Short report

Theoretical injections: On the therapeutic aesthetics of medical spaces

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ABSTRACT

In this paper we present a dialogue about the seemingly innocuous presence of environmental art in hospital settings as a way of furthering critical perspectives on the therapeutic landscapes concept and its application to medical spaces. We explicitly consider the potential utility of two perspectives, Foucaultian and Lacanian readings, for understanding the relationship between environmental art and the hospital waiting room. We use this paper as a vehicle to demonstrate how such theoretical perspectives can enhance critical scholarship on the therapeutic landscape concept, particularly as it is applied to settings such as health clinics and hospitals. A brief agenda for further critical engagements with the therapeutic nature of health care spaces is put forth in the conclusion.

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Recent work in health geography has developed the ‘therapeutic landscape’ concept as a framework for understanding how environments contribute to achieving and maintaining health and well-being (e.g., Kearns & Gesler, 1998; Williams, 2007). While the concept was originally related to the healing powers of physical settings such as natural springs (Gesler, 1992), health geographers have begun to use it to interpret the healing potential of formal health care settings such as clinics and hospitals (Gesler, 2003; Kearns & Barnett, 2000). For example, Gesler, Bell, Curtis, Hubbard, and Francis (2004) have examined the design and incorporation of therapeutic elements within hospital settings, looking specifically at the role of overlapping physical, social, and symbolic environments in producing a therapeutic milieu.

Research focused on the therapeutic nature of clinical spaces has identified nature as an important element in the visual aesthetic of hospital design (Gesler, 2003). This undoubtedly reflects the popular belief, and some medical evidence, that viewing nature can positively impact the healing process (Ulrich, 1984). Increasingly, administrators are incorporating nature into the hospital, often in the form of artwork depicting literal ‘therapeutic landscapes,’ in an effort to counter the negative image of hospitals as cold institutional spaces, and to improve patient well-being (Miles, 1997). In this regard, hospital design is increasingly situated at the intersections of aesthetics and therapeutics, beauty and wellness, and nature and technology. Collins (2007) has aptly named this affinity between art and the hospital as the ‘aesthetic-therapeutic turn’ in hospital design.

Herein we present a dialogue about the seemingly innocuous presence of environmental art in hospital settings as a way of furthering critical perspectives on the therapeutic landscape concept and its utility for understanding the aesthetic-therapeutic turn in hospital design. Recent critical engagements have borrowed numerous philosophies and theories from outside geography to problematize the therapeutic landscape concept with regard to scalar issues, cultural difference, and power relations (e.g., Gillespie, 2002; Wilson 2003; Wilton and DeVerteuil 2006). Such critical applications have led to re-formulations of the therapeutic landscape concept, such as Conradson’s (2005) notion of the therapeutic ‘self-landscape’ encounter. Hospital environments can be considered as one such ‘encounter space,’ especially given the more recent consumer-orientated design of medical spaces (Kearns & Barnett, 2000).

To undertake this critical reflection we draw upon our recent work in a fairly ubiquitous setting in modern health care: the hospital waiting room (see also Crooks & Evans, 2007). During fieldwork undertaken in twelve waiting rooms at three Canadian hospitals, we were struck by the abundance of landscape-style art pieces depicting nature scenes. The artwork observed fitted into four image types: (1) seaside or Mediterranean settings (e.g., Fig. 1); (2) rural settings (e.g., Fig. 2); (3) remote and wilderness images (e.g., Fig. 3); and (4) folk art depicting nature/natural environments (e.g., Fig. 4). The first three landscape-type images were the most abundant.
Using our observations of artwork featuring natural landscapes in the waiting room as a starting point, we ask: how can we draw upon social theory frameworks to explain the affinity between environmental art and medical spaces; and how might these frameworks contribute to critical perspectives on the therapeutic landscapes concept and its application to medical spaces? In the dialogue that follows we propose two theoretical frameworks for pursuing answers to these questions. Our exploration of these two frameworks further point to a remaining question: what is the role of the geographical gaze in the medical environment? In addressing this issue we respond to calls to engage more critically with the therapeutic landscapes concept (e.g., Milligan, 2007) while also contributing to a small, but growing, geographical literature that employs qualitative research methods to examine how people such as clients and clinicians ‘read’ and are affected by medical spaces (e.g., Crooks & Agarwal, 2009; Gillespie, 2002; Rapport, Doel, & Elwyn, 2007).

