

THE ARTS AND HUMANITIES IN HEALTH CARE AND
EDUCATION

A Statement from the Work Group on the Arts and Humanities of the
International Work Group on Death, Dying and Bereavement

PREFACE

We acknowledge that the practice of medicine for many years has been “long on science and short on art.” With the birth of the modern hospice and palliative medicine movements, we have seen the consciousness rise as many persons in medicine and health care are seeking to restore “the art.” Likewise, the consciousness has been rising in the past 25 years as more and more artists have sought to be closer to the amelioration of suffering and be channels of healing and create environments that foster health and well-being.

The last 10 to 15 years have seen the birth of arts/health care organizations in England, through UNESCO in Europe, Soros grants in some eastern European countries, the International Arts Medicine Association, The Society for The Arts in Healthcare in the United States—and most recently a new movement has begun in Japan.

Our work group began in Norway in 1990 followed by four IWG meetings (Portugal, Canada, England, and Greece). The joy of working on this project has been in seeing the evolution of the document reflected in the various perspectives that each person has brought, (i.e., clinician, artist, educator, and researcher). Through

Received 2 April 1999; accepted 2 October 1999

Address correspondence to Sandra L. Bertman, Program in Medical Humanities and the Arts in Health Care, University of Massachusetts Medical School S5-100A, Worcester, MA 01655.

Approved for publication by IWG on 10 January 2000, Robert Bendixsen, IWG Secretariat

this process we also have come to appreciate that the following Assumptions and Principles are relevant to all aspects of life and have framed them in a language that will speak to all.

INTRODUCTION

The integration of the arts and humanities in all health care delivery systems is essential to assure compassionate humanistic patient and family care.

The arts and humanities with their images, symbols, and sounds express themes of life, death, and transcendence. They are the language of the soul and can enable people to express and appreciate the universality as well as the particularity of each person's experience. The arts and humanities reflect the existential, inspirational, and transcendent realms of experience and can contribute to creating an aesthetic, nurturing, and healing environment.

The arts and humanities reflect a person's creativity. Engaging in the arts and humanities can enable people to mourn, grieve, and celebrate life. This process can assist in one's search for meaning and connection to one's spiritual roots.

The arts and humanities allow for other ways of knowing. They are multifaceted and include, but are not limited to drama, visual arts and crafts, literature and storytelling, music, film and photography, movement and dance, and architecture, and are rooted in nature and one's engagement with the environment. They are expressed in a variety of ways both formal and informal, religious and secular.

To assure that compassionate, humanistic patient and family care is provided, it is essential that the arts and humanities are incorporated in the education and training of health care providers for both their personal and professional well-being and growth.

For the purposes of this document, the following Assumptions and Principles will address the role of the arts and humanities in the health care setting and clinical practice, in the education and training of health care practitioners, artists, and therapists; and in general education courses and research related to health care, dying, death, and bereavement.

Because of the universality of the arts and humanities—which can build bridges between persons of diverse cultures, generations,

and abilities—the Assumptions and Principles (*A* and *P*, respectively, below) may ultimately be applicable in and adapted to any health care setting in any country. Their need and manner of implementation will be shaped by the particular culture.

GENERAL

1. *A*: Every person has a unique sense of aesthetics and a creative dimension.
P: In the total care of a person, his or her unique sense of aesthetics and creative dimension must be considered along with the mental, emotional, spiritual and physical dimensions.
2. *A*: Being open or closed to one's creative energies will influence one's sense of aesthetics and one's mental, emotional, spiritual and physical responses to living, dying, death and bereavement.
P: Caregivers should discern if a person's creative energies are open or closed and make appropriate referrals to other members of the interdisciplinary team for follow-up.
3. *A*: Creative expression is a fundamental human need, which impacts one's body, mind, emotions, and spirit. It can influence healing, a sense of well-being, and the quality of life.
P: Opportunities for expressing and nurturing one's creativity should be available and accessible.
4. *A*: The power of the creative process lies in its capacity to initiate change.
P: (a) Persons who are engaged in active or passive creative projects and/or arts experiences should be sensitive to the changes that may be occurring in their own perceptions of reality; and (b) Caregivers should be perceptive to the changes that may occur in the patients' sense of reality and provide appropriate support.
5. *A*: People have diverse perceptions and understandings of aesthetics and capacities in creativity.
P: Persons should be encouraged to explore their own sense of aesthetics and creativity.
6. *A*: Individuals may have divergent aesthetic insights and creative needs.
P: People should be sensitive to an individual's need and par-

ticular interpretation of aesthetics and capacity for creative expression.

