



*CULTURE
AND
HEALTH*

*A WIDER
HORIZON*

*OLA SIGURDSON
[ED.]*

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TRANSLATION

ROSEMARY NORDSTRÖM



UNIVERSITY OF GOTHENBURG
CENTRE FOR CULTURE AND HEALTH

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FOREWORD

Pam Fredman, Vice-Chancellor, University of Gothenburg

CULTURE AND HEALTH. To my mind, these two words belong together. As a new field of research, Culture and Health most definitely belongs to the future, regardless of whether the focus is on prevention to maintain health or intervention to rehabilitate and promote healing. Culture and Health is an innovative area founded upon an interdisciplinary perspective. It encompasses many exciting opportunities – the only boundaries to what can be studied are those set by the limits of our imagination. There are also many challenges, especially the fact that the field is young and relatively unfamiliar to a wider circle.

Achieving success in an entirely new area of scholarship such as Culture and Health will take time, patience, a long-term approach and serious political action. In order to lay a stable foundation with new interdisciplinary structures, researchers from a variety of established scientific and scholarly disciplines must come together across disciplinary lines and be stimulated towards novel thinking and ideas. Only this will make possible that which has occurred in other fields, such as gender studies and environmental science, disciplines that did not exist until fairly recently. Today, they are accepted fields of academic research.

Although Culture and Health is still unfamiliar to the general public, the field has relatively quickly become a matter of great

interest and engagement among politicians at the national level. Only a few years ago, few had ever heard of Culture and Health; now there is a special parliamentary committee for the area in the Swedish Riksdag. As vice-chancellor of the University of Gothenburg, I have on several occasions had the opportunity to present Culture and Health in various parliamentary contexts.

Although there is growing interest in Culture and Health among politicians, it remains a challenge for the field to apply for research grants across traditional disciplinary lines – for the simple reason that Culture and Health has not yet been the subject of truly major research programmes. As a result, the field has yet to establish full legitimacy among funders of research. There is some risk of a Catch-22 here and what is therefore needed now is a significant and targeted research budget. Advertising the availability of such research grants would also signal the importance of the field. Policymakers must also be clear that this research is important and that new knowledge is required in the field of Culture and Health – and must use existing research as the basis for their decisions.

The wide array of skills and expertise found at the University of Gothenburg gives the institution an important role to play in developing Culture and Health as a field of research. This is a logical component of our general ambition to develop and establish our profile as a comprehensive and multifaceted university, but also to regard this breadth as a strength. Even though we have so many different skills at our disposal, this does not mean we should forge on alone. To achieve the best results, we must collaborate and engage in dialogue with other academic institutions and other social actors such as, for example, the national health service, the elder care service or the public schools.

The Centre for Culture and Health is the research node at the University of Gothenburg that will drive the research perspective forward. It is the cement that can bind various disciplines into a stable and cohesive whole. It is also intended to stimulate innovative thinking, create networks among researchers and meetings

that lead to future research projects. The Centre is tasked with coordinating and generating enthusiasm for collaboration within the organisation.

There is, in a nutshell, a great deal to achieve within Culture and Health. The research is not going to cure all human ills, but it has the potential to promote well-being and quality of life, including within the context of chronic disease. Culture and Health is oriented more towards the human dimensions and the soft values often overlooked by traditional medicine. This may be such simple things as that reading literature can work as a medicine for people who are on sick leave or that experiencing music can elevate the sense of life and vitality and hasten rehabilitation from a variety of health conditions. It may also involve critical observation of how modern medicine approaches people from various cultures or the practical and theoretical conditions for how medicine and health are understood in our culture.

As increasing numbers discover the significance of culture to our health, I am convinced that the field of research can make a real difference.



INTRODUCTION TO CULTURE AND HEALTH

Ola Sigurdson

WHAT IS CULTURE AND HEALTH? This book is intended to answer that question from several different perspectives. In this chapter, I will lay out the background of Culture and Health work in Sweden. I will begin by providing a picture of the history of the field in practical Culture and Health activities and in academic research, after which I will define the concepts – what we mean by ‘culture’ and what we mean by ‘health’ when we talk about Culture and Health. A field like Culture and Health has a history which, although brief, determines what the field has become. At the same time, the field depends upon clear definitions so that its work – practical or theoretical – does not degenerate into random fumbling. Considering the broad meanings of both terms, culture and health, it then becomes important to ask how it is possible to study Culture and Health – a question that will be discussed in greater detail in the next three chapters of the book. Thereafter, and finally, I will not only discuss the intrinsic value of culture, but also the intrinsic value of health. Although these are questions whose existential span is far beyond the scope of this book, it is important to realise that work with Culture and Health is grounded somewhere in our notions about the purpose of culture and the importance of health – or in other words, our beliefs about what it means to be human.

But instead of immediately approaching the issue from a contemporary angle, let me begin with a mediaeval example of Culture and Health that will, I hope, provide a horizon of understanding for the work ongoing in our time. A 13th century medical handbook – *Das Breslauer Arzneibuch*, the manuscript of which is found in the public library in Wrocław – provides a number of suggestions for treating lovesickness. I imagine lovesickness refers to unrequited love, among else, but at any rate, love could apparently make people ill. Love was thus perceived in some cases as a sickness, which thus required its remedy.¹ Suitable medicines, according to the handbook, for one stricken by this disease were good wine, string music, talking to sympathetic people and listening to ‘beautiful tales.’² This handbook was a pharmacopoeia, an official collection of instructions and methods for the use of medicines. As a source of its treatment advice, the Wrocław pharmacopoeia cites the Greek physician Galenos as well as the Persian physician, philosopher and poet Ibn-Sina, who were the preeminent medical authorities of their day. Ibn-Sina’s works included one of the most important of all mediaeval medical encyclopaedias. Curing unrequited love in this manner was thus supported by the foremost practitioners of medical science in the Middle Ages.

If ever in history it was à la mode to speak of ‘culture by prescription’ it was in the pharmacopoeia from Wrocław. Lovesickness, however, was not the only complaint believed curable by similar means during the Middle Ages. ‘Things that happen to the soul’ (*accidentia anime*) were an accepted part of a mediaeval theory on the diseased and the healthy person, which regarded the arts, particularly music and poetry but also the less serious arts, as having the potential to heal. In other words, there were relatively elaborate forms of what we now call music therapy and bibliotherapy centuries ago. Music and literature in various forms were considered appropriate remedies (probably combined with other treatment) in connection with such disparate procedures and complaints as bleeding and bronchitis but also as entertainment, a way to pass the time, distraction, comfort, a means of gathering courage before an amputation or prepar-

ing for death. This therapeutic function was ascribed to both sacred and secular literature and music. The arts – music and literature, but also architecture, painting and sculpture – should be used, and they should be used for the sake of people’s health.

I have chosen to begin with the example of lovesickness and its treatment because I believe it says a great deal about what we mean by Culture and Health today as well. We can begin by acknowledging that there is a vast difference between mediaeval medicine, which was based in all essential respects upon ancient medicine, and modern academic medicine. Modern medicine as we know it began to emerge in the 16th century and did not really break through until perhaps the 18th century. By that time, the role of medicine and doctors had narrowed compared to the Middle Ages and uttering opinions about lovesickness and other ‘things that happen to the soul’ is seldom, if ever, part of this role. The mediaeval physician, however, was considered fit to pronounce upon many other dimensions of human existence, for ‘health’ was a broader concept than simply the ‘absence of disease.’ Accordingly, it was not really to be wondered at that one could read about how to cure lovesickness in a pharmacopoeia from 13th century Wrocław.

The self-understanding of art has also changed in that it is no longer taken for granted that a central purpose of art is its use for the sake of human health. Art has an intrinsic value that is independent of any therapeutic function it might have. In his 1790 work *Critique of Judgement*, the German philosopher Immanuel Kant, who set the tone for the modern understanding of art, argues that aesthetic judgement is based on ‘disinterested delight.’³ In other words, art, as art, should produce a delight that is entirely indifferent to any purpose outside itself, such as health. For the mediaeval artist, however, who believed that art should ‘teach, delight and move’ it was thus hardly surprising that a pharmacopoeia could contain opinions on how art should be used; in the very making of the work of art – whether the writing of verse or the playing of music – the idea was there from the beginning that the work could be used for various purposes by the reader or the listener.⁴

The reason for the change in the perception of art may be sought not only in the transformation of art's own self-understanding. As modern anaesthesia has conquered the pain associated with a surgical procedure – for example – medicine no longer needs to lay claim to literature as a means of distraction and literature thus becomes free to seek other purposes for its endeavours. Art and medicine, in other words, have diverged for several reasons: medical progress in modern times has allowed medicine to replace some of the functions previously served by art; rising esteem for the autonomy of art has led to less emphasis on its utilitarian value; a shift in the understanding of the relationship between body and soul/mind towards increasing dualism has led to the notion that medicine and art have nothing to do with one another.

With respect to Culture and Health, my example of unrequited love in the Middle Ages says two seemingly contradictory things. On the one hand, people were already involved in Culture and Health in the Middle Ages, even if they understandably did not use those particular words. On the other hand, people in the Middle Ages were not involved in Culture and Health because, in a way, they did not separate the two. Art was not divorced from medicine, but was instead part of the repertoire of remedies to which the knowledgeable physician should have access. In our time, we talk about Culture and Health and, perhaps, ask ourselves what culture and health actually have to do with each other, for modern medicine, art and our view on humanity often proceed from the notion of their separateness. Recent decades have shown, however, that asking questions like these remains valid in our day. Can music have a therapeutic function? What role does literature play in our understanding of health and disease? How should a hospital be designed for optimal rehabilitation? What is the relationship between the intrinsic value of culture and its use in times of trouble? This book is intended to help us think about questions like these in a systematic way. As I mentioned at the outset, this chapter is meant to serve as an introduction to the field, as it has emerged in Sweden, but also to show how concepts like 'culture' and 'health' relate to each oth-

er and the significance of the intrinsic value of culture and health, respectively, to understanding how culture and health are intertwined. The three following chapters will deepen the understanding of the research related to culture and health.

CULTURE AND HEALTH IN RESEARCH AND PRACTICE

I will not be writing a complete history here of how Culture and Health came to be a concept in Sweden, but a few points may serve to show how the concept has become established in a relatively short time in both Culture and Health practice and in academic research. This overview may also show something of the diversity of resources the field can lay claim to. Although I will begin with research before discussing practice, this does not mean the research came first. It is more reasonable to presume that practice came first, as my introductory historical example suggests. Although Culture and Health has probably always existed as practice, albeit not under that designation, it is nevertheless interesting here to discuss some of the particular efforts within Culture and Health that have been undertaken in various parts of Sweden in recent years.

A suitable starting point is 2005, when the Swedish National Institute of Public Health (now the Public Health Agency) published *Kultur för hälsa: En exempelsamling från forskning och praktik* [English summary: *The Significance of Culture for Health: An Anthology of Examples from Research and Practice*].⁵ The examples cited in the report are derived mainly from a survey and initiation project run by the SNIPH since 2002 when a first hearing in the area of Culture and Health took place. The introduction to [*The significance of*] *Culture for Health* refers to the National Public Health Committee's final report, *Health on Equal Terms*, which finds it likely that greater participation in cultural activities would also contribute to better and more equal health among the population. *Culture for Health* also refers to a New Year's address in 2005 by Leif Pagrotsky, then minis-

ter of cultural affairs, when he said ‘[t]here is a clear correlation between consumption of culture and better health.’⁶ Also mentioned is that the Swedish government bill *Forskning för ett bättre liv* [Research to make life better] stresses the importance of increased knowledge in the field and therefore allocated SEK 5 million in 2006 to research on Culture and Health (Swedish Government Bill 2004/05:80). In its publication *Forskning om kultur & hälsa* [Research on culture & health], the Research Council writes that it had allocated a total of SEK 15 million in the period of 2006–2008 to nine different Culture and Health projects in disciplines including arts education, psychology, sociology, anthropology and public health science. In the Research Council’s review, Gunilla Jarlbro, professor of media and communication studies at Lund University and chair of the preparation group in charge of the research programme, makes the following statement about the success of the programme:

At the final conference, I was struck by the incredible number of publications the programme had generated. Five million kronor times three years is truly not much for a research programme and it is impressive that so much was achieved with so little.⁷

However, Jarlbro also stresses that it is important to follow up this research programme so that the heightened interest in Culture and Health studies would not fade away. A researcher who has had significant impact on the field, Töres Theorell, medical doctor and researcher at Karolinska Institutet, also points out that it is important that the research says something about *how* culture becomes significant to health and not simply that it *is*. Otherwise, there is risk that practice will, despite everything, not be based on research, which could undermine interest in the connection between culture and health.⁸ The review contains brief, concise presentations of the various research projects along with a list of publications for each. In other words, the review is an important source of information about projects, researchers and publications in the continued work with Culture and Health.

Several research initiatives in Culture and Health have also been taken since the Research Council's research programme. One of the most extensive research projects of recent years is 'Humans Making Music', led by Fredrik Ullén at Karolinska Institutet.⁹ Ullén is a professor of neuroscience as well as an active concert pianist. The Bank of Sweden Tercentenary Foundation has allocated funding to this project for no less than seven years starting in 2012. The point of departure for the project is the question of the correlation between the time people spend engaged in music in various ways and what positive side effects this has on cognitive ability and health. It is hoped this will lead to applicable knowledge about how society can optimally encourage musical activity, organise musical training at home and in the public schools and take advantage of the positive effects of music on cognition and health. Neuroscience is the scientific focus of the research project.

Thus, from the very outset, work with Culture and Health has encompassed both research and practice; the thinking is that each should inform the other. If research can elucidate and verify the connections between culture and health which, based upon experience, we suspect exist, it is hoped this will result in more clearly defined work with Culture and Health in Swedish municipalities and regions. It is also important to clarify that research is also dependent upon the existing stewardship, in many areas, of insights into various connections between culture and health, insights that have emerged in practice. Thus, this is hardly a matter of one-way communication between research and practice. The Swedish Arts Council is a government authority organised under the Ministry of Culture. In addition to its principal task of facilitating cultural development and increasing access to culture, the Council is tasked with supporting practical activities in the area of Culture and Health.¹⁰ Among else, the Arts Council carried out a government mandate in 2011, 2012 and 2013 by supporting a number of activities related to 'Culture for Older People.'¹¹ The Arts Council's Culture and Health programmes are carried out in close collaboration with the non-partisan Culture and Health Association

of the Swedish Riksdag, which aims to promote greater awareness of the significance of culture and, in concrete terms, to justify political decisions that strengthen the field.¹² The Association began working in 2007 and has since arranged about fifteen major activities and seminars, both within the Riksdag and outside of it. At present (spring 2014), Anne Marie Brodén (Moderate Party) is chair of the Association and Maria Lundqvist-Brömster (Liberal Party) is the vice-chair.

Many Swedish municipalities and regions as well as private-sector organisations are engaged in various projects and activities related to Culture and Health. They are far too numerous to provide any meaningful overview here, but allow me to at least mention one of the earliest and most comprehensive projects in the field, which has been run by Region Skåne for about ten years.¹³ Region Skåne has made by far the most progress in the effort to define how culture can in various ways have preventive, health-promoting and rehabilitating effects. The regional Culture Committee and the Health and Medical Services Committee have both carried out initiatives in the area and will be jointly preparing a strategy for long-term planning of future efforts. One of the most noted elements of their programme is ‘Culture by Prescription’, which began as a government-supported pilot project in which cultural experiences were prescribed as treatment for a number of people on long-term sick leave in Helsingborg. For the ten-week prescription period, a total of three groups of participants were followed as they engaged in various activities such as walking tours of the Sofiero Palace Gardens and singing in choirs. The project was carried out in 2010 and later evaluated.¹⁴ Based on the positive results, Region Skåne is once again investing in ‘Culture by Prescription’ over the period of January 2012 through December 2014 for a group of 200 patients. The aim is to study whether cultural activities, personal creativity and cultural experiences can be part of a rehabilitation process. As stated in the evaluation report, these cultural activities should not be viewed separately from the fact that participation in the activities also helps break the cycle of social isolation in which some peo-

ple on long-term sick leave are caught, while shifting focus from the patients' conditions to cultural activities and cultural experiences as creative resources. In these concrete cases, the issue is not that culture, isolated from its context, has a rehabilitative effect, but the fact that the practise of culture takes place in a social context. 'Culture by Prescription' is one of several initiatives by Region Skåne and it is important to emphasise that for all of these initiatives the Region is also preparing a more overall strategy for its work with culture and health. Region Skåne is of course not the only organisation to invest in Culture and Health – on the contrary, several regions have recently launched their own programmes or are on the verge of doing so – but Region Skåne's efforts thus far appear to be the most comprehensive.

CULTURE AND HEALTH AT THE UNIVERSITY OF GOTHENBURG

Interest in culture and health has also resounded at the University of Gothenburg and led to the establishment of the Centre for Culture and Health where the book you are now reading was written. One of the initiators was Gunnar Bjursell, professor of molecular biology. A project was begun for which Professor Bjursell was appointed chair and one of the first more public manifestations of the project was an introductory seminar held 18 April 2007 in Vasaparken, one of the main buildings of the University. The seminar was co-arranged with Region Västra Götaland and brought together about a hundred participants, including Lena Adelsohn Liljeroth, minister for culture; Maria Larsson, minister for public health; Göran Johansson, chair of the city executive board of Gothenburg; Arvid Carlsson, professor and Nobel laureate; and Pam Fredman, vice-chancellor of the University. Journalist Kerstin Wallin documented the seminar in a review published by the University of Gothenburg.¹⁵ The discussion was characterised by great enthusiasm as well as emphasis that Culture and Health must be a

multidisciplinary project in order to encompass all the dimensions contained in Culture and Health. In the review, Fredman is quoted as saying that a centre of culture and health research is a matter of national importance, while Bjursell argues that in the future medicine ‘will be a sub-division of the discipline of health.’¹⁶ His remark seems to arise from the insight that health is a broader concept than that traditionally studied by the medical faculties: namely, that which we call well-being.

Jointly with Lotta Vahlne Westerhall, professor of public law, Bjursell took yet another initiative, which resulted in *Kulturen och hälsan: Essäer om sambandet mellan kulturens yttringar och hälsans tillstånd* [Culture and health. Essays on the connection between the expressions of culture and the state of health] published in 2008.¹⁷ The book contains contributions by nine researchers from various disciplines as well as a foreword by former minister for culture Bengt Göransson and a CD, *Triptyk*, featuring music for flute by Gunilla von Bahr, who also wrote a chapter of the book. By including a CD of music for flute, the book emphasised that Culture and Health was by no means only the concern of academic researchers but that research and practice should go hand-in-hand. It is no surprise that Göransson wrote the foreword because the former minister for culture has demonstrated ongoing – but also critical – interest in Culture and Health. Among else, he counselled against any naive expectation that culture will be able to solve our health problems and thus reduce the costs of health care – an opinion he repeated several times in a speech with the deliberately provocative but also insightful title ‘Culture sure as hell won’t make you well.’ On the other hand, Göransson writes that he is pleased by the ‘variety of definitions of the concepts of both culture and health,’ since they compel readers to think things through for themselves.¹⁸ Göransson is absolutely right that Culture and Health contains a multiplicity of definitions, although historian of ideas Karin Johannisson’s chapter, ‘Culture and health: Two challenging concepts’, provides a good overview. Both concepts mean different things in various contexts and at

various times. In addition, both concepts are multidimensional. I will have reason to return to this matter below.

