Workshop Report

Many questions emerged during the Visualising Illness panel discussion and workshop on 14 and 15 November. The following list gives a sense of the challenges involved in representing, exhibiting and looking at illness and pain – and the directions that future collaborations might take.

The art object

- Can a work of art produce empathy? How? (and what is empathy?)
- Is beauty important in the context of illness? Does it have therapeutic value? Is there a risk of aestheticizing suffering? (and what do we mean by aesthetics?)
- What criteria are used to measure clinical efficacy? Does art therapy have to be demonstrably effective? How would one measure the social or educational benefits of art?
- How important are non-visual (eg tactile or auditory) attributes of artworks dealing with illness or pain?
- Why are visual representations of pain and illness so limited?
- Is the voice (of the patient or sufferer) important? Do images of illness need verbal or textual interpretation? Or can the visual image facilitate communication (perhaps even by virtue of its silence or ambiguity)?
- Can the sick body – in art, film or photography – also be sexualised, or are illness and eroticism mutually exclusive?

The clinical encounter

- Can images change our experiences of waiting rooms and clinics? Can they provide a means of communicating important messages? How do we get managers to understand this need?
- How do we achieve ‘patient centred care’ in an increasingly ‘tick box’ culture? Can the humanities help us to achieve this goal?

Curatorial issues

- Are there lines that should not be crossed in an exhibition about pain and illness?
- What are the alternative forms of public engagement (other than a traditional exhibition)?
- Is voyeurism a risk? (and if so, how would one mitigate that risk?)

First versus third person testimony

- What is the value (or added value) of first person testimonies of pain / illness?
- Is it exploitative (or voyeuristic, or patronising) to make art about the suffering of others?
- How does the story differ in first and third person representations of illness?
Group One: How could/should illness be exhibited?

This roundtable focused on the practical, intellectual and ethical issues inherent in curating a possible future exhibition based on visual and material ‘works of illness’. It was agreed that it would be essential to be clear about the motives for an exhibition of this kind, and questions were raised about who the exhibition would be for and what purpose it would serve; in practical terms, what kind of audience would we hope to reach, and how might this inform the choice of exhibition space? It was also agreed that such an exhibition would need a clear conceptual basis; rather than simply illustrating a title (‘Works of Illness’), it should aim to respond to a set of research questions or challenge a series of preconceived ideas.

It was proposed that a future exhibition might be able to explore the potentially problematic nature of exhibiting work of this kind, perhaps by teasing out the nuances of the distinction made between first and third person representations of illness. This distinction had caused some lively debate earlier in the day, provoking questions regarding who has the right to make artwork about illness (only those who are ill? or also engaged, respectful third parties?); issues of voyeurism, consent and authenticity were raised in relation to this point. Other proposed topics for further investigation included the relationship between individual illness testimonies and broader political issues relating to healthcare and public policy; there was a suggestion that politics is often missing from exhibitions of this kind, which tend to focus on illness as a private, personal experience.

It was suggested that, rather than focusing solely on exhibiting images and objects, an expanded form of cultural investigation might prove a more appropriate means of investigating the above issues. Such an approach would involve an intellectual space as well as a physical one, incorporating public workshops and performances into the structure of the exhibition. Finally some practical points were raised regarding proper financial backing for such an undertaking.

Group Two: How might representations of illness inform the clinical encounter or public health?

This breakout group included photographers, artists (some of whom are also practicing art therapists) and an arts manager with experience of working in the NHS. A distinction was made between the medical model of art therapy (prevalent within the NHS) and the work done by artists – often also within hospital or hospice settings – but outside the professional remit of ‘art therapy’. While the art produced in art therapy sessions typically addresses the subjective experience of illness, illness is often conspicuously absent from art exhibited in hospitals. Even when hospital-based art (or arts-in-health more broadly) engages patient groups, it may not be driven by therapeutic aims. As Jayne Wilton, who works with hospice patients put it: this isn’t art as an illustration of science, or a diagnostic tool. Its intention isn’t therapeutic either – although it may have a therapeutic dimension or even a clinical use. Rather, the motivation is the value of this subject matter for art. In this sense, the benefit is not (or not primarily) the patient’s, but the audience’s (and of course the audience may include doctors and nurses, family members and the broader public).

For this group, one of the most difficult questions was that of ownership or rights: who owns illness? Who has the right to represent illness? Why would an artist want to make art about another person’s confrontation with sickness or mortality? In the Friday evening panel discussion Alan Radley suggested that an artist working with patients could communicate with others on their behalf. Deborah Padfield spoke of her photographs in similar terms: having wondered, at the beginning of her project, if
the images could be used as an alternative language of pain, she had come to realise that they don’t work on their own – or very rarely. Instead they trigger language. In his workshop presentation, Tim Wainwright voiced his own concerns about voyeurism. He was aware, he said, of wanting to become more and more absent (from the work) as a photographer and artist. He also emphasised the value of silence. Illness does not always need to take narrative form and talking isn’t the only kind of therapy.

Finally, the group discussed art’s potential to inform clinical practice. Illness isn’t experienced in a vacuum: it is always socially and institutionally mediated. Art has a unique capacity to document, illuminate and find humour in the everyday realities of living with illness. One of the points of departure for Tom Corby’s *Blood and Bones* project was the realisation – familiar to anyone with a serious illness – that he had become an administrator of his own disease. But art can also show that when you are ill, you are more than your illness: and this is equally valuable.