7. *A*: Engaging with the natural and man-made environment can affect a person's inner environment (personal and spiritual) and influence one's sense of aesthetics and creativity either negatively or positively.

P: Persons designing and allocating indoor and outdoor spaces should be sensitive to the particular needs of those living, dying, and working within those spaces and incorporate elements which reflect a healing environment.

8. *A*: The arts can contribute to creating an aesthetic, nurturing, and healing environment.

P: (a) Administrators and caregivers must be aware of the diverse kinds of environments that impact their own as well as others' lives; (b) Administrators need to ensure that resources, both human and material, are allocated to create aesthetic, nurturing and healing environments to support patients, families, staff and others in the health care setting; (c) Administrators should work together with representatives from the arts community, in-house arts staff, interdisciplinary teams, and patients/families when proposing changes in the interior or exterior environment; (d) Artists and arts administrators in the health-care setting should work together with representatives from the administration, and patients/families when proposing changes in the interior or exterior environment; (e) To ensure that a patient's/family's environment is nurturing, healing, and aesthetically pleasing, caregivers should assess the environment to see what is in it as well as what is not; and (f) Caregivers should be sensitive in recommending any changes to the environment and ensure that these changes will be in concert with the patient's/family's needs and desires.

ARTISTS

9. *A*: Artists experience, perceive, and reflect through their work other ways of knowing.

P: To help facilitate the process of discerning life truths, and to educate people in the principles of care and envision the future opportunities for change and growth, especially at times of

crisis, artists should be members of the educational, caregiving and administrative teams.

10. *A*: Throughout history artists, along with people of faith, including the shaman, medicine man, and curandero, have been among the healers of society.

P: The contributions that some artists can make to healing should be recognized, whether through their own personal creations or by facilitating the creativity and well-being of others.

11. *A*: The unique role of artists in the health care setting is re-emerging in the consciousness of society, especially among artists, therapists, and health care providers.

P: Artists should be integrated in the administrative as well as caregiving interdisciplinary teams in all health care settings.

12. *A*: Artists who are healers enable people to enter the pain and suffering as well as the ecstasy of life and create something new out of it.

P: (a) Artists who work in the health care setting must possess a knowledge of and sensitivity to the specific patient population with whom they will be working; and (b) Artists must demonstrate competence in their respective artistic medium and in their capacity to teach and draw forth the creativity of others.

13. *A*: An artist may presume to be sensitive to and understand the population and setting in which she or he is working.

P: To ensure that the artist is sensitive to and understands a particular population and setting, the institution must provide comprehensive orientation, clinical training, on-going mentoring and evaluation of the artist-in-residence.

14. *A*: Artists who are healers help create environments which foster healing and a sense of well-being.

P: Artists must possess a knowledge of and sensitivity to the specific health care setting and the needs of the patients, families and staff for whom they are creating healing and nurturing environments.

PATIENT AND FAMILY

15. *A*. The degree to which the patient and family wish to engage in creative expression is highly individual.

P: (a) Caregivers should be non-intrusive and sensitive to individual desires; and (b) Caregivers should be aware of different needs for creative expression within the family.

16. *A:* Health care institutions and professionals may presume to understand or may ignore the creative needs of ill and dying persons and their families.

P: (a) Creative needs can be determined through a thoughtful review with the patient and family of their previous experiences and current perceived needs; and (b) Creative needs can be met by providing opportunities for patients and their families to work with interdisciplinary team members who are committed and trained to assess needs, explore the possibilities, and enable the process. The interdisciplinary team should include trained professional artists/expressive therapists.