A Foucaultian reading: the art of the cure in the waiting room

Michel Foucault (1926–1984) was a French philosopher and historian best known for examinations of institutions such as hospitals and prisons and for theoretical work on the relationship between knowledge, power, and subjectivity. Foucault’s work has found widespread application, particularly in critical examinations of the illness experience and medical spaces. While Foucault’s writings have been highly influential in human geography (e.g., Crampton & Elden, 2007) and more specifically in health geography (e.g., Gesler & Kearns, 2002), the engagement between Foucault’s ideas and the therapeutic landscape concept has been limited.

A major theme in Foucault’s work pertains to how knowledge about human beings is constructed through various discourses (i.e., the human sciences). According to Foucault, a ‘discourse’ is a set of rules and practices that governs the way a topic can be meaningfully talked about at a given moment in time and space. Discourses authorize certain people to speak, recognize certain statements as intelligible and valid, and identify particular questions as worthy of pursuit. It is through discourses that particular objects of knowledge (e.g., ‘the insane’) become ‘visible’ and certain courses of action (e.g., ‘moral treatment’) are justified. Foucault was particularly interested in how discourses change over time and, by extension, how new objects appear on the landscape of human perception. Moreover, he was interested in how discursive shifts are themselves linked with the birth of new institutions such as the clinic and the hospital.

A second major theme in Foucault’s works focuses on the interweaving of knowledge and power. Foucault emphasized that knowledge production about human beings is dependent upon power relations that are exercised on and through the human body. On one level, power operates through discursive practices that
The medical gaze and disciplinary surveillance.

One of Foucault's earliest publications, *The Birth of the Clinic* (Foucault 2005), was a book-length examination of the origins of modern clinical medicine. He explored seventeenth and eighteenth century France in an effort to reconstruct the early beginnings of what we now know as modern clinical medicine. Foucault examined the conditions under which early empirical statements about illness were formulated. He found that in the late eighteenth century, diagnosis was carried out via a series of hierarchical charts and tables that related symptoms and diseases to each other. The body was entirely secondary. This was to change when medical perception was redirected from the disease tables to the corporeal space of the human body. A detached, objective 'medical gaze' was established between the doctor and the patient's body. The nature of this gaze was one of mastery. The body of the patient was passive (sometimes even a corpse) and the look of the physician was active and dominating.

Foucault's writings on the hospital were influenced by his notion of 'disciplinary power,' an idea developed in *Discipline and Punish* (Foucault 1955). He understood 'disciplinary power' as a strategy for organizing bodies in time and space to maximize their efficiency. Foucault explored the disciplinary regimes that appeared in the eighteenth century, for example prisons and asylums, which aimed to turn human beings into 'docile subjects.' These disciplinary spaces also sought to normalize individuals through various systems of inspection, judgment, and constant surveillance. The introduction of disciplinary mechanisms (e.g., partitioning) into the disorderly space of the hospital facilitated its transformation into a therapeutic instrument (see Foucault, 2007).

Foucault's concepts of the medical gaze and disciplinary surveillance offer unique analytical insight because they connect the discursive to the non-discursive, knowledge to power, and what can be known to what can be seen. Following Foucault, one could theorize the aesthetic-therapeutic turn in hospital design more generally, and the incidence of environmental art more specifically, as a power-laden process.