The book was relatively successful and also had impact through a number of seminars held around the country. The most well-documented of these is the one held 10 November 2008 in the University of Gothenburg lecture hall in Vasaparken, moderated by Gunnar Bjursell. Karin Johannisson, Töres Theorell and I were on the panel and there were several hundred people in the auditorium. The discussion lasted for more than two hours and journalist Kerstin Wallin once again wrote a detailed seminar review, *Kulturen och hälsan: Symposium 10 november 2008* [Culture and health: Symposium 10 November 2008].¹⁹ I refer to this seminar review as well as the earlier review of the introductory seminar because both occasions assembled many of those who are actively engaged in Culture and Health, not least importantly as a field of research, and the articles reflect the discussions of Culture and Health and its possible relevance to practice. Subjects discussed in the seminar review include those such as the possible benefit of culture and the possibility of prescribing culture to patients, as well as to what extent the view of humanity is an important element within the confines of Culture and Health as a field of research.

The initiatives taken at the University of Gothenburg have resulted in several concrete actions: the formation of a research centre at the University as well as several research projects funded by the Sten A. Olsson Foundation for Research and Culture. Allow me to begin by saying something about these research projects, starting with the 'Culture and Brain Health Initiative.'²⁰ The scientific core of this project is research into the brain's plasticity and healing capacity, but it also extends to collaboration with musicians and musicologists. The programme aims to investigate the effects of sensory stimulation through various cultural activities, such as music and dance. One of the purposes is to understand and exploit culture's possibilities to achieve improved prerequisites for brain health, good ageing with maintained cognitive function, as well as increasing the chances of healing and regaining functionality after

damage and disease in the brain. The aspect that has received the most attention in the media is a sub-project called BodyScore, due to its research on the importance of music to human well-being – a project discussed in the final chapter of this book.²¹

The Stena Foundation has also supported the social sciences research project ‘Culture, Health and Personality’, whose objective is to shed light on the interaction between health and well-being, on the one hand, and cultural habits and lifestyles, on the other, while controlling for personality factors. One example from this project is the chapter that the two research directors Sören Holmberg and Lenart Weibull published in a book by the SOM Institute, *I framtidens skugga* [In the shadow of the future] titled ‘Kultur befrämjar hälsa’ [Culture promotes health]. This sub-study has investigated the connection between culture and health and found that no correlation between culture and health, when health is defined as the absence of disease, could be proven. They could, however, show a statistically significant correlation between culture and health when health is defined as a state of well-being. Holmberg and Weibull write: ‘Culture does not cure, but people may perceive that they have become healthier.’²² This was repeatedly reported in the media as if it were evidence that there is no connection between culture and health, but that is not how the results should be understood. Holmberg and Weibull also reappear in Chapter 4 of this book.

Finally, the Stena Foundation has also supported the humanities project ‘Religion, Culture and Health’, which gathers scholars in the fields of film studies, literature, history of religion, political science and theology. The project was initiated by professor of political science Marie Demker, professor of literature Yvonne Lefler and me. The research programme problematises culture and health in an existential context. Within the confines of people’s interpretation of life, the Religion, Culture and Health project studies how contemporary political, social and religious conditions for ‘culture’ and ‘health’ are conceived and used. When issues of religion and health intersect, it becomes important to investigate the role of religion and outlook on life in the understanding of culture

and health and vice versa. The project applies a relatively broad definition of religion and thus encompasses everything from the question of how people use the literary and film genres of chick-lit and romantic comedy as tools for interpreting life to the role of the state in promoting or suppressing religious interpretations of life. Demker and Leffler also present their own projects in greater detail in Chapter 4 of this book.

If the research on the plasticity of the brain in the Culture and Brain Health Initiative focuses on the biological prerequisites for human health and the Culture, Health and Personality project focuses on human perceptions of health, the focus of Religion, Culture and Health is rather on the cultural representation of health; that is, how health is presented in media and in cultural expressions and what is therein considered healthy or diseased. A simple illustration is my introductory example of lovesickness, which would hardly be classified as a disease in our time, but easily was in a 13th century pharmacopoeia.

Finally, I would like to say a few words about the centre responsible for the book you are now reading. The Centre for Culture and Health (CKH) was established 1 January 2010 with the objectives of stimulating initiatives in research and education to shed light on the relationship between culture and health and particularly to promote collaboration among different scholarly fields and disciplines as well as between academia and various social actors, support the effort to seek funders of research in the field of Culture and Health and to support the spread of knowledge about the development of the research field through various activities. Gunnar Bjursell, one of the initiators of the work with Culture and Health at the University of Gothenburg, was the director of the Centre until his retirement in 2011. As of 1 July 2011, the work of the centre is led by a director – who is also the author of the chapter you are reading – and a coordinator, Dr Annica Sjölander, whose research background is in neuroscience. At present, research is conducted by the Centre itself only to a limited extent, although all of us who work there are active researchers. The main role of the Centre is in-

stead to initiate new research, support ongoing research and spread information about the field. The last is accomplished in large part through the website www.ckh.gu.se, whose ambition is to be a national (and international) resource for work in the field of Culture and Health. The website includes a news banner, researcher bios and a constantly growing library of links to additional resources in both research and practice.

Naturally, there are projects that are related to Culture and Health but which do not use the designation as such; one example at the University of Gothenburg is the Centre for Person-Centred Care (GPCC), which has been engaged in interdisciplinary research since 2010 and is funded by a strategic investment by the Swedish government in health and care research.²³ GPCC illustrates the fact that there is considerable research ongoing at Swedish higher education institutions that is not called Culture and Health, but nevertheless concentrates on culture and health.²⁴ The history retold here is relatively brief. As in the 13th century pharmacopoeia, we can expect to find the thing itself in many places where the terminology is absent and so we must be cognizant of this.

The picture of the field of Culture and Health that develops via these research projects and practical initiatives is that the field has garnered considerable attention, but also that it is an area that spans a variety of forms of research and practice. This diversity is justified by the very question of the relationship between culture and health. I hope this will become clear in the rest of this chapter as I turn my attention to what we understand by the concepts of culture and health, but also the matter of the intrinsic value of culture and health, respectively.

CONCEPTUALISING CULTURE

To talk about Culture and Health in a meaningful way, we have to know what we mean when we say both ‘culture’ and ‘health’. So, this is a matter of definition. In this section, I will begin by say-

ing something about the concept of culture and follow with a discussion of the concept of health. As mentioned above, historian of ideas Johannisson argues that the concepts are challenging. The first thing that becomes clear when we talk about definitions of 'culture' is that the word is imbued with multiple meanings. In a chapter in the same book as Johannisson, medical doctor Christina Doctare mentions that when she was in medical school in the 1960s, the only kind of culture anyone cared about was bacterial cultures.²⁵ Such a use of the term reflects the fact that 'culture' is derived from the Latin *cultura*, which means cultivation, and the verb *colere*, which means to cultivate (but also to inhabit or to worship). One can cultivate a wide variety of things: everything from bacteria and plants to oneself. A cultivated person is regarded as someone who has fostered certain personal traits and may therefore be called refined, learned, or civilised. As noted by British literary scholar Terry Eagleton, one of the interpreters of the concept, the word originally referred to an activity, to cultivate or to grow, and only later came to denote an entity.²⁶ One of the remarkable things about this process is how the semantic field of the term has shifted from the material or agricultural to the spiritual. Culture, at least as we often use the word today, involves what we do after we have met our material needs.

In everyday parlance, I presume, the word 'culture' in Swedish (*kultur*) is not used primarily to refer to bacteria cultures, but to such things we might also call the arts or creative expression: visual art, film, music, dance and literature, but perhaps also architecture, sculpture and horticulture. We either practise one of these creative expressions ourselves or enjoy them in some form: we can play the drums ourselves or listen to someone else playing the drums. In this context, culture will refer to artistic or intellectual works and how they are made or shared.²⁷ From the Culture and Health perspective, it is important to avoid, as far as possible, the spontaneous associations that may be attached to a certain form of culture – that music is hard, for example, and that not everyone has the ability to engage in or understand music. For this reason, musicologists have

suggested that we should use the term ‘musicking’ to illustrate how people’s use of music cannot be limited to something they practise themselves or actively listen to.²⁸ Some people may be particularly interested in lyrics, others may wash dishes to music, still others may collect record albums or simply like to read and talk about music – or all of the above. In other words, there may be quite a few activities associated with music that are significant to health, in various ways – and naturally, the same goes for other forms of culture.

The purpose of a term like ‘musicking’ is to try and avoid the sorting of art or culture, in the sense of artistic or intellectual works and how they are made or shared, into categories of high and low, better or poorer. There is an obvious risk that the culture that affects health will be associated with some form of a cultural canon, a sort of a list of what is considered ‘good’ culture. At least one study suggests that it is not any particular type of music that may have a potential rehabilitative function, but rather self-selected music, the music I personally choose to play or listen to.²⁹ In other words, Mozart and Metallica can both reduce stress – but whether or not they do depends largely upon our personal musical biography. That there is reason, from a Culture and Health perspective, to carefully avoid consciously or unconsciously conveying normative beliefs about the value of a particular kind of music or a particular work of art does not mean that such beliefs cannot be legitimate from other perspectives; it only means that it is probably not a good idea to confuse ‘cure’ with ‘educate’. The usual distinction between ‘high culture’ and ‘popular culture’ seems extremely problematic here.

Another problem with the aforementioned conceptualisation of culture is that the dividing line between culture in this sense and other human activities, such as sport, is neither self-evident nor especially useful. That sport (as long as we are not talking about elite-level sport) can be good for the health is hardly news, but is sport also culture? Can watching a football game be considered culture? According to a conventional definition, the answer is probably no, but then we should be aware that things like gender and economic and social class influence the valuation of culture versus

sport in modern society. An open definition of culture is essential to preclude the risk that a certain group of people will end up outside the field that Culture and Health studies. Ultimately, this is not about arriving at a consistent definition of culture at any price, but rather a matter of human health.³⁰

The boundary between culture and sport in our society is not self-evident; it is a distinction that has emerged over time and history. Likewise, the music I like is not only a consequence of my spontaneous preference but at least equally a consequence of my childhood and upbringing: influences from home as well as school, the media, friends and coincidences – that I happened to be listening to that particular music when I met my life partner or was notified of something that would change my life. That I have a relationship to music at all and consider it important in the way I do is probably also a consequence of living in a society that considers music an important part of a human life. What I am trying to say here is that it does not suffice to talk about culture as artistic or intellectual works and how these are made, performed, or shared. That culture plays the role it does in our lives (whatever role that may be) is dependent upon the culture in which we live – and the latter use of the word refers to another concept of culture – culture as a semogenic system that encompasses feelings, habits, values and convictions as well as economic, political, social and religious institutions. One can in this sense speak of the ‘Gothenburg culture’ and when one does, one does not primarily mean that people go around singing songs by Lasse Dahlquist (a beloved Swedish composer, singer and actor from Gothenburg), but rather the way of life that is typical for Gothenburg. Obviously, this involves a large measure of generalisation, since there are many different lifestyles in Gothenburg, but the basic idea is that people, as historical and social beings, are shaped by their surroundings in a way that influences (but not necessarily determines) how we think, act and hope.

Allow me to take an example of this relevant to the issue of Culture and Health. Two Japanese psychologists, Ukiko Uchida and Shinobu Kitayama, argue in a paper that the general understanding

of what happiness is and how one achieves it differs between North America and Japan.³¹ North Americans emphasise the importance of personal independence, while Japanese place more value on mutual dependency. These disparate conceptions of happiness spring from different beliefs about what it means to be human – beliefs that are rooted in history. If North American culture and history over the past few centuries has emphasised the autonomous self as the forge of personal happiness, the Japanese emphasis on the importance of acting in harmony with friends and family has resulted in a more interpersonal ideal of happiness. If the North American lifestyle encourages action against the backdrop of an optimistic horizon that presupposes that it is possible to make dreams come true, happiness from the Japanese perspective is more ambivalent because the horizon of expectation also encompasses negative dimensions. The cultural differences between North America and Japan should not be exaggerated, of course, and we should not expect every individual to exemplify the happiness ideal that the respective cultures encourage. Nonetheless, Uchida and Kitayama argue, these divergent ideals of happiness generally involve different strategies for handling existentially difficult situations. North Americans are wont to assert their independence and blame circumstances, while Japanese strive to restore balance to the situation. But our disparate beliefs about happiness are also connected to various cultural and historical beliefs about health and disease, which in turn entail a variety of approaches to handling health and disease in our lives.³² In this sense, even biomedicine and the health care system are part of the culture – and not only elsewhere, but also here in the Western world, including Sweden.³³

The culture to which we belong also has impact on how we handle and understand the hardships we encounter in life, including those related to health and disease. A discussion such as that of Uchida and Kitayama can certainly be presented in greater nuance than I have done here, but it will perhaps suffice to make my point clear – that the more social and historic concept of culture is also important to research on Culture and Health and not only the first

concept discussed. The significance that culture in the first sense – as an artistic or intellectual work – might have for me personally is dependent upon culture in the second sense, culture as a semogenic system. People are cultural beings in both the first and the second senses.

In summary, there are at least two different conceptualisations of culture to which the field of Culture and Health must relate:

- * Culture as artistic and/or intellectual works
- * Culture as a semogenic system that encompasses feelings, habits, values and convictions as well as economic, political, social and religious institutions

I have also argued that these two meanings of culture are dependent upon each other: the kind of artistic and intellectual works I prefer and which speak to me in a meaningful way depends upon the culture in which I grew up and to which I belong, but culture as a semogenic system is expressed – among else – through its artistic and intellectual works. In the following three chapters, which describe individual scholars, research projects and areas of research in greater detail, it will become even clearer that Culture and Health truly and inevitably embraces culture in both senses.

Finding additional concepts of culture – such as culture as criticism – is easily done, but I will now turn to another question in the wake of this discussion of the conceptualisation of culture. A recurring philosophical question related to the concept of culture is the relationship between nature and culture. This question recurs on multiple levels – for example, how we should understand the relationship between biological heritage and social environment in education and the social sciences, or whether culture is a hobby that a society can pursue if it has the time and means and when the economy and technology so permit. There is no space here to go into each of these discussions, so I will limit myself to one statement – that nature and culture should not be regarded as competing magnitudes. On the contrary, we must understand them as interdepend-

ent and reciprocal: people are by nature cultural beings. On the one hand, the nature of humans sets limits for what they can become and do, but on the other hand, we relate to these limits and shape them through culture. Nature and culture are thus not competitors, where the one asserts itself at the other's expense in some simple way. Translated to the relationship between culture and health, this means that health is always related to culture – in both senses discussed above. What we mean by health depends upon the culture in which we live, but cultural works are also a way for use to relate to and even impact our health or our disease. But what do I mean by health? It is time to look at the definition of the second concept within Culture and Health.

CONCEPTUALISING HEALTH

Like that of culture, the concept of health can be defined in a variety of ways.³⁴ The predominant definition in our time and in our western culture is, beyond doubt, the 'absence of disease', which reflects how medical practice and research have come to determine the meaning of the concept. In bygone days – as suggested in my introductory example of lovesickness – the definition of health was much broader. Interestingly enough, this is reflected in the World Health Organisation's position that health is much more than the mere absence of disease. In its definition drafted in 1948, WHO stated that health is 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.' The WHO definition has been criticised for being utopian through its emphasis on 'complete' well-being, but allow me to leave that issue aside for the moment. For my purposes, there are two things in particular that should be emphasised in this definition. Firstly, it concerns not only a negative definition of health ('the absence of disease') but also a positive one ('well-being') and secondly, the definition stresses that well-being may have multiple dimensions: physical, mental and social.

Health is thus not only a matter of the absence of disease, but also one of well-being. Here we can say that the WHO definition – consciously or not – connects to the understanding of health of an earlier epoch. During the Middle Ages, when the pharmacopeia from Wrocław was written, the understanding of health was much broader than the mere absence of disease; in old Swedish, the word *hälsa* – health – was also used to refer to *frälsning* – ‘salvation’ – and salvation was understood as not only something ‘spiritual’, but also ‘physical, mental and social’. The connection becomes perhaps even more apparent – and even older – if we remind ourselves that *salus* is a Latin word for health and Salus, in Roman mythology, was the equivalent to the Greek goddess Hygieia. Hygieia was the daughter of Asclepius and was the goddess of health, cleanliness and hygiene. At the etymological levels, there is thus already a connection between health, hygiene, vitality and a holistic worldview.³⁵ In other words, the totality of the human being was embraced in the concept of health, not only the physical dimensions.

Something of the perception that health cannot be limited to the absence of disease lives on in our time in the Swedish proverb that ‘health remains silent’. If I say that ‘health remains silent’, I simply mean that health in the sense of well-being may be something I don’t give much thought to, as long as I have it. Health comes to mind only when it is lost. The German philosopher Hans-Georg Gadamer notes the peculiarly transparent nature of health when he writes ‘Health is not a condition that one introspectively feels in oneself. Rather, it is a condition of being involved, of being in the world, of being together with one’s fellow human beings, of active and rewarding engagement in one’s everyday tasks.’³⁶ Or in other words, when I am healthy, I am far too busy living my life to stop and think, other than in exceptional circumstances, about the fact that I am healthy; it is only when I lose my health that what I have lost becomes apparent to me. It is exactly so that philosopher Havi Carel describes this state of affairs in her book *Illness*: not only as a limited physiological or mental problem but as a more or less radical change in how I relate to myself and my body, to other peo-

ple and to the world. She writes: ‘Whereas it is normally taken for granted that the body is a healthy functioning element contributing silently to the execution of projects, in illness the body comes to the fore and its pain and incapacity directly affect the agency of the person.’³⁷ I become incapable of performing actions or projects that were formerly part of my bodily repertoire; Carel describes how a serious lung disease prevents her from riding a bike, running and walking as she once did. All of these activities still exist in her body, in a way; she simply can no longer do them.

The experience of health (and illness) may of course be further varied: if or when I have regained my health after a protracted convalescence, its presence may become more obvious to me, in the sense that I no longer take my health for granted. What Gadamer points out in the quotation above is that there is an element of transparency to well-being, precisely because health in this sense is often a prerequisite for many of our human projects. That health is well-being thus does not only mean that health is a positive feeling, but that health is intimately associated with activities and abilities: now that I am healthy, I can finally see my friends again, I can ride a bike again, or I can travel.

When we talk about Culture and Health, it is apparent that culture – now in the sense of practising or consuming culture – contributes to our well-being. The value of culture to health must not be limited to any rehabilitative capacity it may have, thus health in the sense of absence of disease. It is likely that health as the absence of disease and health as well-being are not independent of each other even if they are not necessarily the same thing: if culture can contribute to elevating my well-being, this may also have positive impact on my recovery from illness. My point here is not to argue that culture may, generally speaking, be good for the health, but to show that its effects can be rather complex. If I assert that life without the music of Emmylou Harris or German brass bands isn’t worth living, it might be a good idea to listen to that particular music in my sickbed, even if this music listening has no direct consequences for my recovery. But could it also be that listening to music I have

chosen for myself triggers processes in the body that, purely physiologically, have a beneficial effect? The answers to these questions do not have to be one or the other, but are probably more complex. To claim on a general level that our perception of well-being is intimately associated with culture in some sense is not a particularly bold assertion.