17. *A:* People are not always aware of nor able to articulate their aesthetic and/or creative needs.

P: Caregivers should be sensitive to unexpressed aesthetic and/or creative needs and knowledgeable of the human and material resources within the institution and larger community to address these needs.

18. *A:* Much healing and creative growth can occur in an individual without assistance. Many people neither desire nor need professional assistance in their creative development.

P: (a) Listening to and affirming an individual's creative voice may be all that is needed; and (b) The artist's/caregiver's role is to create the space for the individual's creative voice to be expressed.

19. *A:* Patients and families may already have provided satisfactorily for their aesthetic and creative needs.

P: The patients' and families' chosen way of meeting aesthetic and creative needs should be honored by caregivers.

20. *A:* The aesthetic and creative needs of dying persons and their families may vary during the course of the illness and fluctuate with changes in that course.

P: (a) Caregivers should be alert to the varying aesthetic and creative needs that may be expressed directly or indirectly during different phases of illness, grief and bereavement; and (b) Caregivers should be flexible in meeting changing circumstances; and (c) Caregivers should recognize that not all aes-

thetic and creative needs can be resolved before death. To the extent possible, they should be carried out according to the dying person's wishes.

21. *A*: The family's need for creative expression may continue throughout the patient's illness and dying and throughout the family's period of bereavement.

P: Opportunities for the family's creative expression are essential in the total care of the dying and may include involvement in the funeral, memorial or celebratory service, and should be available throughout the bereavement period.

CAREGIVERS

22. *A*: Caregivers can experience "burn out" when they do not attend to their own aesthetic and creative needs.

P: Caregivers should be encouraged to explore and develop their own sense of aesthetics and creative expression to enhance their well-being and to grow both personally and professionally.

23. *A*: Caregivers experience a high dose of human suffering when caring for the chronically and critically ill and their families.

P: (a) The administration of health care institutions should provide resources in scheduled time, money, and staff to establish ongoing educational and staff support programs in which the arts and humanities will be integrated (including days away and retreats) to nurture caregivers; and (b) Caregivers should assume responsibility for their personal and professional needs by accessing the opportunities the administration may provide.

24. *A*: All caregivers have the potential to offer support through the arts and humanities to patients and families and to each other.

P: (a) Caregivers should be encouraged to offer support through the arts and humanities to patients and families; and (b) Caregivers need to recognize their limitations and make appropriate referrals when the demands for arts and humanities support exceed their abilities or resources.

25. *A*: Caregivers may feel that they are unprepared or, have had limited personal experience in the arts and humanities.
P: Caregivers should be given opportunities to familiarize themselves with the various mediums of expression and the artists working in the health care setting in order to support their patients and families and make appropriate referrals.

COMMUNITY

26. *A*: The community-at-large has a stake in the quality of life of all its members.
P: The arts and humanities should be valued, promoted, and supported by both private and public means.
27. *A*: The arts and humanities can help build community.
P: The arts and humanities should be utilized to enhance communication between diverse populations, as well as between an institution and the larger community.
28. *A*: The arts and humanities can help unite persons of diverse backgrounds, generations, and abilities.
P: (a) Members of the health care community should recognize the value of nonverbal communication with those less at ease with spoken languages; and (b) Programs of care incorporating the arts and humanities should be tailored to specific populations.

EDUCATION AND TRAINING

29. *A*: Rituals that have sustained people's lives throughout history are expressed through the arts and humanities.
P: (a) Educational courses and workshops addressing issues of health care, dying, death, and bereavement should integrate relevant aspects of the arts and humanities to illustrate and deepen persons' understanding of life issues; and (b) Experiential sessions with visual arts, music, literature, dance or movement should be among the resources used to develop meaningful rituals.