First, parallels can be drawn between early environmentalist medical discourses (see Barrett, 2000) such as Hippocrates' treatise *Of Airs, Waters and Places* and the symbolic content of landscape images in the waiting room. Moreover, on a discursive level, landscape art resonates with more recent medical evidence that views of nature can positively impact the healing process. As well, this artwork resonates with the traditions of particular medical professions. For example, in the case of nursing, use of these images is consistent with the work of Florence Nightingale who, in *Notes on Professions*. For example, in the case of nursing, use of these images resonates with the traditions of particular medical discourses (see Barrett, 2000) such as Hippocrates' treatise *Of Airs, Waters and Places* and the 'visuality' of medical spaces. Rose (1993) describes how landscape portraits invite a particular type of spectatorship from the viewer. In her view, by representing nature as passive and immobile, yet distanced and remote, the image positions the viewer in a place of mastery and detachment over the natural world. The mastery of culture over nature represented in landscape artwork has a certain 'resonance' with the type of mastery implicit in the 'medical gaze.' Picturesque paintings of natural landscapes (see Figs. 1–4) could perhaps be re-imagined as allegorical mirror images of the medical gaze, where the passive and still landscape substitutes for the patient's docile body.

Environmental art, particularly artwork reproducing the traditional landscape aesthetic, can be considered as an abstraction of the medical gaze. This interpretation suggests that 'therapeutic' power effects may be created through the way that landscape images position the viewer in addition to the content of the image itself. From this perspective, the affinity of environmental art with medical spaces is perhaps rooted in the symmetry between the geographical gaze and the medical gaze. In images of landscapes one finds the same gaze underpinning the modern art of the cure. Such a point was not lost on Foucault: "In the cure, nature, the doctor and the disease came into play. In this struggle, the doctor fulfilled the function of prediction, arbitrator and ally of nature against the disease" (2007, 144). With this in mind, one cannot help but wonder if this artwork serves health care professionals as much as it does patients. For the reasons described above, these images reinforce the authority of physicians and the professional hierarchy of the hospital through the practice of the gaze, but shift the focus so that it is the patient who is the gazer and the natural, healthful, landscape that is gazed upon when viewing waiting room artwork. In this regard, environmental artwork within the waiting room serves as a map of the power relations constituting modern medicine.

A Lacanian reading: the real of the waiting room

The French psychoanalyst Jacques Lacan (1901–1981), by drawing on the insights of linguistics, philosophy, mathematics, and social theory, revolutionized the ideas of Sigmund Freud. Lacan's ideas have had an enormous influence on numerous fields of study in the humanities and social sciences. In the discipline of geography, his works have informed research on commodification (e.g., Page, 2005), tourism (e.g., Kingsbury, 2005), and cinema (e.g., Doel & Clarke, 2002). Despite several health geographers' recognition of the value psychoanalytic theories (e.g., Parr, 1998) and the burgeoning interdisciplinary literatures of Lacanian social theory and the 'Lacanian Clinical Field,' Wilton's (2003) examination of the meanings of physical disability remains the only extensive Lacanian study in the subdiscipline. Yet Lacan provides an extremely rich theoretical vocabulary with which to critically study the therapeutic landscapes concept. On questions about the relationships between landscape art and the hospital, including in the waiting room space, Lacan's related notions of the gaze and the *domine-regard* (the taming of the gaze) can be of considerable help.

First, it is important to note some of the key similarities and antinomies of Foucaultian and Lacanian theorizations about people, society, and place. Very briefly, both approaches share the "conviction that it is dangerous to assume that the surface is the level of the superficial" (Cope, 1994, 13). That is to say, Lacan and Foucault are suspicious of studies that delve beneath sociopsychical appearances in order to unveil hidden deep truths. But whereas a Foucaultian approach understands the unconscious, the gaze, and desire as socially constructed categories that are implicated in the disciplinary production of subjects, a Lacanian approach understands these as fundamental modes of embodied psychical apprehension through which people make sense of 'reality.' Furthermore, whereas a Foucaultian approach emphasizes how history, power, knowledge, and sexuality emerge from and take
place through discursive social relations, a Lacanian approach attends to how discursive social relations also involve extra-discursive forces; that is, forces that cannot be entirely reduced to or integrated into language and knowledge. Lacan calls these dimensions of people’s lives the Real: an alluring yet meaningless and menacing part of socio-psychical life that partially supports, yet repeatedly threatens to undermine, the coherence of everyday discursive practices and objects. Spatially, the Real concerns phenomena that are, on the one hand, anamorphic and menace the predictable ordering of things. This is why Lacan aligns the Real with anxiety, violence, and the paradoxes of painful pleasure, which he calls jouissance.