The other aspect of the WHO definition to which I drew attention was that well-being has several dimensions. The definition itself specifies three, the physical, the mental and the social, but recent discussions have chosen to add a further, spiritual dimension to well-being. To begin with, the point of talking about various dimensions of human existence in relation to health and disease is not to say that these dimensions are independent of each other. Instead, it is a matter of emphasising that health is not *only* a matter of people as physical beings, although it is *also* a matter of people as physical beings. The first public health revolution focused on sanitary conditions and infectious diseases and the second on the significance of individual behaviours to non-infectious diseases. The third public health revolution, however, had to do with quality of life and then not only as individually understood but also in relation to collective ways of life and social environments. An example taken from the present of how the individual and the social are intertwined is the ‘obesity epidemic’ in the western world. Although obesity is an individual (physical) problem that is associated with a variety of complications, there are also social variables: urban planning including access to public amenities by means other than car probably plays a part in how successful efforts to fight obesity will be. If one begins to think about how things like fuel prices, bike lanes and footpaths, access to grocery stores, public fitness facilities and an extensive public transport service affect public health, one realises that the question is very complex.

Another dimension of health as well-being that has come into focus in recent decades and which I have already mentioned above is ‘spiritual’ health.³⁸ In Sweden, the term ‘spiritual’ is probably associated with some kind of religious health and that is of course, not

wrong. But for the World Health Organisation, the term ‘spiritual health’ does not refer to how one religion or the other understands health. The instrument that WHO uses to measure spiritual health is called the WHOQOL (World Health Organization Quality of Life) Spirituality, Religiousness and Personal Beliefs (SRPB) Field-Test Instrument. In other words, the organisation denotes that spiritual health comprises ‘spirituality, religiousness and personal beliefs’ and thus cannot be limited to any particular understanding of the nature of life – religious or not. The aim of the measurement is instead to show what role our outlook on life, whatever that might be, plays in our well-being and how we handle human suffering and existential dilemmas based on our outlook and worldview. Spiritual health, the organisation argues, is a distinct dimension alongside physical, mental and social health and one that has strong impact on how people understand, confront and handle both health and illness.

I would like to add something to these four dimensions that is perhaps most easily considered not as an additional, fifth dimension, but rather an experience or relationship that cuts straight across all of these dimensions – something I call ‘existential’ health. What I mean by this is illustrated best by an example. A retired friend of mine once said to me ‘Imagine that you can be so healthy when you have so many ailments.’ I believe her statement about her own health can serve as a reminder to most people of similar states of affairs: you have your minor complaints, but you still feel healthy overall. There are two things to say apropos this expression. Firstly, that our personal experience of health is also multidimensional. Even if the physical, mental, social and spiritual dimensions of health cannot be disentangled, they still do not perfectly coincide. This points to an important insight about our own health: illness and health are not absolute conditions and it is entirely possible to be ill and healthy at the same time. I certainly suspect that this cannot be taken to an extreme: if I am suffering severe stomach flu, it might be difficult to imagine that I am simultaneously experiencing a state of well-being; if I am deeply discontented with my so-

cial situation, this can also have impact on my physical health. But I can also imagine feeling very contented with my social life even though I am suffering from a serious pollen allergy. I do not want to draw any major conclusions about this, but only to point out that it can often be so in our lives that the absence of disease and well-being do not always coincide. We rarely or never experience what the WHO definition calls ‘a state of complete physical, mental and social well-being.’ Our state of health may vary among all of these various dimensions.

Secondly, and now I am coming more directly to what I mean by existential health, my friend’s statement also bears witness to the fact that our health also encompasses our own relationship to this health. Even if I perceive the Swedish proverb ‘it’s not your situation that matters, it’s what you make of it’ to be a little self-righteous – your situation certainly does matter – there is at least a grain of truth in the saying, that we have a relationship to our own health. ‘Imagine,’ says my friend, ‘that you can be so healthy when you have so many ailments,’ and the word ‘imagine’ signals that this involves self-reflection. It is precisely this self-reflexivity in our experience of health that I call existential health. According to the understanding I have suggested existential health is thus not another dimension alongside the other four but rather our personal relationship to these four dimensions. Canadian philosopher Charles Taylor has pointed out that in our age, knowledge about health and illness and the personal experience of health and illness have drifted apart and become two entirely different things: ‘The expert may be leading the most “unhealthy” life, without ceasing to be an expert; whereas the dutiful patient, who (we hope) is brimming with health, understands very little why his régime is a good one.’³⁹ Talking about existential health is an attempt to show that an ‘objective’ third-person perspective and a ‘subjective’ first-person perspective are in fact intertwined. My health is never only a matter of my ‘scores’ on a scale from healthy to ill, whether we are talking about physical, mental, social, or spiritual health, but also and always about how I relate to these scores. A sharp distinction

between observation and experience or object and subject tends to understand health as an object or state independent of my personal plans, longings, or hopes. Towards the end of his life, French philosopher Jean-Paul Sartre was asked whether he regretted having lived such an unhealthy life now that he was blind and sick. Sartre responded: ‘What’s the point of health?’⁴⁰ Despite all deficiencies, shortcomings and illnesses, I am healthy, existentially, when this life I am living is my own.

HOW CAN WE RESEARCH CULTURE AND HEALTH?

Now, if both culture and health can mean so many different things, how is it possible to conduct research in the field of Culture and Health? Does a problem arise when the two words become so ambiguous that it becomes hard to say what the research is supposed to be about? Or is it possible that Culture and Health can encompass pretty much anything, which means that we can say that more or less all research has to do with Culture and Health? However, the problem is not as big as it seems. Many of the major concepts we concern ourselves with in social discourse and which are also the subject of research – I am thinking of politics or religion, for example – suffer from the same problem; that is, that they are, as concepts, highly ambiguous. Part of the solution to this ambiguity is that each individual research project must demarcate how that particular research project uses the concept. As long as I know what I am doing in my research project, for example, that I am researching whether culture in the sense of ‘singing in a choir, writing poetry, or drawing and painting’ or ‘going to the theatre, going to a concert, or reading a book’ (the activities Holmberg and Weibull study in their aforementioned article) promotes health, it is not a problem that culture can also mean a semogenic system or that the boundary between culture and sport may be fuzzy. The claims that a research project can make are limited and they are constrained,

among else, by other research projects that are studying other aspects of similar problems.

This fact can initially be exemplified through two books. In 2011, Eva Bojner Horwitz, a medical doctor who specialises in social medicine as well as registered physical therapist and dance therapist published her book *Kultur för hälsans skull* [Culture for health improvement] in which she aims to ‘strike a blow for the artistic and cultural values that surround us and show how we can use them to feel better.’⁴¹ Albeit not a contribution to the research itself, the book is a presentation that relies primarily on scientific or medical research (which Bojner Horwitz has been personally involved in) on how culture in the sense of artistic works can promote health. When Cecil G. Helman approaches the subject in his standard work *Culture, Health and Illness* (whose original edition was published in 1984 and the fifth edition in 2007) it is instead from the perspective of medical anthropology. In this book, Helman, a professor of medical anthropology who has taught at several medical schools in the United Kingdom and the United States and whose book is used in more than 40 countries, provides a detailed exposition of the cultural and social determinants that affect our understanding and experience of health and illness. Helman emphasises that medical anthropology is found in the overlap between the social and natural sciences.⁴² In other words, we are dealing with a view of culture here as a semogenic system. This meaning is generally the most common in English-language literature in the field; culture in the first sense is instead designated ‘the arts’. I hope it is clear why the two perspectives exemplified by these two books are not competing, but rather complementary. The distinctive – and perhaps inevitable – aspect of how Culture and Health has developed in Sweden is that there is an explicit ambition to bring together research on Culture and Health across traditional disciplinary lines, which therefore encompasses both of these conceptualisations of culture.

This gives me reason to turn to the research within Culture and Health that has been conducted at the University of Gothenburg. Anyone who has followed developments in the field will not be sur-

prised that music and health is a frequently recurring subject of research. We get the sense that the role of music in our well-being is significant even before the area was studied by scholars from various disciplines. Researchers from at least three different faculties at the University of Gothenburg have examined this role from various aspects. Björn Vickhoff, Michael Nilsson and other researchers have written about the ‘goose bump’ effect from a neurobiological perspective in their article ‘Musical Piloerection’.⁴³ The article is not limited to the goose bump effect – that I may get goose bumps from certain music that moves me in a particular way – but also how it is possible to use music to reduce stress in a way that can be measured physiologically. Thus, it is not a matter of a particular type of music, but simply music that is personally chosen and which may trigger personal memories. In 2012, Marie Helsing defended her thesis *Everyday Music Listening*, in which she determines that from a psychological perspective, everyday music listening can be an easy and effective way to positively affect health and well-being through its capacity to arouse positive emotions and thus reduce stress.⁴⁴ Finally, musicologists Thomas Bossius and Lars Lilliestam published their book *Musiken och jag: Rapport från forskningsprojektet Musik i människors liv* [Music and me: Reports from the research project ‘Music in People’s Lives’], which, based on in-depth interviews with people aged 20–95 living in and near Gothenburg, investigates what these people do with music and what music means to them. A perhaps not wholly unexpected result is that music plays a great part in people’s lives; more specifically, they argue that music – and here they refer to ‘musicking’ – thus all aspects of music from practise to listening and CD/album collecting – ‘not only contributes to physical and psychological health, but is also important to existential health’ in the people they interviewed.⁴⁵

Here we are thus moving from the physiological and across the psychological to the existential, which captures several aspects of human health. Naturally, these research results generate many questions; among else, we can consider how the various dimensions of the effects of music listening are connected, from the physiolog-

ical and across the psychological to the existential. We can also ask whether the physiological effects of music listening may have significant effects on health as the absence of disease or whether it is actually and specifically well-being that increases – which may naturally have positive consequences for an individual’s disease condition, but which is also legitimate even if it does not. Finally, we would most likely be eager to know whether it is possible to operationalise these insights into some form of music therapy. But the examples illustrate – I hope – that a great deal of knowledge can be mined specifically by researching similar problems from a variety of aspects. I would argue that this is one of the possible success factors for a field like Culture and Health – that is, the successful linkage of insights gained in various disciplines – as, in this case, medicine, psychology and musicology. As I mentioned above apropos the early research initiatives taken in Sweden, multidisciplinarianism has been a defining characteristic of the field from the outset. The challenge for the future is to bring the diverse research projects even closer together. If we accept that various aspects of the concepts of culture and health are dependent upon each other, this seems a virtual necessity in order to produce the most insightful and practically useful research results possible. If each individual research project clearly understands how the specific project uses the concepts, the ambiguity itself is not a serious problem.

Another way to manage the conceptual ambiguity is to show how different disciplines use these terms. At the Centre for Culture and Health, we have chosen to align with English-language designations for research fields that have to do with culture and health – an overview of the two of these that we feel most clearly correspond to what we call Culture and Health in Sweden can be read in the two following chapters by Gunilla Priebe and Morten Sager and by Katarina Bernhardsson. ‘Culture and Health’ is a designation which, although not entirely unknown, is at least not as fully accepted in countries other than Sweden. But that does not mean that the thing itself does not exist under another name. In order to link to the international (or at least the English-language)

designations for these areas, but also to show how it is possible to conduct research in Culture and Health, despite the wide distribution of fields, we have chosen to talk about four focus areas: Arts and Health, Medical Humanities, Global Health and Conceptual Health Studies.

Arts and Health refers to Culture and Health from the medical and scientific perspective. The primary concern of this area is the rehabilitative effects of experiencing art and practising art. The questions asked concern whether cultural experiences such as music, dance, or the visual arts can stimulate the rehabilitation of patients. Researchers are investigating whether this process can be observed and measured, but also practised in health care.

Medical Humanities covers the views of the humanities and social sciences on health and illness, doctors and patients, hospitals and medicine, as cultural phenomena. Research questions within Medical Humanities include how disease diagnoses affect people's personal identity, how patient charts constitute a literary genre, the view of the body that imbues medicine and how the understanding of what it means to be in good health or how the language used to talk about health has emerged over history.

Global Health discusses the impact determinants such as gender, ethnicity, religion, class or geographical home may have on health issues. Global Health asks how health is distributed, globally or locally, and how everyone can gain equal access to health care. Researchers working with Global Health are found in a wide variety of disciplines, from medicine to the social science to the humanities and economics. A field called 'medical anthropology', which studies the role of medicine in human existence, is particularly noteworthy.

Finally, Conceptual Health Studies asks the critical question of what we mean by health and illness and how health arises in the interface among personal experience, biological symptoms and cultural representations. The area encompasses disciplines such as philosophy, theology, sociology and artistic research. Internationally, we often find these conceptual studies within the medical humanities.⁴⁶

These four focus areas should not be regarded as exhaustive or mutually exclusive. They are simply one way to categorise the comprehensive field we call Culture and Health, which serves its function if it facilitates understanding of both what is included in Culture and Health and how researchers can work with Culture and Health in various disciplines. Naturally, there are often overlaps, between Arts and Health and Medical Humanities, for example, but this is not either an especially serious problem as long as the focus areas are not understood as territories whose boundaries must be maintained. When it comes to the fourth focus area, Conceptual Health Studies, it is hardly the case that this is an established designation internationally; the thing itself is rather to be found under Medical Humanities. We have nevertheless chosen to emphasise this as a special focus area in order to clarify the importance of these particular types of questions. Likewise, one can argue that the questions Global Health formulates are found, or at least should be found, in the other focus areas. We have therefore chosen in this book to focus on Arts and Health and Medical Humanities. For those who are working in Culture and Health, we imagine that it is important to be aware of these focus areas and the resources they offer, for the sake of continued research in Culture and Health in Sweden as well as for how Culture and Health is practised in purely concrete terms in the public health care system.

Naturally, there are other research centres that categorise these areas in different ways. One of the research centres I have encountered that most closely resembles the Centre for Culture and Health is the Kokoro Research Center at Kyoto University in Japan.⁴⁷ The Kokoro Research Center has three focus areas: one that is more humanities-oriented, ‘Consciousness, Values, and Life,’ one psychological, ‘Emotion, Communication, and Interaction’ and one neurophysiological, ‘Mind, Brain, and Body.’ Kokoro translates roughly to ‘heart’ (but not in the biological sense) and represents a holistic view of humanity. The Kokoro Research Center seeks to take advantage of disciplines such as neurophysiology, psychology and

the humanities to study the intersection between the biomedical, psychosocial and existential aspects of human health. Here as well, the Centre for Culture and Health emphasises a multidimensional perspective on human health.

But does it not seem that Culture and Health might continue to be many different things in future? This is entirely true and I believe it is both unavoidable and important that it is allowed to be so. If we return to the Swedish Research Council's brochure *Forskning om kultur & hälsa* [Research on Culture & Health], which presents the nine projects that have been awarded funding through the government's special initiative, the research perspectives are global studies, history, medicine, psychology, social work and sociology. The diversity has thus existed from the outset, and for good reason. Firstly, as said, different projects can mutually illuminate each other's blind spots and theoretical shortcomings and, secondly, it is also highly significant to practical applicability that our human existence is studied in all of its multidimensionality and not only from a single aspect. A brief example may serve to conclude this section and show how complex issues of Culture and Health can be: if neurological examinations can show (which they seem to do) that music can have positive physiological effects in the form of stress reduction, this does not immediately tell us how these insights should be applied (insights that the research in the area was seeking from the beginning). Music therapy is the field that has traditionally engaged in research on the application of musical expression to promote health.⁴⁸ But insights on the accessibility of music and the cultural, social and political conditions that affect the role of music in people's lives may also be important. This is usually the musicologists' bailiwick and it may be of practical benefit in order to avoid elevating a particular type of music or form of music listening to the norm for the use of music in health care. Although the role of music in human existence is more or less universal (there are always exceptions), it remains a fact that the choice of music and use of music differs according to age, sex, social class, geographical home and ethnicity – not to mention personal taste. Addition-

al aspects could be added to my example, but the point should be clear: Culture and Health is and will remain a complex issue, precisely because people are complex beings. The research must reflect this. What is Culture and Health? It depends upon who you ask, and this is entirely as it should be: the challenge of the field is to bring together insights from many disciplines in order to achieve the best possible health care.

THE INTRINSIC VALUE OF CULTURE; THE INTRINSIC VALUE OF HEALTH

One of the questions I asked in the introduction was about the nature of the relationship between the intrinsic value of health and its use in times of trouble. There are fears that the entire Culture and Health project might entail an instrumentalisation of culture, or in other words, that value will be ascribed to artistic or intellectual works only to the extent they can promote health. It would be facile to claim such fears are entirely groundless. Naturally, a form of culture consumption may arise that entirely discounts the intrinsic value of culture, but we must, to start with, separate the question of whether it is possible to observe, measure or argue about the health-promoting potential of culture from the matter of the intrinsic value of culture – if it is possible to determine that certain music may in certain cases have a stress-reducing effect, that does not necessarily mean the same music cannot be valued in other ways. Music can fill many different functions in people’s lives, from stress reduction to entertainment, from critically scrutinising to the expression of spiritual devotion. That some of these functions might affect our health in one way or another does not mean that the other functions fall away. Or perhaps they do fall way from the point of view that a particular research project is studying music, but this methodical reduction will be regarded as final only if the specific research project’s viewpoint is confused with how we view life as a whole. That culture can play a role in our lives does

not mean that there is one, and only one, role that its various expressions can play.

Let us return to my introductory example of culture by prescription in a 13th century pharmacopeia: How can music and literature be remedies for unrequited love? One reason for this is likely that music and literature have been significant to the patient even before he or she sought treatment for lovesickness. We can presume that neither music nor literature would be a particularly effective remedy if the patient had never before come into contact with either one. That music and literature should be able to affect our health is therefore dependent upon the role they already play in our lives. In other words, the prerequisite for ‘culture by prescription’ to work is that there must also be culture *before* prescription, so to speak, which Fredrik Ullén’s research project on Humans Making Music is studying. This does not necessarily mean that only music with which we are familiar might have this function, but it probably means that we must already have an existential relationship to music for it to have any form of stress-relieving or rehabilitative function. As musicologists Bossius and Lilliestam, whom I quoted above, argue, music is important to existential health, but because existential health has to do with our own self-reflexivity this, at least, does not involve any instrumentalisation of music. It is rather a way to ask why music matters in our lives at all.

It is also perfectly possible to ask whether the effects of culture on health are actually side effects. By that I mean simply that it might be that culture may certainly have an effect on health, but only if culture is practised for its own sake and not for the sake of health. If we make or listen to music for its own sake, it might have health effects as an unintended bonus, but if we make or listen to music for the sake of our health, doing so may become counter-productive. I do not know whether this is actually the case, but I hope the argument illustrates my point: that the role of music in our lives, like that of other forms of cultural expression, is both multi-dimensional and complex. Just as it would therefore be a mistake to ignore the intrinsic value of culture through an instrumentali-

sation of the same in the service of health, it is probably also a mistake to interpret the intrinsic value of culture so that appears to be a failure if it does in fact have health-related effects. In the example of the 13th century pharmacopeia, it is perfectly clear that music and literature are relevant to the illness in question. Setting aside the fact that unrequited love might not be the focus of contemporary work in Culture and Health, the argument still applies, *mutatis mutandis*, for our conditions as well. The historical distance between the 1200s and our time puts the changed role of culture in relief, where the relevance of culture – or perhaps more specifically, the arts – is other than it was in the past; the fundamental premise of the Culture and Health project is, however, an understanding of relevance that is broader than mere instrumentalisation or intrinsic value without consequences. We can find yet another illustration of the complexity of the relationship between culture and health by comparing it to the distinction between food as sustenance and food as a meal (and thus social fellowship): even though the importance of eating nutritious food to promote health is of course easily understood, something priceless and ineffable would be lost if we were to replace food with a pill.