30. *A*: Effective education combines cognitive understanding with affective understanding. The intellect and the psyche need to work in concert with one another.
P: (a) Courses and workshops on health care, dying, death and bereavement can offer concrete examples from the arts and humanities to strengthen and enhance the meaning and understanding of facts, figures and scientific realities; and (b) Educators and trainers should utilize the arts and humanities with students and practitioners in developing the special skills needed for effective and empathic communication with patients, families, and staff.
31. *A*: Different cultures have different concepts of aesthetics, of health, dying, death, and bereavement.
P. As part of their education and training, health service providers should be required to become multiculturally literate.
32. *A*: The arts and humanities provide unique ways to reach people through the mass media.
P: Health care providers and educators should look for opportunities to utilize the arts and humanities in their communications with the public through the mass media.
33. *A*: The power in the ideas conveyed through the arts and humanities may have social consequences.
P: Persons should be aware of their responsibility in conveying truths through the arts and humanities related to issues of health, illness, dying, death, and bereavement.
34. *A*: Plays, works of art, stories, video, dance, and music are ways in which the arts and humanities can illuminate end-of-life and bereavement issues.
P: People can be enabled to understand and approach life and death-related issues in a new way through the arts and humanities.

RESEARCH

35. *A*: Because of the subjective and experiential nature of the arts and humanities in people's lives, it is difficult to quantify their value and contribution to the quality of life.

P: Both quantitative and qualitative research methods should be developed and used for analyzing the efficacy, value and contribution of the arts and humanities to the quality of life.

36. *A*: Quality research includes the creative process of shaping the question.

P: The creative process should be used in developing appropriate questions to be tested.

37. *A*: Components of a healing environment for patients, families, and staff may be determined through research.

P: Researchers should assist health care planners and architects in designing interior and exterior spaces for a healing environment.

GLOSSARY

Aesthetics – The theory of the beautiful.

Affective – The cause or expression of emotion or feeling.

Archetype – The original pattern or model from which all things of the same kind are copied or on which they are based.

Artist – The artist is the image maker who makes visible that which is unseen, who makes audible that which is unheard, who makes sacred that which is ordinary . . . returning us to the integrity of the moment.

Art therapist/Expressive art therapist – A person who uses the arts as a therapeutic intervention and is trained primarily from a psychological and/or bioenergetic perspective.

Assumption – A statement presumed to be true, but not proven.

Caregiver – Anyone who takes an active part in the treatment and care of another.

Cognitive – The mental processes involved in perception, learning, memory, and reasoning. The process of thinking.

Community – For the purpose of this document, community is defined as those people who are an individual's support group. For example, an AIDS patient may have a different sense of who comprises his or her community than an elderly person whose main contacts are through a local church, or a young child who has never ventured very far from home.

Conversation – Verbal or nonverbal exchange between two or more people where listening, understanding, and empathizing are important to all parties concerned.

Crafts – Any of the manual arts including, but not limited to, woodwork, ceramics, weaving, metal work, jewelry, and the like.

Creativity – The ability to transcend traditional ideas, rules, patterns, and relationships in order to develop meaningful new ones; being imaginative and original.

Intellect – The power or faculty of the mind by which one reasons or thinks.

Psyche – This term includes the breadth and depth of feelings, fantasies, day and night dreams, and intuition.

Principle – A general or fundamental truth. A governing law of conduct.

Palliative care/Palliative medicine – Active care for the purpose of maintaining and enhancing the quality of life for the whole person.

Ritual – An established, prescribed, or newly created ceremony, procedure, or service which is expressive of values and may bring about inner peace and meaning to the participant.

Co-Chairs

Sally Bailey, USA

Sandra Bertman, USA

Committee Members

Kay Blumenthal-Barby, Germany

Melinda Bridgman, USA

Marjorie Cockburn, England

Gerry Cox, USA

Alfons Deeken, Japan

Lynne Ann DeSpelder, USA

Iola de Veber, Canada

Ester Gjertsen, Norway

Andrew Hoy, England

Kjell Kallenberg, Sweden

Peggy Oechsle, USA

Donna O'Toole, USA

Sam Silverman, USA

Ruthmarijke Smeding, The Netherlands

Marcy Wrenn, USA

Robert Wrenn, USA