

Title: Artwalks and healthcare architecture as curatorial space

Author: Henric Benesch (Architect MSA, PhD)

Affiliation: Chalmers Arkitektur / Centrum för vårdens arkitektur
Sven Hultins gata 6
412 96 Göteborg

Email: benesch@chalmers.se

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Abstract:

If you visit a hospital you will sooner or later run into works of art. You find them in “strategic” places such as waiting areas and corridors where they might at best offer relief and joy. In the context of Swedish County hospitals, these artworks “on loan”, handled, distributed and installed by art-consultants/curators, are parts of regional collections, which sometimes sums up to over 50000 pieces from different artists, from different periods and of different makings.

Curating, as in caring for art and its sites, has over the past decades changed the way we engage with art, turning exhibitions into an artform in its own right. Claiming that an exhibition is more than the sum of its pieces and that, depending on what pieces you choose and how you relate them, new meaning might be brought into motion.

In considering the hospital as a site for art, historically there has been a strong emphasis on the single art-works and their sites, presuming a more or less passive and immobile audience. In this, when it comes to constructing narratives (as in exhibitions), calling for the combinatory interplay between numerous sites, the curatorial potential of the hospital as exhibition is underdeveloped.

The art-walks (Konstpromenader) at Akademiska Sjukhuset in Uppsala is a first step towards this line of thinking, where the existing art-works have been curated into artwalks, supplemented with a brochure where you find directions and biographical notes on each piece. Developed to promote physical activity and cultural stimulation, these art-walks provide caretakers as well caregivers with a comprehensive narrated art exhibition (and not only single and isolated art-works).

The concept of art-walks is not new but it´s implementation into a healthcare architecture context, turning the hospital into a dynamic multimodal space of experience, is with out precursor. This paper outlines the implications of this practice (Konstpromenader) and further on, proposes a new understanding of hospitals as spaces of experience, promoting health as well as art and architecture, addressing subjects as subjects, and not as patients.

Artwalks and healthcare architecture as curatorial space

1)

“Start at the reception, entrance 70

At Entrance 70 there are five acrylic paintings.

...

Now go past the elevators, turn right and cross the Blue Room. On the left side in a niche on the wall:

...

Continue along the corridor to the Grönwall-hallen.

...

Proceed to Stair 71 and take the stairs or the elevator to the 2nd floor. Turn right into the corridor and follow the signs to Children's Hospital. Turn right at the end of a glazed passage, walk a few steps into the corridor and look to the left.

...

Go back a few steps and follow the signs to the children's hospital. Stop at the wall on your right after Rosén-salen.

...

Look ahead and look through a glazed section to the left.”

...

These are the initial instructions you find in the booklet “Konstgalleri Akademiska” at Akademiska Sjukhuset in Uppsala. If you follow the directions you will encounter 24 different works of art at 24 “stops” routed into three different routes or *konstpromenader* (artwalks). In between the directions you find information on each work of art in terms of artist, media, dating and background. For instance, Bror Hjorth's sculpture “*Vörndnad för livet -Hyllning till Albert Schweitzer*” in wood from 1959 which is stop 2 in a niche just past “*Blå rummet*”, or stop 19 at the emergency entrance; Andrea Hvistendahls installation “*Inringad av parklind*” in mixed-media/neon from 1994.

Akademiska Sjukhuset, as most hospitals in Sweden, is owned and run by a county, in this case Uppsala Län. Further on all the art works installed at the various regional facilities (not only hospitals) are bought, commissioned, handled and archived by specific art-units and their art-consultants. In Uppsala Län there are a total of 19000 art-works temporarily installed (on loan), permanently installed (site-specific) or archived. Simplified this activity can be described as a kind of match-making service which through various processes seeks to find the right works of art for the right places for the right people. In reality this means that the single art-works in various cycles are either renovated or removed, making place for new art. The argument put forward in this paper is that the focus on the handling of the single pieces (just as single pieces) leaves out much of the combinatory potential which we find in a broader curatorial approach where the focus is extended past the single art-works and their setting towards the relations between single art-works and the relations (as in this case) between sites. The argument here is that such a reading of the curatorial potential of healthcare milieus, have architectural implications whose importance should not be underestimated, and which reaches into the heart of architecture and its

performance.

The path taken here is speculative - an essayistic elaboration on consequences and potentialities with the ambition to shed new light and pointing out new trajectories. The ambition is not to give “proof” but rather to change the way we conceptualize and build upon the notion of artwalks as it is situated within the specific context of healthcare space. Thus no evidence is presented but rather a series of possibilities to be actualized, as well as what is at stake if we fail to do so.