The matter of the intrinsic value of culture in relation to health, however, points to another question that is perhaps asked less often, that of Sartre I mentioned above concerning what is the point of health. In our time, the intrinsic value of health is usually considered self-evident. In a study of beliefs and values in Sweden in the 1990s, researchers found that health is one of the most important values in life among Swedes today.⁴⁹ Medicine and technology combined as a component of our modern ambitions to create happier human beings and a happier civilisation have resulted in physical health becoming a vital aspect of the meaning of life, far more important than, for example, economic fairness, self-realisation or faith in God, to the average Swede, if one can rely on the aforementioned study. In brief, this means that health as the absence of disease has come to be synonymous with health as well-being, as in the saying ‘at least I have my health!’ The risk of such an identifi-

cation, however, is that it becomes difficult to argue that one can be healthy even though one has so many ailments, or that the multidimensionality of health will be lost. It is likely that these effects are partially due to that good health until well into old age is possible – at least in Sweden – in a way that was not possible in the past, but also partly because medical science has increasingly claimed the right to interpret not only what is healthy and what is diseased, but also human identity as such. As philosopher Fredrik Svenaeus points out, medical diagnoses have become deliverers of human identity – we identify with our diagnoses in a way that we previously identified with moral or religious identities.⁵⁰ Health has, in other words, become an intrinsic value. We also see this in that the question of whether culture can contribute to health is more common than the opposite, that is, whether health can contribute to culture – but perhaps that is why it is a good idea to keep in shape, since that makes it possible to sing better in a choir or paint more pictures or read more arts reviews?

Exaggerated and one-sided obsession with our own health bears its own risks, however. To return to Karin Johannisson, she has noted that health in our time has become a ‘projection screen for dreams of success, happiness and pleasure as well as an instrument for making these dreams come true.’⁵¹ This is true for the entire 20th century. Although the context for health changed during the 20th century, the value of health has maintained its position, albeit with a somewhat different content. In his thesis, theologian Wilhelm Kardemark compared health magazines from the early 1900s to contemporary magazines.⁵² If the Swedish health magazines *Hälsövindar*, *Hälsökällan*, or *Hälsövänneren* from 1910 argued that people should stay healthy for the common good, the perspective of *Må bra* or *I form*, as the health magazines are called today, is that people should stay healthy for their own sakes. Health has become an individual project, rather than a collective one, and the health that is the subject of these magazines is both health as absence of disease and health as well-being. As Johannisson sees it, there are two problems with such an individualisation of

health: first, it tends to obscure the ‘relationship of the health message to political categories like sex, class, ethnicity, language and social exclusion’, and secondly the paradox in the ‘elitification’ of health: it is only when we mortify the flesh on the jogging trail that we have the right to call ourselves healthy.⁵³ At-risk groups are stigmatised and Johannisson presents a long list: ‘the obese, the unemployed, singles, smokers, and all abusers of food, alcohol, sex, gambling, time.’⁵⁴ One example is the supermarket cashier who is encouraged in the magazine *I form* to try Pilates and yoga to counteract the physical strain of her job, rather than demanding a better work environment.⁵⁵ Another is that some people develop an unhealthy obsession with exercise and health or with a ‘healthy diet’ to the point where it becomes a disorder sometimes called orthorexia.

If health has become one of the primary values in modern times, being ill is increasingly becoming abnormal, at least if measured based on our dreams about our health. The responsibility for health is put on the individual and people who are not in full health have some explaining to do, in other words. Naturally, there is such a responsibility, but it should be pointed that not being in the pink of health is part of life and if this is my only goal, sooner or later it is going to be hard to live up to. The ‘healthism’ that Johannisson talks about puts us at risk of becoming far too fixated on our own physical health and thus potential victims of various purveyors in the health market. But it also involves risk of obscuring the suffering and death that is the inevitable fate of all humanity. There are undeniably many answers to the question of what is the point of health, but what Sartre’s question brings to the fore is precisely whether health should be given the status of the ultimate value for human existence and what, in such case, the consequences of this will be. One of the grounds that make culture – again in the sense of artistic or intellectual works – relevant is that it has the capacity to ask questions about the meaning of life and to shed light on existential attitudes. There is probably yet another area where culture can be relevant here – that of challenging the understanding of and

fixation with health that characterises our own time – and thus contribute to better existential health.

The conclusion of this review of work with Culture and Health in Sweden as it is today and its significance is that Culture and Health can mean many things and that researchers must understand what they are doing themselves, without therefore losing sight of the larger context. I hope it has become clear that the relationship between culture and health is central to human existence in many ways and that this is, in a way, an insight that is not particularly new, but rather one that can be found as far back in history as a 13th century pharmacopeia – and even earlier.

The following chapters of this book contain a more detailed presentation of research in Culture and Health in our time, which will serve to further clarify what Culture and Health may entail in research and practice.

NOTES

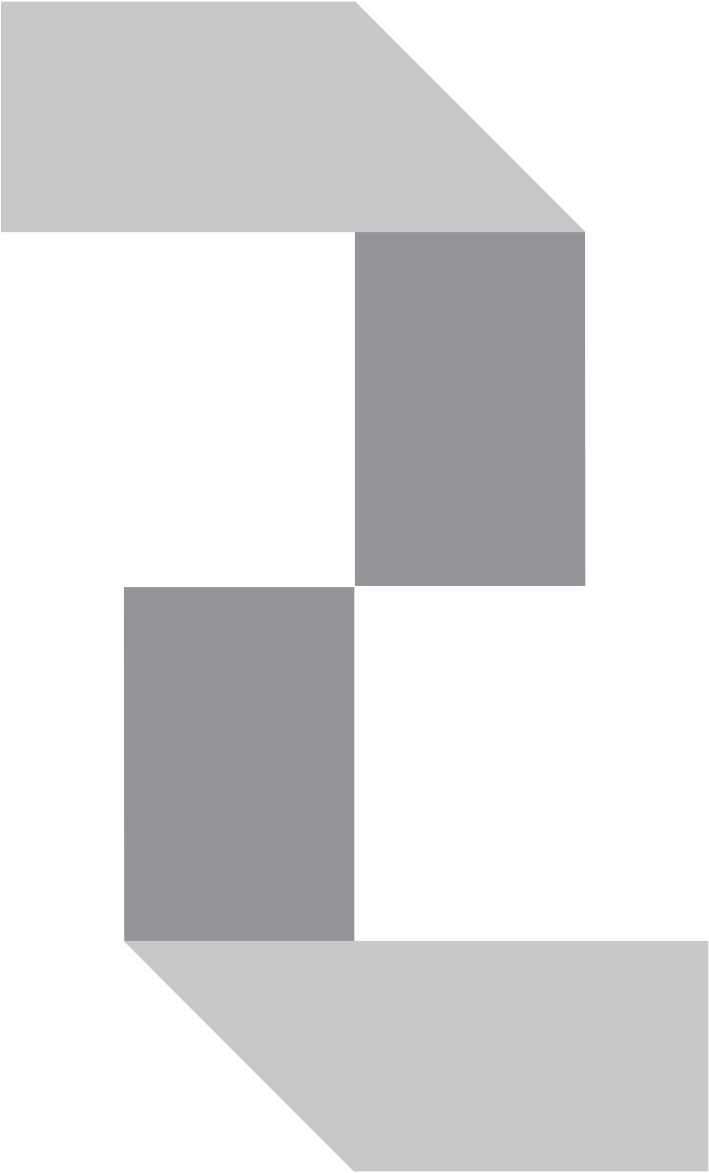
1. The example is taken from Gerhard Eis, *Vom Werden altdeutscher Dichtung: Literarhistorische Proportionen*, Berlin: Erich Schmidt Verlag, 1962, p. 80 f. See also all of chapter five, ‘Spielmann und Buch als Helfer in schweren Stunden’, for more examples and their historical contexts. Thanks to Martin Hellström for the reference.
2. Das Breslauer Arzneibuch: R. 291 der Stadtbibliothek, C. Rulz and E. Rulz-Trosse (eds.), Dresden: Friedrich Marschner, 1908, p. 34.
3. Immanuel Kant, *Critique of the Power of Judgement*, Paul Guyer (ed.), Cambridge: Cambridge University Press, 2002, §2.
4. Ernst Robert Curtius, *Europäische Literatur und lateinisches Mittelalter*, eleventh edition, Tübingen/Basel: Francke Verlag, 1993, pp. 71–88, 471 f.
5. Regina Winzer (ed.), *Kultur för hälsa: En exempelsamling från forskning och praktik*, Public Health Agency of Sweden 2005: 23. Stockholm: Public Health Agency of Sweden, 2005. Accessible at <http://www.folkhalsomyndigheten.se/pagefiles/12082/1200523kulturforhalsa0510.pdf>. This website and all websites mentioned in the following were last accessed 10 February 2014.

6. *Kultur för hälsa*, p. 6.
7. Ragnhild Romanus (ed.), *Forskning om kultur & hälsa*, Stockholm: -Swedish Research Council, 2010, p. 4. Accessible at <http://www.vr.se/download/18.4ab1c26512c1e91c6c080001560/1289577788625/Broschyr+Kultur+o+Hälsa.pdf>.
8. *Forskning om kultur & hälsa*, p. 5.
9. See <http://www.musicerandemanniskan.se>.
10. See <http://www.kulturradet.se/sv/verksamhet/Kultur-och-halsa/>.
11. See *Kultur för äldre: En inspirationsskrift*, Swedish Arts Council publication series 2012:5. Available for download from http://www.kulturradet.se/Documents/publikationer/2012/kultur_aldre_low.pdf.
12. See <http://www.kulturradet.se/sv/verksamhet/kultur-och-halsa/riksdagens-kultur--och-halsagrupp/>.
13. See http://www.skane.se/sv/Webbplatser/Kultur-Skane-samlingsnod/Kultur_Skane/Kultur_i_varden/.
14. The report *Kultur på recept: Rapport från pilotprojektet Kultur på recept* (2011) is Accessible at http://www.skane.se/Upload/VardHalsa/Hälsoochsjukvårdsavd/Sjukskrivningsprojektet/kultur_pa_recept.pdf.
15. Kerstin Wallin, *Kultur och hälsa: Upptaktsseminarium 18 April 2007*, Anders Franck (ed.), Gothenburg: University of Gothenburg, 2007.
16. *Kultur och hälsa*, pp. 10, 33.
17. Gunnar Bjursell and Lotta Vahlne Westerhäll (eds.), *Kulturen och hälsan: Essäer om sambandet mellan kulturens yttringar och hälsans tillstånd*, Stockholm: Santérus förlag, 2008.
18. Bengt Göransson, 'Inledning', *Kulturen och hälsan*, p. 14. See *Kulturen och hälsan* in the following note, p. 12.
19. Kerstin Wallin, *Kulturen och hälsan*: Symposium 10 November 2008, Gunnar Bjursell and Lotta Vahlne Westerhäll (eds.). Gothenburg: Centre for Culture and Health, University of Gothenburg, 2008.
20. For more information about these, see www.ckh.gu/forskning and then click through to the individual research projects.
21. See Björn Vickhoff, et al., 'Musical Piloerection', *Music and Medicine*, 2012, pp. 82–89 and idem, 'Music structure determines heart rate variability of singers', *Frontiers in Psychology*, 4 (2013), pp. 1–16.
22. Sören Holmberg and Lennart Weibull, 'Kultur befrämjar hälsa', *I framtidens skugga*, Lennart Weibull, Henrik Oscarsson & Annika Bergström (eds.), University of Gothenburg, SOM Institute, 2012, p. 369.

23. <http://www.gpcc.gu.se>.
24. See e.g. Inger Ekman (ed.), *Personcentrering i hälso- och sjukvård*, Stockholm: Liber, 2014.
25. Christina Doctare, 'Nämndes ordet kultur handlade det om bakterier, aldrig om människor och värdegrund', *Kulturen och hälsan*, pp. 61–74.
26. Terry Eagleton, *The Idea of Culture*, Blackwell Manifestos, Oxford: Blackwells, 2000, p. 1 f.
27. I use the term 'work' in a very broad sense to refer to artefacts, practices and phenomena. The distinction between 'artistic' and 'intellectual' is also pragmatic, intended to emphasise that things such as philosophy, literary studies and theology are also classified as culture, and not only novels, music and dance. But if someone were to point out that 'art' can also be 'intellectual' and 'intellectual works' produced in an artistic manner and that the distinction is therefore problematic, I would immediately agree.
28. See Lars Lilliestam, *Musikliv: Vad människor gör med musik - och musik med människor*, second edition, Gothenburg: Bo Ejeby förlag, 2009, p. 24.
29. Björn Vickhoff, et al, 'Musical Piloerection', *Music and Medicine*, 2012, pp. 82–89.
30. It seems a tad ironic, however, that the not entirely obvious distinction between culture and sport has not been problematised more from the Culture and Health research community considering the well-developed work that already exists related to 'physical activity by prescription.' See <http://www.fyss.se> on 'physical activity in disease prevention and disease treatment.'
31. Yukiko Uchida and Shinobu Kitayama, 'Happiness and Unhappiness in East and West: Themes and Variations', *Emotion*, 9:4 (2009), pp. 441–456.
32. See e.g. Emiko Ohnuki-Tierney, *Illness and Culture in Contemporary Japan: An Anthropological View*, Cambridge: Cambridge University Press, 1984.
33. See Margaret Lock and Vinh-Kim Nguyen, *An Anthropology of Biomedicine*, Malden, MA/Oxford: Wiley-Blackwell, 2010.
34. For a detailed discussion of these, see Jennie Medin and Kristina Alexanderson, *Begreppen hälsa och hälsofrämjande – en litteraturstudie*, Lund: Studentlitteratur, 2000.

35. For a further examination of these linkages, see my chapter 'Vill du bli frisk? Om relationen mellan fysisk, psykisk och existentiell hälsa', in *Kulturen och hälsan*, 2008, pp. 189–218.
36. Hans-Georg Gadamer, *The Enigma of Health: The Art of Healing in a Scientific Age*, transl. Jason Gaiger and Nicholas Walker, Cambridge/Malden, MA: Polity, 1996, p. 113.
37. Havi Carel, *Illness*, Stocksfield: Acumen, 2008, p. 73. For additional perspectives on the concepts of health and illness, see Lennart Nordenfelt, *Samtal om hälsan: En dialog om hälsans natur*, Stockholm: Almqvist & Wiksell Medicin/Liber, 1996, and Fredrik Svenaeus, *Sjukdomens mening: Det medicinska mötets fenomenologi och hermeneutik*, Stockholm: Natur och Kultur, 2003.
38. Cecilia Melder has described this aspect of health in her thesis *Vilsenhetens Epidemiologi: En religionspsykologisk studie i existentiell hälsa* [The epidemiology of lost meaning. A study in psychology of religion and existential public health in a Swedish context], Acta Universitatis Upsaliensis, Psychologia et sociologia religionum, Uppsala: Uppsala University Press, 2011. Melder prefers, however, to translate 'spiritual health' as 'existential health' while I prefer to reserve the use of 'existential health' to refer to another dimension of human health.
39. Charles Taylor, *A Secular Age*, Cambridge, MA/London: Belknap, 2007, p. 501.
40. I have not been able to confirm the quotation, but even if it is apocryphal, it illustrates my point. Thanks to Ingrid Elam for the suggestion.
41. Eva Bojner Horwitz, *Kultur för hälsans skull*, Stockholm: Gothia förlag, 2011, p. 7.
42. Cecil G. Helman, *Culture, Health and Illness*, fifth edition, Boca Raton, FL: CRC Press, 2007, p. 7.
43. Björn Vickhoff, et al, 'Musical Piloerection', *Music and Medicine*, 4:2 (2012), pp. 82–89.
44. Marie Helsing, *Everyday Music Listening: The Importance of Individual and Situational Factors for Musical Emotions and Stress Reduction*, Gothenburg: University of Gothenburg, diss., 2012.
45. Thomas Bossius and Lars Lilliestam, *Musiken och jag: Rapport från forskningsprojektet Musik i människors liv*, Gothenburg: Bo Ejeby förlag, 2011, p. 299.

46. See also Wilhelm Kardemark and Ola Sigurdson, *Medicinsk humaniora vid Humanistiska fakulteten, Göteborgs universitet: En rapport*, Gothenburg, Faculty of the Humanities, 2014. Accessible at <http://hdl.handle.net/2077/35509>.
47. See <http://kokoro.kyoto-u.ac.jp/en/AboutUs/greetings.html>.
48. In this connection, Ingrid Hammarlund, formerly with the Royal College of Music in Stockholm, is a prominent figure in Sweden. See also Anci Sandell, *Musik för kropp och själ: Modell för interaktiv musikterapi [Music for Body and Soul – Model for Interactive Music Therapy]*, Gothenburg: Nordic School of Public Health, diss. 2013.
49. Kjell Kallenberg, Carl Reinhold Bråkenhielm and Gerry Larsson, *Tro och värderingar i 90-talets Sverige: Om samspelet livsåskådning, moral och hälsa*, Örebro: Libris, 1996, pp. 87–99, 135–138.
50. Fredrik Svenaeus, *Homo Patologicus: Medicinska diagnoser i vår tid*, Stockholm: Tankekraft, 2013.
51. Karin Johannisson, 'Kultur och hälsa: Två besvärliga begrepp', *Kulturen och hälsan*, p. 18.
52. Wilhelm Kardemark, *När livet tar rätt form. Om människosyn, genus och hälsa i svenska hälsotidskrifter [When life gets the right shape: On anthropology in Swedish health magazines, 1910-13 and 2009]*, Gothenburg: University of Gothenburg, diss. 2012.
53. Johannisson, *Kultur och hälsa*, p. 18.
54. Johannisson, *Kultur och hälsa*, p. 20.
55. Example taken from *I form*, issue 18 (2009), p. 24; Kardemark, *När livet tar rätt form*, p. 171.





ARTS AND HEALTH

Gunilla Priebe and Morten Sager

THE FIELD OF ARTS AND HEALTH is part of the broader field of Culture and Health. The orientation of the field is practical and methodological and it translates and examines the idea that the arts can have a healing effect and promote well-being. ‘The arts’ is understood here in the plural and the designation therefore includes not only the visual arts, but other aesthetic forms such as music, drama, dance, literature, theatre, architecture and sculpture. In the literature, Arts and Health is consistently described as multifaceted in terms of the research disciplines, practical programmes and concrete activities that are included, as well as their aims and focus. What unites the varied programmes and activities is the interest in the significance of the arts to health and well-being.¹ This chapter is an analytical introduction to the Arts and Health field and is not an exhaustive or systematic overview. The hope is that the chapter will engage and intrigue and lead the reader to explore further, for example via the extensive reference list. We also present a few concepts that can create understanding for the field – beyond the isolated examples that we discuss.