Lacan’s notion of the gaze is intimately bound up with the Real. Following Foucault, most critics interpret the gaze as a mode of viewing which regulates, unifies, and objectifies space via a master (e.g., masculine, imperialistic, white) subject. Crucially, for Lacan, the gaze does not emanate from the spectator’s all powerful and all seeing-eye, nor does it simply inspect or objectify people. Rather, the gaze “is on the side of the object” (Žižek, 1991, 109) and takes place as a blot in people’s visual fields that incites desire and/or anxiety (see Lacan, 1977, 65–119). Thus the gaze is not the same as a person’s glance or look, nor is it an objective or transparent view.

To elaborate on Lacan’s notion of the gaze, let us turn to the very first opening scene of the popular HBO television series The Sopranos (1999–2007). In this scene, Tony Soprano, the New Jersey mafia Don who has recently suffered a panic attack, sits impassively on a couch in the waiting room of psychiatrist Dr. Melfi. He gradually becomes captivated, then confused, and then intensely disconcerted by the inert presence of a small artistic statue of a nude woman. Here, the statue soon becomes the Real of the waiting room because it is a point of disconcerting Otherness for Tony: it gazes back and immobilizes him by making him feel “photographed” (Lacan, 1977, 106). Tony (already nervous) becomes extremely anxious because he cannot help but think that he is somehow being watched by this artistic yet strange statue. In short, Tony falls under the statue’s gaze.

Therapeutic environments such as the hospital, as sites of recovery, illness, and death, bring to the fore strategies such as aestheticization that attempt to shield subjects from traumatic intrusions of the Real such as the gaze. It is on this point that Lacan’s (1977) notion of the domte-regard, the taming of the gaze, is particularly relevant. Lacan (1977, 101) aligns the domte-regard with the “pacifying, Apollonian [ordered, soothing, and dreamy] effect of painting” that encourages “the abandonment, the laying down, of the gaze” (emphasis in original). In other words, the domte-regard is related to all those things that aim to shield people from the terror of the gaze. Lacan’s example of the domte-regard of a “landscape” by a Dutch of a Flemish painter” directly evokes the above representations of natural environments in hospital waiting rooms (see Figs. 1–4). These illustrations of harmonious nature help people avoid encounters with the Real (e.g., via the gaze) by installing spaces aligned with what Freud called ‘the pleasure principle’; that is, the reduction of levels of excitation, or in Lacanian terms enjoyment or jouissance.

In Lacanian theory, the pleasure principle is ruled by the logic of balance or homeostasis that helps the subject avoid traumatic enjoyment and the Real. Lacan was intensely interested in how people were able to install the pleasure principle through spaces of vision and the visible. As Lacan (1992, 99) notes, “society takes some comfort from the mirages that moralists, artists, artisans, designers of dresses and hats, and the creators of imaginary forms in general supply it with” (emphasis added). From this perspective, the framed mirages depicted in environmental artwork on waiting room walls provide some comfort for those patients who may already feel the threat of the Real; that is, the prospect of encountering a potentially terrifying diagnosis.

**Across the dialogues: revisiting the therapeutic landscape**

In the above dialogue we have put forth two different bases for explaining why environmental art is often showcased in hospital waiting rooms. In both the Foucaultian and Lacanian dialogues the notion of the ‘gaze’ is a central construct for pursuing answers to why this artwork in particular may have an affinity for these specific spaces. That there are also symbolic parallels and symmetries (i.e., distance, control, and passivity) between the natural landscape as portrayed in environmental artwork and the medical encounter more broadly, including that undertaken within the waiting room, is central to both dialogues. Using a Foucauldian reading we suggested that the re-creation of a particular relationship with nature through the landscape aesthetic evokes the same power relations imbued in what we might call the ‘art of the cure’ (i.e., the gaze, namely the doctor, holds power that is skillfully and artfully used to make sense of the gazed upon, namely the patient).