2)

The Artwalks at Akademiska sjukhuset deals with a generic situation, which you may find at any midsized or larger Swedish hospital or healthcare department. In fact it addresses a situation, which you may find in any midsized or larger regional facility, which are hosting a number of artworks, either permanently or temporarily installed. Further on, art takes on a specific meaning in the context of healthcare where it is suggested that art may provide “positive distraction”, reducing stress and pain, supporting healing processes.

The notion of art as a healing agent is a contested ground for many reasons which has to do with a contemporary notion of art as a place of aesthetic experience, free thought and critique emerging out of autonomous but situated selves – a position which you might not identify yourself with while hospitalized. Here the notion of autonomy (as the position where free thought and critique can be exercised) implies a position where you are healthy enough to exercise this autonomy – which may not always be the case. In fact, art may not only support autonomous self. In cases it might also bring subjects down, causing stress rather than relief.

For instance, through surveys with larger patient groups it has been showed that figurative imagery, preferably depicting natural sceneries have a more positive impact in this regard, than for instance, abstract imagery (Ulrich 2012). That is, a landscape painting installed in a healthcare setting is statistically more likely to have a positive influence (as positive distraction – taking away the focus from illness and pain) on the (generic) patients healing process than an abstract nonfigurative image.

On the other hand many of us have in hours of need read a particular novel, seen a particular film or have experienced a particular artwork or piece of music which have broken our circle of illness, our apathy. Where art at its best, in various ways and for various reasons, can bring light, insights, joy and reflexivity into the darkest places and the oddest situations in way you cannot imagine in forehand. The problem from a healthcare point of view is that you don't know in advance which work of art that will break the vicious circle for which person. And although you statistically can show differences in the healing capacity of different kinds of art such an approach fails to address the fact that neither a patient or an artwork in the end can be accounted for in numbers.

Such a statistical approach fails to address the capacity of art to speak directly to the patient, not as a patient, but as an autonomous subject (under siege from illness). And even though such approaches may contribute intelligibly to the way we work with art in a healthcare context it may also undermine the position from which art at its best connects directly to subjects independent of their health status. And even though you

can measure certain aspects of art, the point with art in the end is that it cannot be measured and if so it would not be art. There is, to use Deleuze (2006), a fundamental difference between difference in *degree* – as in the *extensive* world of measurables (of the natural sciences, economics and industrial production), and difference in *kind* – as in the *intensive* world of experiences and sensations (as in music, arts and bodily experiences). That is to say that a scientific approach to art says more about science than art just as an artistic approach to science says more about art than science. Science can claim art just as little as art can claim science. The question is how this difference can be put into play in a non-reductive way?

Having outlined some of the tensions and dilemmas inherent in the relation between science and art as it comes about in the context of healthcare I now would like to turn the attention to the specific performative aspects of art and curating as we find them in our hospitals and healthcare departments.

3)

Hiding (without success) behind a column you find a huge seated hound (or wolf), an assembly of pieces of wood reaching for the hinged ceiling, (*Hyndan* by Torsten Renqvist from 1970). And beside a commercial banner with a smiling woman you find a (just as happy) child-sized decorated and joyous creature with a big copper head and a hat (scribbled with letters and drawings) standing on tiny legs having a mouth in the shape of a horn or trumpet (*Glädjebåsar/Blåsar i hatt* by Max-Walter Svanberg from 1974). Here you also find an image, made out of perforated aluminum, depicting a female face looking directly at you (*Anette* by Anna-Karin Furunes from 2002). There are also some recurring elements such as the full-height patterned screens made out of white-lacquered iron-plates which you find integrated into the architecture at numerous locations (*Skärmväggar i korridoren* by PO Ultvedt from 1968). There is also the column (in concrete) running from stem to flower right through the floors, something you have to visit all the floors to understand (*Pelare* by Leif Bolter). And somewhere in the labyrinth I surprisingly find a hand-coloured landscape (without sign) by (a guess) Magnus Bårtås, depicting a beach with a standing man overlooking the sea just to the right.

These are just some of the artworks you find at Akademiska sjukhuset or “Akkis”. Some of them are just passing through (which seems to be the case with the work of Magnus Bårtås) whilst others will be there as long as the buildings stand (as in the case with Leif Bolters *Pelare*). And although these work share the same public character they differ in temporality – an artwork which have been on site for two-hundred years are perceived differently than an artwork which is just there for an hour. Further on, if an artwork is located in a museum or gallery you may or may not choose to look at it. But if it is located in a square, a station or as in this case a hospital you will encounter the artwork regardless if you would like to or not. Its there and you have to be there to - even if you do not like it. Of course this argument goes two ways. The reason for having public art like this in the first place is to provide something out of the ordinary. But still, the experience and response of the “autonomous subjects” has to be anticipated and acknowledged to a higher degree than with art that per se is not “public”. But how do you anticipate “autonomous subjects” one or twenty years in advance?