The chapter is divided into three sections, which gradually elevate the analytical level. In the first, ‘The arts as health-promoting link between body and mind’, we present examples of how people in the Arts and Health field justify their activities, because

these seem to embrace a similar fundamental view on art as remedy vis-à-vis the biomedical division of human beings into body and mind. The health-promoting effect of the arts is thus the focus of attention, but precisely what kind of projects this results in varies. In the second section of the chapter, 'From spiritual inspiration to measurable health outcomes', we present a model, the Arts and Health Diamond, which illustrates the various aims in relation to which Arts and Health projects are usually designed. This illustrates how the field encompasses projects that mainly focus on individuals or social interaction within and between groups, that certain projects take health-promoting potential as their point of departure, while others work as a complement to the traditional healing approaches of medicine.² The chapter ends with the section 'Arts and Health between science and society', in which we analyse a few fundamental questions about the nature of science, art and social benefit. Arts and Health may be seen as incorporated in a multifaceted 'boundary project' in which the boundaries of good science and art are negotiated. This boundary project has bearing far beyond the field of Arts and Health.

THE ARTS AS HEALTH-PROMOTING LINK BETWEEN BODY AND MIND

As a field of research and policy, Arts and Health is only a couple of decades old, which is illustrated among else by the fact that the first scholarly journal with this specific focus – *Arts & Health* – was started as late as 2009.³ Additional journals have arrived since 2009, such as the *Journal of Applied Arts and Health*. The notion that the arts promote well-being and fulfil basic human needs is, however, not a new idea. A specific argument that enthusiasts in the Arts and Health field usually use when explaining its relevance is that the biomedical understanding of health and illness is too narrow and therefore must be augmented with other perspectives. Health can be said to encompass physical, mental, in-

tellectual, emotional, social and spiritual aspects (see Ola Sigurdson's introduction on various definitions of health), but the biomedical understanding of health and illness takes only some of these into account.⁴

The biomedical model is often described (including outside the Arts and Health field) as based upon notions that the mental and the existential can be separated from the somatic and that complex phenomena can be explained on the basis of isolated variables.⁵ One philosopher usually ascribed such an idea is René Descartes (1596–1650). He explained the human being as composed of two main components – the body and the mind, the intellectual consciousness.⁶ In this dualist view, ‘consciousness is a non-physical or thinking substance (*res cogitans*) while the body is a physical substance extended in space (*res extensa*).’⁷ Interaction between the two components is thought possible, but they are understood and described as separate and radically different by nature. Based on such a notion, it makes logical sense for modern biomedicine to focus solely on *res extensa* (the body) while concern for *res cogitans* (the mental and existential) or interaction between the two is passed to other institutions.

The biomedical model is usually also described as methodologically reductionist, wherein larger phenomena are separated into smaller components so that each can be studied on its own.⁸ A fundamental idea in this model is that human beings are best understood (and medically treated) by first separating the physical from the spiritual and mental and then progressively zooming in so that smaller and smaller organic parts are brought into focus: from the entire physical body to the organ to the cells to the functions of a cell, and so on.

The consequence of this Cartesian dualism and methodological reductionism is that the human being is reduced to ‘a physical body, composed of separate body parts’ and that disease is defined as a ‘deviations from the norm of measureable biological (somatic) variables’, that is, human being’s physical health is regarded as separate from social, psychological and behavioural

factors.⁹ The figure below illustrates how a thought process that aligns with this model may appear.

The point of departure for the human being ('Systems Hierarchy', left-hand column) is the greater context – that labelled 'Community' and 'Family' at the top of the left-hand column. As the person is fit into the biomedical worldview, the person is reduced gradually to a molecule (follow the labels in the figure, from Community to Molecule).

An alternative narrative of the person's (the patient's) medical journey is provided in the right-hand column. It describes how the patient's 'whole' collides with the reductionist and dualist interpretation by medical resources of the patient's symptoms (biological and mental/existential separately).

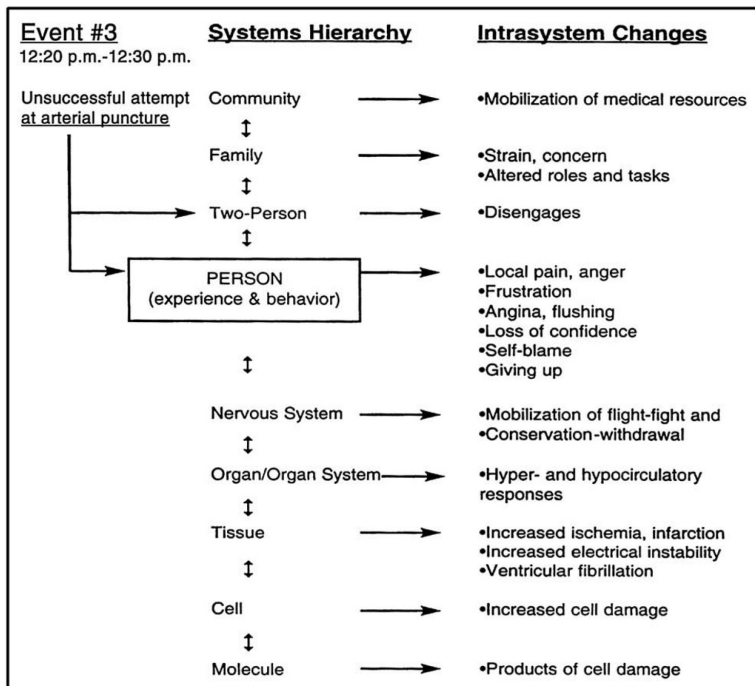


FIGURE 1. Model of reductionist (atomistic) thinking in biomedicine.¹⁰

The right-hand column in the figure illustrates a man's arrival in the emergency room, where medical resources are mobilised to manage his heart attack. It shows how the care setting simultaneously changes the definition of the man's life: from that moment on, the focus is on biological processes, which are given biological explanations.

In the middle of the right-hand column, however, the author has made notes of 'Loss of confidence', 'Self-blame' and 'Giving up'. In so doing, he wants to illustrate that the patient's physical reactions did not have only biological consequences. The author argues that the patient's condition deteriorated (ventricular fibrillation had set in) after his arrival in the emergency room because he got angry at the doctor's inadequate skills and because he felt abandoned and hopeless when the doctor left to get assistance from his superior. These psychosocial processes were not, however, perceived by doctors. Their picture of the course of events is described otherwise: they congratulate the patient for not having gone into fibrillation until he was in the emergency department; that is, their interpretation completely excluded possible psychological or social aspects because they, in keeping with the biomedical approach – regarded the biological body as an isolated system.¹¹

This critical discussion recurs in the Arts and Health field: a critique that argues that important aspects of the person, of illness and recovery processes, are overlooked as a consequence of biomedical reductionism and dualism. The example above illustrates that one effect this is considered to have is that medical professionals interpret patients from a one-dimensional and naturalistic angle. The patient is seen only as a physiological body rather than understanding body, mental perceptions and social experiences as an integrated whole. The outcome of the one-dimensional biomedical paradigm is that the principal task of medical professionals becomes to identify and treat dysfunctional body parts; critics claim that the art of medicine and the ability to care for patients as individuals has 'been lost in a

morass of expensive high-technology investigation and treatment.¹²

The division of body and mind is, however, reflected not only in how patients are treated personally and medically, but also in the technologies, architecture, economics and organisation of health care practice – something that has even been described as a quality-of-care crisis.¹³ Despite the success of biomedicine in many other respects, practitioners, patients and other commentators sometimes express disappointment about the lack of a holistic view, which the critics argue leads to fragmented assessments and shortcomings in how people are treated personally and medically in the health care system. However, neither the problem itself nor awareness of the same is new. In a famous talk given in 1927, for example, American physician and scholar Dr Francis Peabody described how older practitioners complained that young graduates were ‘scientific and knew a great deal about the mechanism of disease, but very little about the practice of the art of medicine or how to take care of patients.’¹⁴

As this criticism is not new, several attempts have been made to augment the biomedical model. Attempts have been made to develop biopsychosocial mind models. Others are currently trying to develop more patient-centred mind and methodological models, among else based on alternative understandings of the essence of health and illness (as discussed in the first chapter).¹⁵ The health theme in the health care system is also given greater scope, among else through emphasising preventive and health-promoting work – work that is based on models that include an individual’s entire life situation as well as institutional and structural determinants.¹⁶

The common denominator of these ‘solutions’ is the attempt to bridge the very real gaps between the various aspects of life to which the thought constructions of dualism and reductionism lead. For example: when the specialised and technified care setting separates individuals from their everyday lives, loved ones, home environment and control over their own bodies, they are

removed from part of that which makes life meaningful. The argument from the Arts and Health field thus becomes: the arts can bridge the gap between the whole, the personal, the familiar and the foreign because the arts are a platform and catalyst of empowerment and meaningfulness.¹⁷ The shaping of the Arts and Health field may therefore be considered part of a movement that is striving towards a holistic view because it can be argued that the arts can function as a remedy to alleviate the effects of fragmentation and alienation.

Against this backdrop, scholarly studies of connections between experiences of art and health may seem an anomaly, because such studies always work with demarcations, precise problem statements and questions. Neuroscience, for example, focuses on certain specific aspects of human life, while public health science concentrates on other aspects.¹⁸ It is, however, not reductionism in and of itself that the Arts and Health field objects to, but that the next step – the step in which facts about the specific must be reconveyed to their greater context – is usually omitted. Scholarly studies, which thus – to various extents – are always methodologically reductionist, may therefore be used to prove the significance of the arts and culture to health, but the parts studied in isolation must also be – at some stage – reincorporated in a context.

THE ARTS AS CREATIVE COMPLEMENT TO TRADITIONAL HEALTH SERVICES

Emotions are expressed, places are idealised, the mind inspired, thoughts provoked, ideas challenged, new worldviews presented ... yes, many things happen in art. Through this, all art contributes indirectly to health and well-being.¹⁹ One consequence of striving for a holistic view is that the Arts and Health field encompasses projects with widely divergent methods, aims and principals. As we begin to provide examples of what kind of practical

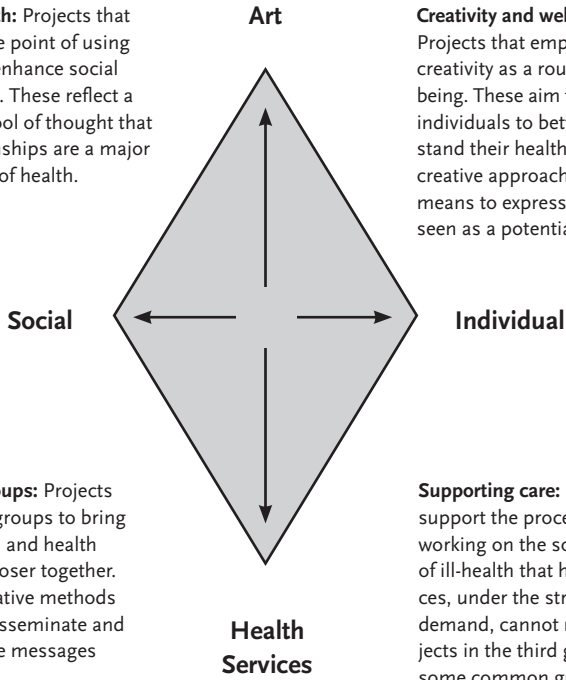
projects may be included in the Arts and Health field (in Sweden and abroad), however, we see that they are dominated by this logic: from the arts to health. Projects coming from the other direction – from the health sector to the arts, aimed at enriching the arts – do occur, but are not particularly common. An example of such a project is the one in which an artists' collective in north-east England arranged drop-in art workshops, prioritising people with mental health needs, in exchange for subsidised rent. The sessions not only generated income, the artists also reported that the project had been creatively enriching.²⁰

Generally speaking, however, focus seems to be on the therapeutic effect of the arts, both because the projects generally presume that exposure to art promotes individual and collective well-being and because they systematically study or use the arts in concrete therapeutic settings.²¹ The literature presents various models and figures where the field is summarised and we have chosen to do this below with the 'Arts and Health Diamond'.²² The model illustrates how the field is characterised by four key dimensions: the arts vis-à-vis health services and the individual or social/institutional focus.

The figure illustrates (1) that certain projects are primarily oriented towards individuals, while others are oriented towards groups or populations and that (2), certain projects work with art on its own, as method and means, while in other projects art is used as a complement to traditional medicine in health care settings.

The upper right-hand corner of the figure and the heading 'Creativity and well-being' thus illustrate that certain projects are rooted in the therapeutic encounter between art and the individual. Examples of such projects are when art forms are used to help patients or clients communicate about their life situation. The communicative power of the arts may be enlisted to help individuals express themselves in the health care setting as part of a recovery or diagnostic process (compare with the Rorschach test, for example). Research methodology projects investigating whether the

Unity is health: Projects that start from the point of using creativity to enhance social relationships. These reflect a growing school of thought that good relationships are a major determinant of health.



Creativity and well-being: Projects that emphasise creativity as a route to well-being. These aim to work with individuals to better understand their health, using creative approaches as a means to expression. Art is seen as a potential therapy.

Engaging groups: Projects that engage groups to bring communities and health promotion closer together. They use creative methods to explore, disseminate and communicate messages about health.

Supporting care: Projects that support the process of care by working on the softer aspects of ill-health that health services, under the strain of heavy demand, cannot reach. Projects in the third group share some common ground, but aim to communicate with communities as a whole.

FIGURE 2. *The Arts and Health Diamond*²³

arts can be used to further develop conventional data collection methods, such as interviews, can also be placed in this category.

People who have undergone severe trauma may for instance find it difficult to put their experiences into words, regardless of whether in a therapy session or an in-depth interview. Poetry, drawing, theatre and musical expression have therefore been tried as means of expression.²⁴ Towards this aim, artists may work at hospitals, schools, community arts and cultural centres, prisons and various urban settings – sometimes working with doctors in a more systematic fashion, sometimes with a more informal and intuitive style with broadly stated aims for the promotion of health, aesthetics or social relationships.²⁵

The lower right hand corner clearly illustrates that pointed out in the foregoing: many projects in the Arts and Health field are aimed at complementing technically and biologically oriented medicine. One concrete example is the hospital exhibition *Ubuntu* in which professionals from the University of Gothenburg Centre for Person-centred Care (GPCC) partnered with members of staff of the Röhsska Museum of Art and Design to redesign a hospital ward at Östra Sjukhuset in Gothenburg. The word ‘ubuntu’ comes from the South African Bantu languages, but is sometimes also used as a concept when focus is on ‘people’s loyalty and relationships with each other’.²⁶ In this exhibition, ‘ubuntu’ was intended to emphasise reciprocity, which is a central tenet of the person-centred care philosophy: the professional is not the only expert in the care encounter; the patient also has an expertise that must be put to use. Interior decoration and design were used to explore this issue in part of the exhibition. In different rooms, furnished and lighted in various ways, 650 medical professionals at the hospital were afforded the opportunity to look at themselves, patients and the hospital setting in a new way. Dozens of mirrors were hung in one room, where visitors literally asked themselves ‘Who am I?’ In another room, hospital employees could write a brief explanation of why they had chosen a caring profession and then post their note on the wall and to read and ponder other people’s motivations. Yet another room experimented with lighting, aimed at giving hospital employees an opportunity to think about what a room can communicate to the person who is being cared for there. The overall aim of the exhibition was to provoke thought about what the patient/care worker encounter can be like when the patient is also regarded as a person with thoughts, feelings, experiences, memories, fears, skills and so on.²⁷

In summary: the right side of the figure illustrates that projects focused on individuals can both be aimed at complementing medical attempts to manage the disease condition and at using the creativity of the arts for health-promoting aims. The left side of the figure has the same logic: the lower corner illustrates

that some projects have a distinct social focus on an identified determinant of ill health, while the upper corner illustrates that group-oriented arts projects may also focus on health-promoting or more ‘intermediary’ (more indirect) health factors.

The upper left-hand corner: several Arts and Health projects are working to promote good relationships in a community or within and between groups. In scholarly terms, this refers to social and public health studies that have shown that social unity and a sense of context are of critical importance to health.²⁸ Such research findings were the basis for the development of the ‘Intergenerational Encounters between Young and Old’ project. The justification was that the arts can have emotional, social, mental and physical effects and that these combined can therefore promote older people’s cognitive or ‘mind/spirit’ development and give them a more ‘meaningful life.’²⁹ The project was part of the Swedish Arts Council’s *Kultur för äldre* [Culture for older people] initiative and was carried out in the city centre district of Gothenburg. There were about twenty sub-projects that included song and dance sessions with participants from a preschool and a senior housing facility, discussion groups made up of secondary school students and senior citizens and a theatrical production featuring both students and pensioners. Their overall aim was to use various forms of art to create and develop intergenerational encounters – that is, to promote unity.

The idea of linking the arts to therapeutic and health-promoting work (that is, in projects that can be placed in the upper or lower section of the diamond) was expressed by Tua Stenström, an administrator at the Swedish Arts Council, when she presented the Arts Council’s latest grant awards:

Research findings on the effect of the arts and culture on well-being already exist – now they need to be put into practice. It is important to support the development of methodology so that the arts will be able to meet health and social care on their terms’, says Tua Stenström.³⁰

The lower left-hand corner of the figure: One of the most common project forms in the Arts and Health field is gathered under the heading ‘Engaging groups’. These are projects that use the communicative power of the arts to reach large segments of the population with health information. The use of art as a non-verbal motivator and communicator of health information was established during World War II.³¹ Ever since, various forms of art, primarily the visual arts, have been used to communicate information about things like the value of using seat belts, the risks of smoking or the importance of hand hygiene during the flu season. In these cases, art can function as a pedagogical complement to written health information, based partly on the idea that pictures communicate something other than the written (factual) word and partly based on the idea that art-based information can reach groups with various forms of linguistic limitations.³²

NEGOTIATIONS ON THE RELATIONSHIP OF THE ARTS TO SCIENCE AND EVIDENCE

The idea of the positive and restorative effects of the arts is so well established that practical activities and targeted policy initiatives have preceded scientific research on concrete health outcomes. International state-of-the-art articles are thus dominated by reports on practical projects, politically initiated strategy documents and attempts to support the development of the field (networks, online portals, etc.) rather than presentations of research.³³ Nowadays, however, it is becoming increasingly difficult to justify interventions (from the economic and patient safety perspectives alike) that cannot demonstrate evidence. As a result, funding decisions (such as the Swedish Arts Council’s latest grant awards), policy documents and debate articles in scholarly journals are seeking more research that provides evidence that the arts have quantifiable effects on health.³⁴

The matter of the scientific basis of the Arts and Health field is thus a current topic in a kind of discussion sometimes called ‘scientific boundary work’. In such boundary work, various stakeholders are encompassed in a ‘work’ to determine where or how the boundary between science and non-science should be drawn. That this is considered important is related to questions of the philosophy of science, but also to economic, practical and administrative issues. From the perspective of the philosophy of science, for instance, questions may be asked about how a research study should be designed and executed so that it will yield reliable (scientific) knowledge about the health effects of exposure to art. In a more practical administrative form, the boundary work has to do with which social institutions are responsible for Arts and Health projects and what economic resources these can be allocated (research grants? resources allocated to the health sector?), or whether universities should include this theme in their teaching.³⁵

Boundary work narratives usually focus on four fundamental questions:

1. Which stakeholders are arguing about scientific legitimacy?
2. How do the stakeholders argue: What metaphors and what tone do they use?
3. What are the arguments about: What is the content of the arguments and what do the stakeholders reference to bolster their positions?
4. Why are the arguments being made: What view of knowledge and what values or resources are at stake?

