arena for arts and the role of the hospital curator is, overall, a ground breaking, specialist role that can bring benefits to hospital life. The role of curator or arts manager in hospital deserves to be supported and developed by both the arts and health sectors.

PLANNED OUTCOMES AND FUTURE DIRECTIONS

- Publication in peer reviewed journal (Dec 2016)
- Dissemination of this report (Jan 2016)
- Seminar on curatorship in hospitals (early 2016)

ACKNOWLEDGEMENTS

I wish to thank the ten participants in this research for their generous sharing of experience; the Meath Foundation for funding this work and Prof Des O'Neill for research mentoring and collaboration.

FOR MORE INFORMATION CONTACT

Dr. Hilary Moss, Director of Arts and Health
Adjunct Assistant Professor, School of Medicine, Trinity College Dublin
National Centre for Arts and Health
Tallaght Hospital, Tallaght, Dublin 24

Tel: +35 3 1 414 2076
Website: www.artshealthwellbeing.ie
Email: hilary.moss@amnch.ie or mosshi@tcd.ie

Hilary Moss, 28th October 2015

REFERENCES

1. Moss, H. and D. O'Neill, *The aesthetic and cultural interests of patients attending an acute hospital – a phenomenological study.* Journal of Advanced Nursing, 2014. **70**(1): p. 121 - 129.
2. Moss, H. and D. O'Neill, *Aesthetic deprivation in clinical settings.* The Lancet, 2014. **383**: p. 1032 - 1033.
3. Caspari, S., K. Eriksson, and D. Naden, *The aesthetic dimension in hospital - An investigation into strategic plans.* International Journal of Nursing Studies, 2006. **43**: p. 851-859.
4. Moss, H., C. Donnellan, and D. O'Neill, *Hospitalization and Aesthetic Health in Older Adults.* JAMDA, 2014. **16**(2): p. 173.e11–173.e16.
5. Caspari, S., K. Eriksson, and D. Naden, *Why not ask the patient? An evaluation of the aesthetic surroudings in hospitals by patients.* Quality Management in Health Care, 2007. **16**(3): p. 280-292.
6. O'Neill, M., *Museums, professionalism and democracy.* Cultural Trends, 2008. **17**(4): p. 289 - 307.
7. Moss, H., C. Donnellan, and D. O'Neill, *A review of qualitative methodologies used to explore patient perceptions of arts and healthcare.* J Med Ethics; Medical Humanities 2012. **38**: p. 106 - 109.
8. Oxford University Press. 2015 [cited 2015 27 October 2015]; Available from: http://www.oxforddictionaries.com/definition/english/curator.
9. Museum Associations Organisation. *Curating the Nation*. 2015 [cited 2015 23/06/15]; Available from: http://www.museumsassociation.org/museums-journal/news/11062015-curating-the-nation.
10. Kieran, M., *Value of Art*, in *The Routledge Companion to Aesthetics*, B. Gaut and D. McIver Lopes, Editors. 2005, Routledge: Abingdon. p. 293 - 307.
11. Dumenco, S., *Why calling yourself a curator is the new power move*, in *Details: Critical Eye*2011.
12. The Arts Council, *The Public and the Arts*, 2006, The Arts Council: Dublin.
13. Moss, H., *A phenomenological study of the role of arts and culture for patients in an acute hospital*, in *Medical Gerontology Study Day*2012: Trinity College Dublin.
14. Aston, J., *Hospital arts co-ordinators: an accidental profession?*, 2009.
15. Van Manen, M., *Researching lived experience: Human science for an action sensitive pedagogy*1990, New York: State University of New York.
16. Lane, M.R., *Spirit body healing - a hermeneutic, phenomenological study examining the lived experience of art and healing.* Cancer Nursing, 2005. **28**(4): p. 285 - 291.
17. O'Sullivan, C. and G. Chard, *An exploration of participation in leisure activities post-stroke.* Australian Occupational Therapy, 2010. **57**(3): p. 159-166.
18. Patton, M., *Qualitative Evaluation and Research Methods*1990, Newbury Park, CA: Sage.
19. McFarlane, J., *Curator, Arts in Health, Health Service Plannning, Canberra, Australia*, 2015: Canberra.
20. The Arts Council England, *The Arts, Health and Wellbeing*, Centre for Public Health, Editor 2007, John Moores University: Liverpool.
21. Anderson, D. and Karczmar, *World of Museums: What shall we do with curators?* . Museum Management and Curatorship, 1990. **9**(2).
22. DeNora, T., *Music Asylums: Well-being through music in everyday life*2013: Ashgate Publishing Limited.
23. Alexander, V., *Sociology of the Arts*2003, Oxford: Blackwell publishing.
24. Plagens, P., *Cool Curating.* Arts in America, 2013(Jan): p. 41 - 44.
25. McNaughton, R., *Art in Hospital Spaces: the Role of Hospitals in an Aestheticised Society.* International Journal of Cultural Policy, 2007. **13**(1): p. 85 - 101.

26. Chatterjee, H.J. *Museums, Health and Wellbeing: The ezine of the Heritage Council*. 2012 [cited 2012 12 November 2012].
27. Obrist, H.U., *Ways of Curating*2015, Random House UK,: Penguin.
28. Jacobs, E. *Streaming services: confessions of a music curator*. 2014.