If we turn to architecture, the anticipation of “autonomous subjects” goes without

saying. If art, at least in a modern and contemporary perspective have cherished it's ruptures and inconsistencies, architecture on the other hand is all about making smooth transitions, minimizing friction and disturbances. Architecture, in order to operate, favors the mundane, ordinary and avoids friction and artworks like Leif Bolters *Pelare* or even more obvious PO Ultvedts *Skärmväggar* is perhaps not so much art as art-becoming-architecture in this regard. They have become integrated in the everyday to such a degree that you don't notice them any more. Or to put it differently, artworks like *Pelare* and *Skärmväggar* does not only lack a proper name, they also fail to present themselves as art and gradually fade into the everyday and mundane (which very well might be their purpose from the beginning). And in comparison to the "white cubes" (O'Doherty 1986) of the art museums or art galleries, the hospital as institution does not sustain art as art by default. Accordingly the artworks here have to sustain themselves (as artworks) or perish (as artworks). Where many artworks often are *"no more than odd ingredients in the decor. Unlike art in specifically earmarked venues capable of setting up "reading tools" – such as an exhibition that uses historical or scientific text to introduce the interrelationships between the artworks, the scenography and the lighting – artworks in functional places such as hospitals have a hard time of it. They do not benefit any of these tools, even though they have the same need to play a vital part, to be maintained, and to ö-po*

In other words the competition for attention is fierce and if an artwork somehow has managed to present itself as an artwork, as something out of the ordinary, it still has to co-exist with the everyday in all its abundances which we find nothing of in the so called white cube. I.e. in order to present itself as art in this context the artwork somehow have to work with, acknowledge and at best put this abundance into play (or use). Where the question is - how do you differ one singularity from another? Or more explicitly how does a work of art establish this difference that makes us able to relate to a work of art as art (and not as a sign, poster or any other visual messages).

It is in this context it is interesting to note the double connotation we find dormant in the concept of *curating*. Although we today associate the concept to the art-sphere it is, to quote Boris Groys (2010, p 52-53): *"no coincidence that the word "curator" is etymologically related to "cure": to curate is to cure. Curating cures the powerlessness of the image, its inability to show itself by itself. Exhibition practice is thus the cure that heals the originally ailing image, that gives it presence, visibility; it brings it to the public view and turns it into the object of the public's judgment. However, one can say that the curating functions as a supplement, like a pharmakon in the Derridean sense: it both cures the image and further contributes to its illness."* If this is true within in a white cube setting – for exhibitions, it is even truer for the art left to its own devices in hospitals. The curator then it seems is a key when it comes to the mediation of art. And if we follow Boris Groys once more, the curator is the one who safeguard's the public character of art, the one who make the art public, where the *"individual artwork cannot assert its presence by itself, forcing the viewer to take a look at it. It lacks the vitality, energy, and health to do so. In its origin, it seems, the work of art is sick, helpless; in order to see it, viewers must be brought to it as visitors are brought to a bedridden patient by hospital staff."* Paradoxically, in this sense an art-gallery or museum is in truth, a kind of hospital filled with art that cannot survive outside the museum in the same way as the hospitals are filled with patients that might not survive outside the hospitals. And if the art museum is a hospital the

hospital might just as well be an art-space. If anything the notion of art and healthcare might very well be more intertwined than neither the arts nor healthcare would like to acknowledge.

As stressed by Boris Groys the main task of the curator is to safeguard the public character of art, but in a contemporary perspective the curator have since long passed a mere safeguarding position in favor of being an artistic practice, or meta-artistic practice, in its own right. If we go with this new expanded position where the claim is that an exhibition is more than the sum of its pieces and that, that curating is more than a mere “publication” of art, where depending on what pieces you choose and how you relate them, new meaning might be brought into motion. The blueprint for such a practice is the dj - extracting new artistic expressions out of the old, where “*The artistic question is no longer: “what can we make that is new?” but “how can we make do with what we have?”*” (Bourriaud 20021, p 17).

To sum up, art has to be cared for, regardless if its in a museum or an hospital, but dependent if the art is in an hospital or not art has to be cared for in different ways. And depending upon how you look at artistic and curatorial practice the mundane character of hospitals and healthcare departments does not necessarily have to be that which wears art down but might just as well be a resource for bringing new artistic and curatorial practices about – for instance in the context of artwalks.