Because the field of Arts and Health is so multifaceted, the answer to the question of which stakeholders are participating in the boundary work concerning the scientific status of the field can become very long. If, for example, we look at which scientific/scholarly disciplines are included in knowledge overviews, we see public health studies, sports science, theology, nurs-

ing, psychiatry and psychology, biomedical specialities (such as neuroscience and rheumatology), art history, education and more.³⁶ A similar picture develops if we focus on the journals *Arts & Health* and *Journal of Applied Arts and Health*. Both emphasise that their journals are open to a wide variety of scientific/scholarly disciplines, but that other perspectives – other than scientific/scholarly, that is – are also represented, such as policy and ‘best practice’ perspectives. This is justified by the complex relationship of interdependence between research, policy and practice: ‘The impetus for research sometimes comes from advances in practice which require systematic evaluation before they can be incorporated into the mainstream. On the other hand, research can itself stimulate new areas of practice and exploration. Without political leadership innovative developments in practice and research are difficult to sustain’.³⁷ Thus, scientific boundary work within Arts and Health is performed not only by researchers, but also by artists and health workers, politicians, the public and various patient advocacy organisations. An array of ideals, institutional and professional cultures, material conditions and incentives therefore come together when the relationship of the field to scientific legitimacy is to be negotiated.

One answer to the question of what metaphors and tone characterise arguments about scientific legitimacy (question two above) has already been given in the introduction to this chapter: the main metaphor is the conflict between Cartesian dualism and biomedical reductionism and biopsychosocial holism. The arguments have occasionally been made on an ideological level with polemic elements. This is not unusual in boundary work, as motivation (question four above) is often a matter of access to economic and institutional resources, as well as the privilege of defining what is valid and meaningful – both in society in general and, in this case, more specifically within health care practice and research. Thus, it is not *only* about money, but it is *also* about money. It also has to do with what kind of society we want, what

science and what art – that is, questions of a profoundly fundamental nature.

A study of scientific boundary work thus provides insight into how our time and culture understands scientific legitimacy, art and utility. The arguments of boundary work thus circulate around these three themes (question three above) as the Arts and Health field is defined and redefined by the various stakeholders: scientific legitimacy (What is good science and what is considered scientific fact?); art (Can or should the arts be scientifically defined?); and utilisation (Can or should the arts be defined in terms of social benefit?). The two latter themes can be distilled in a single question: Is it possible or desirable to scientifically measure the health benefits of exposure to art?

ARGUMENTS ON SCIENTIFIC LEGITIMACY

The scientific boundary disputes of past centuries were distinguished among else by the attempts of various stakeholders to assert their authority as reliable knowledge producers. When Gieryn describes the boundary disputes between science, engineering and religion in the Victorian Era, he describes how the proponents of science claimed that only science combined theory and empirical observation in such a way that objective and reliable knowledge was the outcome of these activities.³⁸ For example, it was argued that the engineers lacked theoretical reflections, while the Church lacked an empirical foundation for its claims to the truth.³⁹ One of the most important contemporary definitions of scientific credibility in healthcare is formulated by that referred to as the evidence movement. The emphasis here is not only on the combination of theory and empirical observation, but more specifically on the compilation of several controlled and comprehensive clinical (empirical) studies. Large, quantitative studies that investigate the efficacy of a treatment method, for instance, are contrasted with the indi-

vidual observations of health professionals – or in this case, also those of artists.⁴⁰

The boundary work in the Arts and Health field is, however, more complex than that. Understandings of scientific legitimacy vary among decision-makers, as they do among scientists and scholars. Thus, not even the scientists speak in one voice; among them are found a multitude of conflicting ideas about what is required of a knowledge process for it to be regarded as reliable and of high scientific quality.⁴¹ Biomedical science, public health science and art history – that is to say, the knowledge traditions that dominate the conceptual discussions within Arts and Health, represent for example opposing (or complementary) arguments for scientific legitimacy. Even if both public health science and art history proceed from the World Health Organisation's holistic definition of health, their scientific/scholarly application of that definition varies. Most public health research works within the same tradition of methodological reductionism as biomedicine, and in this quantitatively dominated research tradition, rigorous demands are imposed for statistically unambiguous results that are based on studies with linear, controlled design and predefined health outcomes.⁴²

Art history, on the other hand, proceeds to a higher extent from a qualitative view of knowledge in which focus is on interpretation of human perceptions.⁴⁴ The evidence requirement (as formulated in the GRADE evidence hierarchy) is therefore often challenged with reference to the evidence movement's narrow view on knowledge. People working with Arts and Health in a social context must be able to navigate between different knowledge systems, but from a health perspective, evidence often refers to quantitative, generalisable data generated in randomised controlled studies, while qualitative research is dismissed as anecdotal.⁴⁵

The discussion, that is, the arguments about while kind of scientific knowledge has a high evidence value, is not unique to the Arts and Health field; it aligns with the boundary work of other

fields in both content and form. One common argument is that there is no strong evidence for specific applications in actual situations. Another is that evidence in terms of support by biomedical research cannot be the only knowledge base for practical activities. Methods supported by statistics capture only certain aspects of clinical activities, for example. Many argue that such evidence must therefore always be combined with patient and client preferences, as well as the resources that personnel and the organisation comprise at any given time in the form of expertise, technology and finances.⁴⁶

A tentative discussion about how a meeting could be brought about between different scientific/scholarly traditions, or between science and other forms of knowledge ('proven experience' for example) has begun.⁴⁷ Within central Swedish government agencies for evidence-based policy, the definition of scientific/scholarly knowledge has also been modified during the last ten years, with higher value ascribed to qualitative research. The new chapter on qualitative research in the guide to the evaluation of methods in health care published by SBU, a government agency whose mandate is to assess health care interventions, is the clearest example.⁴⁸

With regard to the Arts and Health field, it has been suggested that the field could be placed within a social paradigm (in contrast to the biomedical) and thus be defined as 'applied public health science'.⁴⁹ In the evidence discussion, one could then seek support in such public health research that has shown that individual lifestyles, social networks, living conditions and institutional and cultural determinants are significant to health. This view on what have come to be called the 'determinants of health' is often illustrated with the 'crescent moon' diagram (see Figure 3).

With such a reference, Arts and Health projects can be described as an application of public health (social epidemiological) research, partly because they are intended to create favourable living conditions for individual and groups and partly because they are intended to link the various levels that affect health (from the

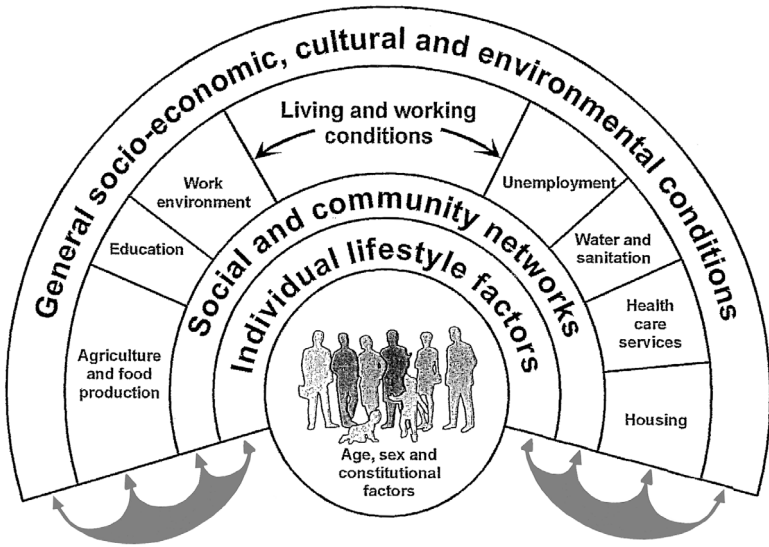


FIGURE 3. *The main determinants of health*⁵⁰

individual to the macro level). The evidentiary value of, for example, artistic activities for a group of people then resides in that these activities can give the group members the sense of context in supportive and trust-promoting networks that public health epidemiological research has determined promotes both mental and physical health.⁵¹

ARGUMENTS ON THE SCIENTIFIC LEGITIMACY OF THE ARTS

To further complicate the picture, we can add that some stakeholders question the relevance of evaluating art based on scientific theories in the first place. In the boundary work, it is thus not only scientific legitimacy that is defined (and redefined) but also art. Art and science are historically mutable phenomena. At

different times and in different places, these social activities have had different roles, meanings and functions. It is thus unsurprising that the view on the arts and their role in relation to science and society otherwise is negotiated in the boundary work. Challenges to the notion that art can be scientifically evaluated often espouse the idea that the dynamics and value of the arts cannot be determined through the measuring, quantifying practices of traditional science.

This is one of several fundamental attitudes towards art and science that are included in the boundary work. Such an attitude is sometimes formulated in terms of intellectual arguments that focus on criticism of science or proceed from a particular theory of art. But antagonisms between art and science can also be seen in the execution of practical projects, without necessarily referring therefore to intellectual arguments. This is especially apparent if we study how practical Arts and Health projects are usually evaluated. Because such practical projects have often existed and been designed based on driving forces other than scientific methodological standards, it is common that they do not encompass or precisely define that which is required to make scientific evaluations possible.

The evaluation of the project mentioned above, ‘Intergenerational Encounters between Young and Old’ describes this specifically: those who performed the project have not collected the type of data that permit systematic evaluation, which meant that possible effects of the project could not be scientifically determined.⁵²

A review of evaluation in the British Arts and Health field reaches the same conclusion: similar projects rarely have clearly declared or demarcated health aims, which is requisite for scientific evaluation of health effects. The author of the review, John Angus, speculates as to why this is so; that is, why many projects do not use a more clearly scientific method. He suggests that ‘practitioners may assume that the intention to improve health and well-being and so do not feel that it is necessary to state that

as an aim'.⁵³ It might also be, according to Angus, that practitioners do not regard the art project as the only factor on a multifaceted road to health. When health effects are stated, they are often focused on such factors usually referred to as intermediary factors (such as personal development) that may over the long run contribute to improved health, but which are not measurable health aims.⁵⁴ In such case, the aims of the project are indirect or complementary, so that they capture human needs that other (biomedical) interventions do not address – that is, they could be placed in the right-hand section of the Arts and Health Diamond. Advice to the stakeholders, in their boundary work, could therefore be to specify the type of evidence that is being sought or applied in order to clarify which types of evaluations are appropriate or possible.

ARGUMENTS ON UTILISATION OF THE ARTS

The matter of the scientific legitimacy of the arts is closely related to the theme of instrumentality and utilisation, which is often discussed when stakeholders are engaged in scientific boundary work. The science-oriented society of the Victorian era argued for example that science was a higher and nobler form of knowledge compared with engineering knowledge, precisely because scientists sought knowledge for its own sake and did not – like the engineers – conduct research for instrumental reasons.⁵⁵ In this way, the champions of science have proclaimed the value of knowledge liberated from demands for utility ever since the days of Ancient Greece.⁵⁶ In the boundary work with Arts and Health, however, scientific measurability is closely related to utilisation, even though arguments for quantifiable health benefits can co-exist with arguments that art also has other values. The following quotation from the knowledge overview *Kultur för hälsa* shows that one kind of value does not necessarily preclude others:

The final report of the Swedish National Committee for Public Health, *Health on Equal Terms*, establishes that there is scientific support for the premise that cultural activities can be a valuable complement to rehabilitation and treatment. There is also research that shows that participation in cultural activities can promote health and contribute to a longer life. But that does not mean that one assesses the value of cultural experiences only according to their health benefits. Obviously, cultural activities have inherent value. Human history and development show that art and culture have profound and existential meaning in people's lives.⁵⁷

Scientific support for health benefits can demonstrate the utility of cultural activities and may result in greater economic support, but some of those engaged in the debate nevertheless believe this is a dubious way to define Arts and Health. In the quotation above, it is representatives of public health research who draw attention to the multifaceted value of the arts beyond that which is scientifically quantifiable and of direct social benefit. Otherwise, it is primarily representatives of the arts sector who participate in this aspect of the boundary work, and then proceeding from a sharply critical position. The criticism is that the utilisation of art is an unnecessary legitimisation of something that basically does not need to be justified in such terms.

When representatives of working artists and the field of art history discuss instrumentality, it is described as the opposite of art. In an opinion piece in the Swedish daily newspaper *Dagens Nyheter*, for example, Margaretha Rossholm Lagerlöf, professor of art history, writes that art becomes effective precisely when it makes no effort to be useful.⁵⁸ She argues that the aim of art history is to demonstrate the role of art as provocateur; that it is an arena for reflection and representation of our complex and disorderly sub-conscious. When she claims that 'Great art holds truth; it reveals something', she also suggests a specific picture of the nature of objectivity: that the objective in the experience of art arises in a different epistemological space than that which a standard-

ised questionnaire can penetrate or a statistical analysis can capture.⁵⁹ Once again, a criticism of the combination of scientific legitimacy, art and utility: there are kinds of truth other than the scientific or economically quantifiable.

In parallel with representatives of the arts sector seeking to accentuate its significance to health, concern is thus expressed that the linkage with various kinds of health research will reduce the value of the arts and culture to that of a mere instrument for achieving health.⁶⁰ An interesting example of how stakeholders within Arts and Health resolve the problem comes from the new *Journal of Applied Arts and Health*. In the inaugural issue, we once again see how a representative of the field wants to insert the term ‘applied’: the editor of the journal explains that its aim is to clarify the numerous values of the arts by differentiating ‘art’ from ‘applied art’:

I support the value of art for art’s sake. I abhor the notion that art must have a particular purpose other than that which art already does best and that is to use and play with aesthetic qualities. Aesthetics act upon our senses to make us feel more, hear more and see more than we otherwise might. Yes, art is highly manipulative and it should make no apology for that. However, alongside the arts is recognition of the powerful effect they can have for health; after all, feelings are intertwined with mental, physical, spiritual and social health. Arts which are applied to a purpose outside of their usual context can be termed ‘applied arts’ which defines them more clearly than the use of the term ‘arts’ alone.⁶¹

With a view to preserving the distinctive nature of the arts, the editor thus chooses the paradoxical solution of talking even more definitively about ‘applied art’. This is entirely consistent with how scientific boundary work has been historically pursued. In previous centuries, access to economic resources was a key aspect of scientific boundary work. By separating the instrumental aspects of art from the free arts, the editor (and other debaters)

creates an opportunity for the latter to reside in at least two different spaces: a space defined by science and social benefit and a space that is defined by art per se, with other rules for determining value.⁶²

Art is thus given two entirely different logics for its *raison d'être*. The best of two worlds, one might say. Representatives of the arts can keep both free and instrumental art; they can avoid unilateral reductionism but simultaneously gain access to the economic resources that are otherwise reserved for the health sector. But how is this complex solution reconciled with Rossholm Lagerlöf's idea that instrumentality is the opposite of art? Does instrumentality always entail a weakening of the power of art or can this be accepted in certain contexts? One answer to these questions, which departs from that of the editor mentioned above, is that art is a human right and that it is therefore unnecessary to get tangled up in the vocabulary of science or economics. The value of the arts can and should instead be confirmed through references to such political and rights-defining documents such as the UN report *Our Creative Diversity*. Winzer notes that 'UNESCO emphasises that development is not merely about goods and services, but also encompasses people's chosen way of life and access to a rich cultural life'⁶³

SUMMATION OF BOUNDARY WORK IN ARTS AND HEALTH

Based on Gieryn's questions, we can now briefly summarise the boundary work in which the Arts and Health field is engaged:

1. *Which stakeholders are arguing?*

The Arts and Health field is interesting for several reasons, including that there are so many different stakeholders involved. Health professionals and artists are not the only ones arguing about the relationship of the field to science;

politicians, decision-makers and the public are also participating in the discussion.

2. *How do the stakeholders argue: What metaphors and what tone do they use?*

The clearest metaphors used in a sometimes polemic debate have to do with wholeness and parts, holism and reductionism.

3. *What are the arguments about: What is the content of the arguments and what do the stakeholders reference to bolster their positions?*

The arguments mainly have to do with how science, art and utility should be defined; that is, how they should be stated and expressed to be considered legitimate examples of their respective genres. In order to bolster their arguments, the stakeholders reference widely disparate themes: various forms and theories of knowledge, various aims and justifying logics, such as economic sustainability vis-à-vis existential meaning and human rights.

4. *Why are the arguments being made: What view of knowledge and what values or resources are at stake?*

The fundamental issue is how we view human and social development, ideologically, but also institutionally. Thus: How should health care be designed with respect to Arts and Health? What types of activities should we invest our common resources in? How do we justify interventions and decisions?

It is important to note that questions three and four are closely related: the definition of terms like art, science and utilisation is not only philosophically interesting, but is constructed against the backdrop of fundamental questions about the nature of humanity and how society should be designed. It is also where the

boundary work on Arts and Health provides keys to understanding the chosen paths of science, culture and society. Four different stances or positions become clear in the relationships of various stakeholders to art, science and utilisation:

- a) The therapeutic effects of art can and should be measured in terms of (at least indirect) health benefits according to the evidence-based policy movement's standards for systematic and aggregated data, which justify increased resources.
- b) The therapeutic effects of art are not measurable according to the standards of the evidence-based policy movement, but its health benefits can be understood and (to a certain extent) measured scientifically through an interdisciplinary approach and complementary methodological traditions, which justify increased resources.
- c) Art should not be regarded as useful or scientifically measurable at all, because art is a fundamental human right and, moreover, its essence does not reside in its utility or measurability. Herein lies its *raison d'être* and the justification for increased resources: our society needs to promote and reinforce the existential and non-quantifiable dimensions of our lives.
- d) The relationship of art to health can be understood in several ways and the important thing is to specify which genre is meant. Art can exist both as non-quantifiable and beyond utility, but in certain cases may be applied for quantifiable, therapeutic purposes.

The questions to which these positions relate are complex and there are probably no clear-cut answers, but they are still necessary and fundamental for every society and thus apply to more

than the field of Arts and Health. What is valid knowledge? What is useful, valuable or meaningful? How should we handle various claims that something is useful, valuable or meaningful – especially if these claims cannot be presented as reliable knowledge or science? Who should judge and decide what is sufficiently meaningful for us to invest our joint resources in? The boundary work surrounding Arts and Health provides a few examples of how we can confront these fundamental questions.

*ARTS AND HEALTH: THE CONFLUENCE
OF EPISTEMOLOGICAL IDEALS AND
APPLICATIONS OF KNOWLEDGE*

We have presented a general overview of the Arts and Health field in this chapter. We have determined that it encompasses stakeholders from a variety of social sectors whose views on the relationship between art and health sometimes agree and sometimes are diametrically opposed. Many within the field are united in their criticism of the biomedical division of human beings into body and mind and the consequences this division has for individuals, health care and society. Many also agree on the basic thesis: that art is a fundamental human right and that the arts have the potential to increase participation and meaningfulness so that unhealthy alienation and fragmentation within and between people can be prevented. Opinions as to how this should be done, however, often diverge. A variety of practical and scientific/scholarly projects can be seen within the Arts and Health field that interpret the shared common outlook in various ways. Some of these differences can be attributed to the target group of the specific artistic expression.

We also see an analytically interesting difference in the various ways that science, art and social benefit are defined. There are stakeholders in the Arts and Health field who argue that the arts can certainly be understood in terms of social benefit, while oth-

ers argue that such instrumentality contradicts the inherent value of the arts. A third faction seeks to find a middle way by differentiating and clearly defining the applied, utilitarian aspects of the arts while other aspects are allowed to exist based on other criteria. Still others argue that we – in Sweden – have absolutely no need to discuss measurement or utility, because the status of the arts in society has been justified politically (and thus economically) through our commitment to work in accordance with certain UN declarations.