In such an instance the medical gaze which is deployed in the hospital space (i.e., doctor as gazer and healer) is reinforced by visual references to a particular way of relating to nature (i.e., person as gazer, nature as healer). In our Lacanian reading we suggest that environmental artwork diverts attention away from the Real of what is happening in or to a patient’s body and evokes notions of pleasure through escape from the anxiety brought on by spending time in the hospital waiting room space. In this reading one’s gaze upon the landscapes of nature in the artwork is meant to tame the dissolution of the self sparked by the proximity of ‘Other’ bodies (see Tanner, 2002).

In the introductory section we framed this paper around the geographic concept of the therapeutic landscape. As we noted, this is a concept being increasingly employed by health geographers as a way of understanding how places instill or inspire healing (Williams, 2007). Above we employed Lacanian and Foucauldian theoretical concepts in order to both scrutinize the inclusion of environmental art in the waiting room specifically and also to consider its therapeutic potential more broadly. In doing so we have integrated critical social theory into our exploration of this issue and thus build upon the recent – though still sparse – critical engagements with the therapeutic landscapes concept. An important outcome has been our arrival at the question: who benefits from the therapeutic affect of natural landscapes? At the end of our Foucauldian reading we suggested that even though the patient may benefit from gazing upon nature, given its long-standing construction as being health promoting, doctors may gain as much benefit through calming the patient while in the waiting room in advance of the medical encounter when the medical gaze will be applied to his/her body. This also holds true of our Lacanian reading, whereby the gaze upon nature may tame the patient’s read of the medical gaze that surrounds him/her in the hospital. It is only through applying a critical lens to the waiting room space and the interactions between patients, environmental art, and doctors that we have problematized the notion of benefit, whereby both doctors and patients may experience noteworthy outcomes. In order to further advance critical scholarship on the therapeutic landscapes concept in the ways that Conradson (2005) and others have started to already, this very question (i.e., who benefits from the [potentially] therapeutic affect of the landscape?) should be asked of the findings of future research.

In furthering geographic research on therapeutic landscapes we suggest that consideration of Foucaultian and Lacanian theories can help to push both the exploratory and explanatory capacities of this...
health geography construct. While the physical, symbolic and social dimensions of therapeutic landscapes have been the main focus of past literatures on the concept (see Gesler, 2003), they have more or less been addressed as conceptually separate. The continued use of social theory in unpacking this concept can potentially assist with uncovering the intersections of these dimensions. For example, considering Foucault’s notions of the medical gaze and disciplinary surveillance could further understandings of how power relations operate through the interrelationships between the physical, social and symbolic dimensions of therapeutic landscapes (see Gibson, 2004). In addition, considering Lacan’s notion of the Real could further understandings of how the latter two – symbolic and social – intermingle with the Real during the self-landscape encounter. Here the domte-regard proves useful in understanding how aesthetic practices shield subjects from traumatic intrusions to produce ‘therapeutic effects.’

Further to the above point, an engagement with natural landscapes reputed to heal, including those depicted in artwork and other mediums, could yield interesting insights into the constitution of health and wellness. In doing so we may wish to consider which objects are lit or highlighted in some of these natural landscapes and which ones are shadowed or obscured. Further engagement with psychoanalytic ideas on the gaze could also advance re-formulations of the therapeutic landscape concept along the lines of what Conradson (2005) has called the ‘self-landscape’ encounter. In this context, nature-inspired therapeutic aesthetics may play a role in shaping the affective dimensions of medical spaces and, by extension, the processes of self-formation among patients and staff. In sum, this thinking exercise has mapped out some promising avenues for engaging in more critical explorations of the therapeutic landscapes concept that could assist in both its refinement and relevance.

Conclusion

The purpose of this paper has been to rationalize why it is that we observed so much environmental artwork in hospital waiting rooms while undertaking fieldwork in this space by drawing upon explanatory theoretical frameworks, and in doing so critically engaging with the therapeutic landscape concept. According to Tanner (2002), the waiting room is a complex ‘space of public display’ that through its design exposes some of our deepest assumptions, or perhaps more accurately our deepest illusions, about ourselves and our bodies. It is thus not surprising that waiting room walls in Western hospitals such as those we observed are viewed by care providers and administrators as a space upon which to appeal to the visual desire of those waiting within: that is, their desire, in particular, to see and escape to (or be subdued by) landscapes other than the ones where they are situated. Interest-

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