4)

To begin with, as the name suggests, “artwalks” is not only about art but also about walking. The general health aspects of walking is well documented but here I would like to address an aspect of walking which is in direct conjunction with some key aspects of art, namely reflexivity (and in the long run, criticality). Strangely enough one of the most well known artistic interpretations of the human act of reflexive and critical thinking, of an autonomous subject, is August Rodin’s “The Thinker”, a man-sized bronze which you find in a number of casts, for instance outside the Musée Rodin in Paris. A male body, seated with every muscle as if in severe tension, leaned forward with the weight of his head supported by his hand and knuckles, thinking really hard on something – on what we only can guess. One peculiar thing in this context is that the sculpture’s original name is not “The Thinker”, but the “The Poet” and it is said to depict Dante Alighieri or “Dante” as the crowning element of “The Gates of Hell”, a sculpted portal. How “The Poet” came to be “The Thinker” is an unanswered question, but this slightly Freudian slip, if nothing else, points at the proximity of art and reflexivity.

One might also ask oneself about the way this immobile bronze-cast have become an emblematic image of thinking and critical thought, suggesting a position outside the world from which the essence of things might reveal themselves as if a modern elaboration on Plato’s Allegory of the cave. But in this context it is interesting to note that Plato’s most famous pupil, Aristotle, who developed a more pragmatic philosophy than his idealistic teacher, came to be known as a “peripatetic” lecturer. Where the word “peripatetic” has its origins in the colonnades, or *peripatoi*, of Lyceum in ancient Athens where the lectures took place – on foot. Where *peripatetic* has come to mean wandering, meandering or just walking and where the followers of Aristotle came to be known as the Peripatetic School.

Thus it should not come as a surprise that the history is full of accounts of the inherent reflexive capacity of walking and it seems that mobility, rather than immobility, which “The Thinker” might lead us to think, is the driver of reflexivity. In fact there are multiple, social, political, aesthetical and critical traditions of walking including ancient Greeks, aboriginal song-lines, religious pilgrimage, the Grand Tours from the 17th century, the fin-du-siecle notion of the Flaneur, the Situationist *derivé* in the sixties (Solnit 2000, Careri 2002). Today we find different forms of guided tours, by person, booklet, internet or audio, not only in museums but also in natural parks as well as city centers and suburbs.

Practices as the Situationist *derivé* as well as the various forms of tours either adds an additional layer or highlights an existing one in relation to an actual site or setting. It is about revealing and bringing to our attention that which is dormant, forgotten or simply waiting to be actualized or realized – it is practices which put a site or setting into question - saying that it have not always been like this and it will not be so in the future either. At its best it is about dealing with the given in a productive and imaginative way which changes the way we think not only about the past but also about the future. And in relation to exhibitions, which occurs in spaces if not emptied of meaning at least as far as possible reduced to a bare minimum - tours take place in contexts which are filled to the rim with meaning - with things, stories and so on. If exhibitions are about concentration, the tours are about abundance. So if the question for a curator in an exhibition context would be: - How can we fill this space with meaning? - (insertion), the question for the curator in a artwalk context would be: - How we can bring meaning out of the abundance that are given? - (extraction).

Up until this point the curatorial practice in healthcare settings have primarily adopted the *insertion* strategy adding artwork after artwork into spaces which are far from emptied of meaning, where the artwork become stranded in a world they do not fully recognize (but still may bring some joy into). But these artworks will (as shown) if left on their devices sooner or later slip into the mundane. They have to be accounted for. An *extraction* strategy, such as the booklet “Konstgalleri Akademiska” which gives directions and biographical data on the single artworks, can at the first instance be seen as a rescue mission – as way of retrieving the artworks capacity to single them out. That is liberating the single artworks from isolation, bringing them to our attention, relieving them from the burden of sustaining their art status all by themselves. An added layer with the specific aim to establish connections and directions, which connects the single artworks despite the interference (and disturbance) of the mundane, bringing them to our attention (once again) in a coherent way.

But the extraction strategy does not have to stop there. This practice can be extrapolated and expanded. The actual route can be planned in various ways - shorter, longer, through specific areas and so on. The actual instructions can be developed and elaborated - becoming even more descriptive and discursive (or counter-discursive). And then the biographical data – you can stop at the dates or just as well bring in numerous accounts and anecdotes. And the booklet – you could make more out of it or arguably develop new forms and new formats. Various and parallel tours, routes, instructions, discourses and formats, i.e. the “reading tools” to use Mari Linnman’s vocabulary, could be developed, adding depth as well as width. In this way not only the burden of the single artworks can be partly lifted, but also, the possibilities to

address “autonomous subject” beyond a mere statistical approach increases.