We encounter the same complexity in the matter of how scientific legitimacy or evidence is defined. Here as well, we see that the field encompasses researchers who choose to work based upon divergent methodological ideals (quantitative, experimental, qualitative), that some researchers argue that the evidence is found in intermediary or indirect factors and that still others (researchers among them) wholly repudiate the notion that we can or should measure the effects of the arts in a scientific way. We also see that the discussions of both scientific legitimacy and social benefit (inside and outside the Arts and Health field) are pursued in relation to resource allocation.

Considering that our resources are both shared and finite, most activities need to justify their existence, whether cultural initiatives, education, social care, research or health care. The demands for evidence of the effects of exposure to art are therefore sometimes presented as obvious and unproblematic: decision-makers must clearly understand that interventions will have the anticipated effects. However, if we scratch a bit beneath the surface we find unresolved problems in such a standpoint as this. If we accept that every intervention should be justified on the basis of evidence, this begs at least two more general questions. The first has to do with what we mean by ‘evidence’, while the other has more to do with what we should do in the meantime while waiting for the ‘evidence’.

Are only large, quantitative studies (of the RCT type) considered evidence, or do we also accept qualitative research? There is no consensus on this issue within the research community. Fundamentally, this has to do with our views on knowledge, but it is also

about complex scientific questions concerning whether it is possible to apply study results outside the laboratory or outside the exact group of people included in the research study. In laboratory studies, researchers may for instance prove mechanisms and causality (evidence) at the cellular or tissue level, but that does not mean we have evidence that these effects will be sustained at higher levels (the entire person or certain groups or populations). Likewise, intervention studies can show effects within a particular population, in a particular place, in a particular setting, but this is no guarantee that these effects will be sustained for other populations, places and settings. There are similar questions related to qualitative studies. We currently have methods for compiling the results of multiple qualitative studies ('metasynthesis'), but these are still under development and there is no consensus concerning the role qualitative studies should have as evidence carriers.⁶⁴

The second question, that which has to do with situations in which no evidence exists, has to do with whether we can – within a reasonable time – produce evidence for every publicly financed intervention. We can see such an ambition today, sometimes referred to as evidence-based policy, but it has not been established that such an approach is equally relevant to all social sectors or that this is the solution to difficult political issues that encompass several aspects outside the medical.⁶⁵ Ultimately, in the encounter with a patient, service-user or client, an evidence-based policy incorporates values and professional judgement – position-takings that are not determined solely through scientific research or standardised guidelines.

The Gordian knot thus becomes: what form should the justification of Arts and Health take? What we have shown in this presentation is that there seem to be aspects of the relationship between art and health that are measurable – and that these probably need to be measured more meticulously and systematically. Greater efforts in both education and research are probably needed here. At the same time, we have seen arguments that art also owns a value that is so fundamental that it might not be quantifiable, but still can be the object of comprehensive discussion, systematic and doc-

umented reflection and critical and problematising argumentation – if for no other reason than to retain legitimacy and support.

This way of untying the knot does not provide adequate guidance for anyone who is seeking a swift Alexandrian cut, but it does provide a clear indication of what strands of the knot can be pulled. The strands, we suggest, are not unique to the Arts and Health field, but are found in many publicly financed areas: a widely supported and in-depth discussion, reflection, and critical argumentation about the relationship between and constitution of the arts and health based on respect for various knowledge ideals and values, which are certainly found within all social arenas but which become especially clear in the Arts and Health field; more and better research on the relationship between the arts and health based upon methods carefully adapted to the research questions and aims – and this, as well, based upon widespread support and in-depth critical reflection about the view of knowledge and social values.

NOTES

1. John Angus, *A Review of Evaluation in Community-based Art for Health Activity in the UK*, London: Health Development Agency, 2002 (downloaded from: www.hda-online.org.uk 13-12-11).
2. Stephen Clift, 'A Brief Introduction to Arts and Health', *Perspectives in Public Health*, 131:1 (2011), p. 8.
3. Paul M. Camic, Stephen Clift and Norma Daykin, 'Editorial: The coming of age for arts and health: what we hope to achieve', *Arts & Health*, 1:1 (2009), pp. 3–5; Paul Sznewajs and Anita B. Boles, 'Letter from the president and executive director of the society for the arts in health-care', *Arts & Health*, 1:1 (2009), pp. 1–2; Gareth Wreford, 'The state of arts and health in Australia', *Arts & Health*, 2:1 (2010), pp. 8–22.
4. Regina Winzer (ed.), *Kultur för hälsa: En exempelsamling från forskning och praktik*, Swedish Agency for Public Health 2005: 23. Stockholm: Swedish Agency for Public Health, 2005 (downloaded from: <http://www.fhi.se/PageFiles/3318/r200523kulturforhalsa0510.pdf>, 13-08-30).

5. George Engel, 'The need for a new medical model: A challenge for biomedicine', *Journal of Interprofessional Care*, 4:1 (1989 [1977]), p. 3753; Jennie Medin and Karin Alexanderson, *Begreppen Hälsa och hälsofrämjande – en litteraturstudie*, Lund: Studentlitteratur, 2000.
6. The relationship between body and mind is a more or less chronic philosophical problem that has been argued at the very least since Plato, in various forms (Peter Dear. *The Intelligibility of Nature: How Science Makes Sense of the World*, Chicago: University of Chicago Press, 2000). In the modern era, however, René Descartes occupies a unique position in relation to the dualism of body and mind (Howard Robinson, 'Dualism', *The Stanford Encyclopedia of Philosophy* [Winter 2012 Edition], Edward N. Zalta [ed.], downloaded from: <http://plato.stanford.edu/archives/win2012/entries/dualism/>, 13-12-13).
7. James A. Marcum, 'An Introductory Philosophy of Medicine: Humanizing Modern Medicine', *Philosophy and Medicine*, vol. 99, Dordrecht: Springer Netherlands, 2008, p. 20.
8. Marcum, *Philosophy of Medicine*, also describes theoretical and ontological reductionism, but methodological reductionism is the most germane to the purpose of this text.
9. Marcum, *Philosophy of Medicine*, p. 10; Engel, 'The need for a new medical model', p. 39.
10. Engel in Rolf H. Adler, 'Engel's biopsychosocial model is still relevant today', *Journal of Psychosomatic Research*, 67 (2009), pp. 607–611.
11. Adler, 'Engel's biopsychosocial model'.
12. David Weatherall in Marcum, *Philosophy of Medicine*, p. v.
13. Marcum, *Philosophy of Medicine*.
14. Francis W. Peabody, 'The care of the patient', *Journal of Interprofessional Care*, 5:3–4 (1990 [1927]), pp. 129–140.
15. See also Medin and Alexanderson, *Begreppen hälsa och hälsofrämjande*, which is a comprehensive literature study that recounts the various directions of the health concept, such as the biomedical, psychosomatic, statistical, behavioural and holistic, and how these have evolved over time.
16. An example of this is the Swedish National Board of Health and Welfare's *Nationella riktlinjer för sjukdomsförebyggande metoder, Tobaksbruk*,

- riskbruk av alkohol, otillräcklig fysisk aktivitet och ohälsosamma matvanor, Stöd för styrning och ledning*, [English summary: National Guidelines for Methods of Preventing Disease. Tobacco use, hazardous use of alcohol, insufficient physical activity and unhealthy eating habits; support for control and management] 2011, ISBN: 978-91-86885-66-3 (downloaded from: <http://www.socialstyrelsen.se/publikationer2011/2011-11-11,13-12-11>).
17. Angus, *A review of evaluation*. An example from Sweden can illustrate this: in a brochure about university courses, researcher Britt-Maj Wikström explains that ‘aesthetic care means that the patient’s “illness environment” should correspond to the greatest extent possible with her “healthy environment”.’ (Emma Gustafsson, *Konstens betydelse för hälsan*, Region Dalarna: Dalarna County Council, 2012).
 18. For an easily accessible website dedicated to neuroscientific studies of the effects of various forms of culture on the brain, see: <http://www.kulturellahjarnan.se>.
 19. Angus, *A Review of Evaluation*, p. 14.
 20. Angela Everitt and Ruth Hamilton, *Arts, Health and Community: A Study of Five Community Health Projects*, CAHHM, Durham, 2003 (downloaded from: www.dur.ac.uk/cahbm/131211). Examples of how art projects use individual health conditions or epidemiological data exist, of course, but they rarely have explicit therapeutic aims. See for example the discussion that followed the work of artist Anna Odell in which some debaters argued that her work gave ‘hope to everyone with a mental illness’ (Åsa Moberg and Torsten Kindström, ‘Anna Odell ger alla psykiskt sjuka hopp’, *Svenska Dagbladet*, 2009-08-24).
 21. Clift, ‘A brief introduction’, p. 8
 22. Jane Macnaughton, Mike White and Rosie Stacy, ‘Researching the benefits of arts in health’, *Health Education*, 105:5 (2005), pp. 332–339.
 23. Macnaughton et al., ‘Researching the benefits of arts in health’, pp. 332–339.
 24. Kimberley Diane Fraser and Fatima al Sayah, ‘Arts-based methods in health research: A systematic review of the literature’, *Arts & Health*, 3:2 (2011), pp. 110–145.
 25. Anni Raw, Sue Lewis, Andrew Russell and Jane Macnaughton, ‘A

- hole in the heart: Confronting the drive for evidence-based impact research in arts and health', *Arts & Health*, 4:2 (2012), pp. 97–108.
26. *Tanke och idébok om personcentrerad vård*, University of Gothenburg, Gothenburg Centre for Patient-centred Care, 2012, p. 27.
 27. Jeanette Tenggren Durkan, Irma Lindström and Malin Högberg. *Rapport Ubuntu, en pilotutställning om personcentrerad vård*, Gothenburg Centre for Patient-centred Care, University of Gothenburg, 2012. In a film that has been made available online (<http://gpcc.gu.se/aktuellt/fulltext//se-filmen-om-ubuntu-.cid1098259>) the guide from the Röhsska Museum explains the purpose of each room in Ubuntu.
 28. Winzer, *Kultur för hälsa*.
 29. Oxford Research, *Utvärdering av de verksamheter som har fått stöd inom Kulturrådets uppdrag Kultur för äldre*, Stockholm: Oxford Research, 2013, p. 3.
 30. Daniel Brodén, 'Göteborg får 4,7 miljoner till kultur för äldre', Centre for Culture and Health. News 2013-11-25 (downloaded from: <http://www.ckh.gu.se/aktuellt/nyheter/fulltext//goteborg-far-4-7-miljoner-till-kultur-for-aldre.cid1194263> 140128).
 31. Fraser and al Sayah, 'Arts-based methods', pp. 110–145.
 32. Fraser and al Sayah, 'Arts-based methods'.
 33. Stephen Clift, Paul M. Camic, Brian Chapman, Gavin Clayton, Norma Daykin, Guy Eades, Clive Parkinson, Jenny Secker, Theo Stickley and Mike White, 'The state of arts and health in England', *Arts & Health*, 1:1 (2009), pp. 6–35; Hilary Bungay, 'The effects of participating in creative activities on the health and well-being of children and young people: A rapid review of the literature', *Perspectives in Public Health*, 133:1 (2012).
 34. Wreford, 'The state of arts and health in Australia', pp. 8–22.
 35. Attempts to establish lines of demarcation between science and non-science have preoccupied philosophers of science for a long time. According the Gieryn, the dominant idea in the 1850s was that that which separated science from theology was that scientific pronouncements were based upon empirical observations, while the philosophers of science of more recent times (such as Popper, Carnap and Ayer around the 1950s) were instead preoccupied with trying to

- formulate logical rules for a scientific language (Gunilla Priebe and Catharina Landström, 'Den vetenskapliga kunskapens möjligheter och begränsningar – grundläggande vetenskapsteori', *Vetenskaplig teori och metod: från idé till examination*, Marie Henricson [ed.], Lund: Studentlitteratur, 2012, pp. 31–50). The term 'boundary work' is more contemporary and pragmatically focused contribution to the question of boundaries between science and non-science (Thomas Gieryn, 'Boundary-work and the demarcation of science from non-science: Strains and interests in professional ideologies of scientists', *American Sociological Review* 48:6 [1983], pp. 781–795).
36. Raw, Lewis, Russell and Macnaughton, 'A hole in the heart', pp. 97–108; see also Fraser and Sayah, 'Arts-based methods in health research'; Winzer, *Kultur för hälsa*.
 37. Camic, Clift and Daykin, 'Editorial', pp. 3–4.
 38. Gieryn, 'Boundary-work'.
 39. Gieryn, 'Boundary-work'.
 40. Ingemar Bohlin and Morten Sager, *Evidensens många ansikten: Evidensbaserad praktik i praktiken*, Lund: Arkiv förlag, 2011.
 41. Raw et al., 'A hole in the heart'; see also Winzer, *Kultur för hälsa* and Gieryn, 'Boundary-work', where this ambivalence and fragmentation become apparent, that is, opposing arguments are adopted depending upon the focus of the discussion: 'scientific knowledge is at once theoretical and empirical, pure and applied, objective and subjective, exact and estimative, democratic /.../ and elitist /.../, limitless and limited" (Gieryn, 'Boundary-work', p. 792). See also Lorraine Daston and Peter Galison. *Objectivity*, New York: Zone Books, 2007, for various definitions of objectivity over the past two hundred years.
 42. This also applies to neuroscientific studies of the effects of culture, which is an important area of research within Arts and Health. Researchers are using neuroscientific methods in the attempt to provide evidence of the biological and physiological effects that arts practise and participation have on the body, primarily the brain. In Sweden, the editors of the website 'Den kulturella hjärnan' [The cultural brain] summarise projects in this field. (See also <http://www.kulturellahjarnan.se> for references to various studies.)

43. Ross W. Prior, 'Editorial', *Journal of Applied Arts and Health*, 1 (2010), pp. 3–6.
44. GRADE stands for Grading of Recommendations, Assessments, Development and Evaluation (<http://www.gradeworkinggroup.org>). This is an international working group that is developing criteria and templates for assessing the scientific support of studies concerning a certain issue. In their hierarchical definition of the quality of evidence, randomised, blinded and controlled trials are ranked highest and other studies, such as register studies, observational studies or qualitative studies are ranked lower (Howard Balshem, Mark Helfand, Holger J. Schünemann, Andrew D. Oxman, Regina Kunz, Jan Brozek, Gun E. Vist, Yngve Falck-Ytter, Joerg Meerpohl, Susan Norris and Gordon H. Guyatt, 'GRADE guidelines: 3. Rating the quality of evidence', *Journal of Clinical Epidemiology*, 64:4 [2011], pp. 401–406).
45. Wreford, 'The state of arts and health in Australia', p. 14. See also: Heather Hartwell, 'Arts and Health Editorial', *Perspectives in Public Health*, 133 (2013), p. 2.
46. Ragnar Levi, *Vettigare vård: Evidens och kritiskt tänkande i vården*, Stockholm: Norstedts, 2009; Hartwell, 'Arts and health, Editorial'.
47. See for example Marsaili Cameron, Nikki Crane, Richard Ings and Karen Taylor, 'Promoting wellbeing through creativity: How arts and public health can learn from each other', *Perspectives in Public Health*, 133 (2012); Ana M. Ning, 'How "alternative" is CAM? Rethinking conventional dichotomies between biomedicine and complementary/alternative medicine', *Health*, 17:2 (2012), pp. 135–158.
48. SBU, *Utvärdering av metoder i hälso- och sjukvård: en handbok*, version 2012-02-03. Stockholm: SBU (downloaded from: <http://www.sbu.se/metodbok>, 13-12-13). However, the National Board of Health and Welfare's work with national guidelines also integrates clearly qualitative elements (Swedish National Board of Health and Welfare, *Nationella riktlinjer för sjukdomsförebyggande metoder, Tobaksbruk, riskbruk av alkohol, otillräcklig fysisk aktivitet och ohälsosamma matvanor, Stöd för styrning och ledning*, 2011).
49. Christine Putland, 'Lost in translation: The question of evidence linking community-based arts and health promotion', *Journal of*

- Health Psychology* 13 (2008), pp. 265–276 (see also Raw et al., ‘A hole in the heart’ and Angus, ‘A review of evaluation’).
50. Göran Dahlgren and Margaret Whitehead, *Policies and Strategies to Promote Social Equity in Health, Background document to WHO – Strategy paper for Europe*, Working Report/Institute for Futures Studies; 2007:14, ISSN: 1652-120X, ISBN: 978-91-85619-18-4, Stockholm, 1991: 11 (downloaded from: http://ideas.repec.org/p/hhs/ifswp-sA2007_014.html, 131211).
 51. Putland, ‘Lost in translation’
 52. Oxford Research, *Utvärdering*.
 53. Angus, ‘A review of evaluation’.
 54. Angus, ‘A review of evaluation’.
 55. Gieryn, ‘Boundary-work’.
 56. Dear, *The Intelligibility of Nature*.
 57. Winzer, *Kultur för hälsa*, p. 22.
 58. Margareta Rossholm Lagerlöf, ‘Konsten är inget instrument’, opinion piece in *Dagens Nyheter*, 2013-10-07, p. 6.
 59. Rossholm Lagerlöf, ‘Konsten är inget instrument’, p. 6.
 60. Putland, ‘Lost in translation’; Wreford, ‘The state of arts and health in Australia’.
 61. Prior, ‘Editorial’, p. 4.
 62. See for example Wreford, ‘The state of arts and health in Australia’.
 63. Swedish UNESCO Council. *Vår skapande mångfald* (translation to Swedish of *Our Creative Diversity*) Stockholm: Norstedt, 1996. Winzer, *Kultur för hälsa*, p. 30. See also Wreford, ‘The state of arts and health in Australia’.
 64. The SBU guide, for example, consists of twelve chapters, of which only one applies to qualitative studies. There is also one chapter on ethics. Most of the other chapters apply to quantitative studies. SBU. *Utvärdering av metoder*. See also Ingemar Bohlin, ‘Systematiska översikter, vetenskaplig kumulativitet och evidensbaserad pedagogik’, *Pedagogisk forskning i Sverige*, 15:2/3 (2010), pp. 164–186.
 65. Bohlin and Sager, *Evidensens många ansikten*; Nancy Cartwright and Jeremy Hardie, *Evidence-based Policy: A Practical Guide to Doing it Better*, Oxford: Oxford University Press, 2012.



MEDICAL HUMANITIES

Katarina Bernhardsson

MEDICAL HUMANITIES IS a field of enquiry that encompasses a variety of perspectives and disciplines. Because it is so multifaceted, it is difficult to define with precision, but as the editors of a new book about the field point out, such a definition is arguably unnecessary: ‘a clear-cut definition could remove the diversity of approach that makes the medical humanities so appealing in the first place’.¹ Medical humanities is still in an emerging phase and although its contours are beginning to solidify, it will probably never be so uniform that a simple definition will suffice.

That said, it is still necessary to make a more tentative definition. As the name implies, the field has to do with humanities – and certain social scientific – perspectives, oriented towards medicine in the broad sense. Martyn Evans, philosopher and prominent champion of the field, has formulated a definition: ‘... “medical humanities” denotes humanities looking at medicine, looking at patients, and – crucially – *looking at medicine looking at patients*’.² The full spectrum of the field is included in this definition, which becomes even more apparent if we replace the word ‘patient’ with the word ‘human’. Humanist perspectives are used in the medical humanities to study medical science and medical practice and the human being in the role of the object of this activity, but also the society and the culture shaped by medicine. Philosopher Fredrik Sve-

naeus expresses the aim as that of ‘examining and contemplating the human on the basis of corporality, culture, society and history.’⁷³ In other words, the medical humanities is a wide field of enquiry.