As it adds up, artwalks could be the perfect tool make the art-becoming-architecture art again. Further on, which will be addressed in the next passage, artwalks does not have to stop at making the art-becoming-architecture art again, but may be importance beyond this scope – for the field of architecture.

5)

When Marc Augé in *Non-Places: Introduction to an Anthropology of Supermodernity* writes that “*If a place can be defined as relational, historical and concerned with identity, then a space which cannot be defined as relational, or historical, or concerned with identity will be an non-place*” (Augé 1995, p 77-78), he has airports and shopping-malls on his mind but the definition above could just as well be applied to most of our healthcare spaces. In the end it is hard to single out one space or room from another – looking back, and in comparison, they differ no more than one airport differ between another airport, no more than one shopping-mall differ between another shopping-mall. Who can differ one hotel-room from another? Who can differ one vestibule or hallway from another - dressed up in wall-to-wall carpets, candelabrum, prints from either all to well known or utterly unknown artists? Or as in this case – who can differ one patient-room from another?

Here, the point of recognition is not primarily the materials or the solutions - they differ. What we recognize is the modus operandi of these spaces, these buildings. They are developed and operated with similar economical and managerial concerns, be it a luxury hotel or a county hospital. Thus these building are not, which we sometimes are led to believe, designed for different forms of habitation – as in harboring all kind of human activities, but designed for maintenance. Where the single most important factor for a hospital, as in this case, is that the maintenance does not fail. And if the maintenance does fail everything else will fail too.

These spaces are contractual. You enter these spaces as a passenger, a customer, a guest or a patient – not as you, not as an autonomous subject. You have a ticket, a trolley, a key-card or are registered as patient. You are no longer at home, or in public space; instead “... *a person entering the space of non-place is relieved of his usual determinants. He becomes no more than what he does or experience in the role of passenger, customer or driver. Perhaps he is still weighed down by the previous day’s worries, the next day’s concerns; but he is distanced from the temporarily by the environment of the moment. Subjected to a gentle form of possession, to which he surrenders himself with more or less talent or conviction, he tastes for a while – like anyone who is possessed – the passive joys of identity-loss, and the more active pleasure of role-playing.*” (Augé 1995, p 103)

Following this the notion of hospital-sickness takes on a double meaning. Not only does staying at a hospital increase the risk to contract diseases, the actual hospital space as non-place (if this is the case) also *subjectifies* (to use Michael Foucault’s (1995) term) autonomous subject into patients. And in the same way that you become a criminal in a prison regardless how guilty you really are, you become a patient regardless of how ill you are in a hospital. You knowingly or unknowingly come to play your part (as patient).

Separated from the turns and cycles of life outside the hospitals the days become increasingly alike. One day ceases to differ from another and the past as well as the future seems to slip into an everlasting present. Where “*Everything proceeds as if space had been trapped by time, as if there were no history other than the last forty-eight hours of news, as if each individual history were drawing its motives, its words and images, from the inexhaustible stock of an unending history in the present*” (Augé 1995, p 104-105). Where “*The space of non-place creates neither singular identity nor relations; only solitude, and similitude*” (Augé 1995, p 103).

Without identity and relations, these spaces are mute, they don't have the capability to communicate, to express, to relate – they have to be explained, communicated and related to us. How else can we know that behind one door we will find the emergency ward and behind the other one we will find the morgue? How can we differ the toilets from the patient rooms? Or for that sake, to repeat, how can we differ one patient room from another. Here, as Augé notes, the “*link between the individuals and their surrounding in the space of non-space is established through the mediation of words, or even text*” (1995, p 94)

Given this, it is clear that it is not only art that lacks the capacity to stay art in this context, architecture also fails to stay architecture and becomes non-places in this context. Thus it seems it is not only art which is in need of being saved, it also seems there has been another rescue operation going on with various result for many years – namely that of architecture. What else are the numerous acronyms, sign and pointers but a “curatorial” attempt to save architecture from becoming an endless array of indifferent spaces, becoming non-places?

As such it seems, what is at stake here is not only art, architecture as well. And artwalks, for instance by means of booklets, signage, by means of discourses and stories, by connecting and relating – by *reading tools* - not only might save the art from becoming architecture and the architecture from becoming non-places. They might also – in the spirit of the peripatetic school - speaking to us as autonomous subjects, save you and me from becoming more patients than we have to.

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