This chapter begins with a relatively long discussion of the medical humanities and its various orientations, based on a typology suggested by Martyn Evans. Thereafter, I have chosen to address the medical education orientation and research activities separately. I will first discuss educational activities and how the humanities have been integrated into medical education. A longer section is devoted to medical humanities as taught at the Lund University School of Medicine, where I am active, and the deliberations behind the decision to offer this course. Thereafter, I will discuss current research and describe some of the most important sub-disciplines: medical ethics, philosophy and religious studies; medical history; ethnology and medical anthropology; literature and medicine, narrative medicine and the aesthetic disciplines. I will also briefly discuss two other descriptors of the field used in Swedish, ‘humanistic health research’ and ‘humanistic medicine’. Finally, I will provide examples of various activities in the field: research centres and networks, journals and interdisciplinary book publications.

THE THREE ORIENTATIONS OF THE MEDICAL HUMANITIES

Medicine is a powerful force in our modern society and affects our views on notions like normality, deviance, health and illness, which is why humanities-based studies of medicine and its worldview are important. As an example, Fredrik Svenaeus captures with his ‘children’s party’ metaphor how medical models of understanding have increasingly encroached upon our cultural beliefs. Svenaeus discusses how it has become increasingly natural for parents, observing how kids at a children’s party behave, to think in terms of diagnoses. Svenaeus calls this a ‘new perception’ that has infiltrated how we look at and think about chil-

dren, where categories like rambunctiousness or liveliness have been replaced by categories like ADHD and other neuropsychiatric conditions.⁴ Rolf Ahlzén, physician and senior lecturer in the medical humanities, argues that critical reflection is necessary in an age when we ‘are to an increasing extent pursuing medically defined risks and medicalising one aspect of human life after another [...]. The interpretive prerogative of medicine in several areas must be challenged, even in cases when medical interventions are of inarguable value’.⁵

Over and above the basic definition I quoted above, Martyn Evans has constructed a more detailed typology that provides a good overview of the field, in which he divides the activities of the medical humanities into three kinds.⁶ The first is the most applied part, ‘Arts in Health’, which is a therapeutic orientation. This includes, among else, music therapy and bibliotherapy – thus, explorations of how the arts can have a therapeutic and healing effect on people. A number of the projects currently ongoing at the University of Gothenburg, which are described in the next chapter, belong in this category. Not everyone wants to include these activities in the medical humanities; Ahlzén, for example, prefers to categorise them as a separate field, that of ‘medical therapeutics’.⁷ Arts and Health has been given its own chapter in this book (see the preceding chapter) and will not be further discussed here.

The second orientation Evans identifies is medical education, which is geared towards changing medical education and other medical training by offering courses in the humanities. There is often a sort of ethical imperative here and a distinct idea of social relevance, and this has been a core activity within the medical humanities ever since the field of enquiry began to take shape.⁸ One of the outcomes is that it is not unusual abroad to find scholars and teachers in the humanities employed full or part-time by university faculties of medicine. There are a few such examples in Sweden as well, and there is some element of the humanities in all Swedish medical education.

In both of the aforementioned orientations, Arts in Health

and Medical Education, Evans also includes commentary, analysis and critical reflection on the field.

Finally, Evans identifies a third, more obviously theoretical and academic orientation within the medical humanities, whose aim he describes as ‘the task of attempting better to *understand human nature* through the lens of a critical examination of technological medicine and its limitations’.⁹ This includes analyses of society and culture – the historic, social and cultural context of medicine – as well as individual experience and artistic expression. The three orientations often have fundamental differences in method and aim, but they have significant overlaps and are partially interdependent. Over the long run, it is impossible to imagine the two first orientations without the third. Ahlzén argues that the medical humanities must be able to alternate between ‘the critical, analytical perspective and that rooted in insight and empathy’.¹⁰ Both of these perspectives are essential within the various aspects of the medical humanities.

The three orientations that Evans suggests are not the only aspects that make the medical humanities a complex and multifaceted field. Depending upon the discipline (or disciplines) involved, the points of departure and interests of the studies may vary considerably. The humanities field is wide and certain social scientific disciplines are usually included in most descriptions of the medical humanities, despite the name, and as Wilhelm Kardemark and Ola Sigurdson argue in a report, it might be more fitting to talk about ‘medical human science’ or perhaps the ‘human science of health’.¹¹ In addition, the field seeks out the multidisciplinary and the interdisciplinary, where individual disciplines are challenged in the encounter with others – first, within the humanities and the social sciences, which is a challenge in itself, and second through the interface with medicine. This naturally entails difficulties, but it is also what makes the medical humanities so dynamic. Svenaeus notes that the medical humanities further developed, might result in ‘parts of the humanities themselves finding a new direction and common ground through the

medical link'.¹² In a study of the future of humanistic knowledge, historians of science and ideas Anders Ekström and Sverker Sörlin point to the medical humanities as an example of 'integrative humanities'. In using that term, they argue that the evolution of scholarship in recent decades has revitalised humanist knowledge 'by addressing novel areas of interest that in this way expand the humanist knowledge domain'.¹³ This is an expansion that is important to both the humanities disciplines per se and the areas they study. Humanities scholars approach a problem field 'not only to observe it from the outside – a study *of* – but also to contribute from the inside to the production of knowledge relevant to an area – a study *within* and *for* – although the boundaries here are of course not clearly demarcated.'¹⁴

As a further complexity, it is also noteworthy that this field of enquiry concerns – at least – two different conceptualisations of culture: culture as a widespread, semogenic system and culture as artistic and intellectual works, which Ola Sigurdson disentangles in the introduction to this book. Consequently, different studies may have very disparate emphases in their research materials and methods.

After this introduction, I will discuss educational activities within the medical humanities before addressing research in the field in greater depth.

MEDICAL EDUCATION

The medical education component of the medical humanities has been present from the outset and has emerged in response to a perceived lack. Medicine has undergone an impressive development of methods and techniques to cure disease. In the meanwhile, increasing frustration has arisen over the rigidly scientific view of knowledge and its often reductionist approach, where people have come to be objects of the science and not subjects in their own right (see also the discussion in the preceding chapter). This frustration is shared by many factions – not only patients

and their families, but equally by doctors and those responsible for educating doctors – which has led to an interest in incorporating humanities studies in medical education.¹⁵ Through the humanities subjects, the ambition is to reach the human being, the holistic and the existential perspective that is necessary for health care and medicine to realise their full potential. In this sense, the medical humanities are related to a medical orientation such as patient- or person-centred care, and in Swedish medical education it is sometimes organised within the larger educational module of ‘Professional Development’, which emphasises early clinical training and discussions of psychology and ethics.

In his medical memoirs, physician and novelist P.C. Jersild gives a striking depiction of this sense of something lacking in medical education, and of the collision between two different perspectives on human beings. Jersild describes his early days in medical school:

So began the process of mental hardening, the de-humanisation, that is probably necessary to withstand the pressures of being a doctor. In certain situations, you are forced to regard another human being, living or dead, as an object, someone that you avoid identifying with at any price. And then you must reconnect to your human side, your empathy, again. Not everyone is able to do that.¹⁶

Jersild emphasises here that this involves two different views of human beings – as objects versus individuals – both of which are valid and necessary and which a doctor must be able to move to and fro between, and the risk the doctor runs of losing the latter view of humanity.

One of the responses to this problem has thus been to bring humanities studies into medical education. In this educational project, there are at least three essential aspects, which I call here *reflection*, *self-reflection* and *critical reflection*. The first involves an understanding of the patient as a whole person, and that this individual’s perspective and lifeworld often differ dramatically from

the medical student's own. Perspective is a key word here, and the opportunity for medical students to engage both emotionally and cognitively at the same time is profoundly important. The second involves students seeing their own perspective, but not in a de-personified manner, as the doctor's role is traditionally viewed in for example the writing of patient charts, but instead re-personified. This provides an opportunity for medical students to reflect about their own positions and professional role and to create an understanding of themselves and their colleagues.

These reflections and understandings are necessary for medical practice to reach its full potential. Understanding a patient or one's own role not only makes the patient feel acknowledged or the doctor happier, it is a clinically relevant activity that is the basis both for making a diagnosis and for being able to communicate in such a manner that the patient understands and complies with the doctor's orders, which is actually quite often not the case.¹⁷

The third aspect I mentioned above, critical reflection, can sometimes have a less immediate impact in medical education, but it is at least equally important – and is partly the foundation of – the other two. Critical reflection involves developing a critical perspective on medicine, health care and the influence medicine has on our society today in order to develop a personal, reflective view of medical practice. The perspectives of many humanities subjects are relevant here and on the whole this involves, as Ahlzén argued, alternating between 'the critical, analytical perspective and that rooted in insight and empathy'.¹⁸

The medical humanities in medical education has elements that are essential to students who later become practising physicians and these, alongside the rest of medical education, lay the foundation for a personal, lifelong development. This is also important in order to build a future platform for the encounter between physicians and scholars of the humanities.

As mentioned, there are some strands of the humanities in all Swedish medical schools, but what is taught, how, by whom and at what stage of the education differs. Activities have evolved in

each medical school in relation to local needs and opportunities. I believe it is time for a more serious discussion of these educational issues as an aspect of professionalising this type of educational element. There is a tendency for education in the humanities – the reading of literature, for example – to be seen as a kind of hobby for doctors who are already engaged in medical education rather than as an educational orientation in its own right. Not uncommonly, these courses are provided without using humanist competencies and with no significant pedagogical discussions of aims and methods.¹⁹ One project at Linnaeus University, led by Margareta Petersson, closely examines how such courses may proceed and shows that it is often person-dependent and its practise is not always carefully considered in terms of education theory.²⁰ There is potential for development of the medical humanities within medical education through focus on pedagogical reflection and more elaborated collaboration between humanities scholars and physicians. If the humanities elements could progress from short, isolated and basic modules or strands to a more carefully designed and in-depth course of study with clearer progression, it would be an important evolution. Considering how similar work is also being done in the other Nordic countries, it would be worthwhile to engage in not only national, but also pan-Nordic, discussion. Some universities have made progress towards such an evolution; others have in fact undergone one but have not always succeeded at holding onto it. A good and recent example of a discussion of the humanities element in medical education and particularly the reading of literature comes from the University of Aarhus, through the anthology *Lægers dannelse* [The shaping of doctors].²¹ For the past five years, the medical school at Aarhus has been offering an optional humanities course with a special concentration in philosophy and literature. *Lægers dannelse* is based on experiences gained through the course.

One of the stumbling blocks for the medical education orientation of the medical humanities is the demand for evidence within medicine. In a literature study of papers on the humanities in med-

ical education, Jakob Ousager points out that papers often stop at the expectations on the humanities and omit any actual presentation of evidence.²² It is unsurprising – as Ousager also concludes – that isolating and measuring such a thing as the long-term impact of humanities studies on medical students is very difficult indeed, if not impossible. With the term ‘narrative-based medicine’, the parallel to the established evidence-based medicine is brought to the fore, which may be seen as an acknowledgement that the first cannot be included in the traditional evidence-based discourse. Martyn Evans challenges the one-dimensional orientation towards learning outcomes that can be assessed and argues that it is not always the most appropriate way to regard learning. He would like to provide a place for learning outcomes that are ‘beyond assessment’, which I would argue is an important contention in this work.²³ The problems associated with demands for evidence are discussed in greater detail by Morten Sager and Gunilla Priebe in Chapter 2, in relation to the Arts and Health field.

As rigorous standards of evidence are problematic in a context such as this, which involves a doctor’s personal and professional development over time, other types of material is often used as a basis of argument. This applies primarily to student course evaluations, to which I will also refer, and personal reflections based on teaching experience. The course evaluations show that medical students often find the humanities courses enriching. I will now describe such a course programme, taught at Lund University, in greater depth.

The Lund University example

Over the last seven years, the University of Lund School of Medicine has made a conscious investment in the medical humanities. As at many other institutions, there was also a prior commitment inclined towards the medical humanities, but this has occurred in a more systematic manner in recent years. In order to shed light

on the medical education orientation of the medical humanities and its potential in greater detail, I discuss here how the work is being done in Lund; this may be regarded as a manifesto of a sort, based upon an empirical example.

Although the university has implemented an initiative in the field, there is still no uniform view of the medical humanities and its role in education. Administrative and practical circumstances, such as how the various terms are organised as separate units, make it difficult to coordinate the whole, although relatively broad consensus has been achieved. Lund University's unique contribution to the medical humanities in Sweden is the advanced five-week course that concentrates on the aesthetic disciplines. I will describe it here along with, briefly, two other elements of medical education. Medical ethics was already a well-established subject at the medical school and I will describe here only the other initiatives within the medical humanities.

As in several other medical schools, the students encounter narratives in the very first term. This includes the reading of books, film screenings and group discussions under the guidance of tutors, i.e., doctors who teach in the programme and stay with the student groups over time. The group discussions are required elements of 'Professional Development', a course module that also covers a variety of other elements in which the students, among else, are introduced to clinical meetings. As Petersson described in her study, the group discussions are led by the students' regular teachers; as a result, the discussion groups vary in character, depending on the individual tutor. In the first couple of terms, Professional Development provides an essential glimpse of the profession and the clinical challenges it entails, and the use of literature and film works as a sort of 'experience bank' that can be drawn upon to discuss illness from the patient's perspective. The students are, however, only recently admitted to medical school and have essentially no clinical experience, which means they do not always have a medical context to which they can relate the reading. Once the students have acquired clinical experience, the

humanities perspectives offer an important opportunity for reflection, something for which the students do not have the same need – or the tools for – in their preclinical training.

For the past few years, an intensive course in Professional Development, which lasts about a week, is provided in the eighth term. In this course, students undergoing clinical training engage profound discussions of care encounters, ethics in the context of death and dying and in communicating devastating information. The course includes a study of literature taught by a literary scholar, in which the students all read the same work of fiction. I am the literary scholar involved and in addition to the literary discussion, I also provide an overview of the field of medical humanities itself. A lecture given to a large group of more than a hundred students is far from the optimal situation for literary seminars, but there is some scope for discussion in smaller groups. Above all, this is the only required element of medical school taught by a literary scholar. It acts as an important reminder to the students of the potential of the medical humanities at a point when they have been working clinically for a couple of terms and are beginning to understand in earnest how the humanities can enrich their day-to-day work.

The most ambitious component of the medical humanities in Lund is a five-week, full-time course provided in the eleventh term, the final term of the programme.²⁴ The course was initiated in 2008 by Anders Palm, professor emeritus in literature, who has been the course director since then and is responsible for the lion's share of teaching and advising. The course concentrates on the aesthetic disciplines, but also offers historical perspectives and an overview of the medical humanities. This course is an optional advanced course – with resources and requirements comparable to, for example, courses in emergency medicine, diagnostic imaging and public health nutrition – and 10 to 15 percent of medical students opt to apply for the course. Thus, not all medical students study the humanities, but those who are accepted to the course are provided five weeks of full-time in-depth study of the

humanities. It is a key point for this course and for the medical humanities that it is not a marginal supplement that the students are expected to pursue in their free time, but rather a course of study that takes place within their medical education. It is also important to note that the students who take the course have actively chosen to do so. Thus, in their interest and engagement, they are not necessarily representative of the entire student population.

The course in medical humanities works as a supplement to the students' other studies and clinical practise, but also as a reflection about these and an avenue to a sort of counterculture.²⁵ One fundamental precept is that the students are allowed to depart from the detailed learning of comprehensive materials that they are used to and instead encounter a different type of study and reading with the explicit aim of providing room for reflection, analysis, interpretation and perspective-switching, all in relation to important subjects including the professional role, illness, patients and families, but by extension also society, culture and the role of medicine in them both. This is accomplished through lectures combined with seminars and reading material that must be studied in a different, slower and more qualitative way than the usual reading material. The course also differs from ordinary humanities courses in that it has no ambition to cover a certain amount of historical or theoretical material. The point is to use the humanities perspectives as keys to discussion and reflection – not primarily to provide general education, but rather integrated education.²⁶

The course consists of two equally important parts. First, a lecture and seminar series in which the course director and guest lecturers expand upon various perspectives on medicine and health. It is important here that the lecturers come from the fields of both medicine and the humanities, which offers a plethora of angles and encounters with specialists in disciplines unfamiliar to the students, as well as with physicians who can act as role models. The potential of the course would decline considerably if it did not have lecturers from both of these fields.

The second part is the students' final project, which they work on in parallel with the lectures. The project is an independent special study within a humanities subject or with a humanities perspective on medical activities. Unlike a conventional final exam, this project requires the student to delve deeply into the subject and create a personal relationship to the material, which differs from much of the medical education programme. The students choose their assignment based on their personal interests. Over the years, the choices have covered many different subjects and methods: creative writing about for example being a medical student or encountering patients; other creative expression such as musical composition or film-making; reflections about the role of the physician and medical education; studies of the philosophy and history of medicine; studies of novels, autobiographical stories, works of art, TV series, film or specific phenomena such as Gunther von Hagen's exhibition *Body Worlds*.

The students present their final projects as oral presentations in front of the rest of the group in a final two-day conference at which the students also comment upon and discuss each other's subjects. This approach to the final examination further emphasises the focus of the course design on dialogue and discussion and how it involves a departure from the physician's putatively objective role in favour of a personal, individual perspective. The students are used to making oral presentations, but not with the personal angle or at the level of ambition required in this course.²⁷

As mentioned, a quantitative, evidence-based evaluation of the long-term effects of this type of education is very difficult – arguably impossible – to carry out. What we have to go on are, first and foremost, the course evaluations, which show in a qualitative manner how the students perceived the course immediately after completion. Striking aspects of the detailed evaluations are that the students think the course is distinctly different to the rest of the programme; their awareness of the shortcomings of medical education; and that they in fact believe that five weeks of humanities studies can make a difference. One student wrote that the course

‘dealt with exactly that which medical school is lacking: the opportunity to discuss, reflect, criticise, illuminate and think deeply about our future profession, our future role as doctors and the encounter with patients.’ The change of setting from the usual studies – both in how the course literature is studied and discussed, but also through that the course is physically located at the Centre for Languages and Literature – is perceived as an intrinsic value. The diversity of perspectives is considered inherently enriching and the concluding conference model of the course is also given very positive evaluations. One student emphasised that this gave the studies a clear application; another pointed out that it made the individual projects part of a team effort. The students appreciated the orientation of the final examination towards advancing a personal argument and having personal opinions, and several noted that this is not something they are otherwise encouraged to have.²⁸ For these students, the humanities perspective thus provides something qualitatively different from the rest of the programme and they consider it important to their future work and professional role.

I will now turn to the third orientation within the medical humanities: research and activities not primarily oriented towards medical education.

RESEARCH IN THE MEDICAL HUMANITIES

As mentioned, Martyn Evans characterises the third, more theoretical or critical orientation as ‘attempting better to understand human nature through the lens of a critical examination of technological medicine and its limitations’.²⁹ There is a wide range of enquiry here, which, depending upon the disciplinary affiliation, may have disparate materials, methods and aims. Is there, Evans asks, anything that the various humanities disciplines have in common that makes them able to contribute to the study of medicine? His answer is yes, and that these are, ‘first, a concern with experience – with recording and understanding and interpreting

individual human experience [...] or, if you like, a concern with the world as it is humanly encountered'. The second, which follows upon the first, is the concern to take subjectivity seriously: 'the individual point of view and its qualitative content' and how this is embedded in contexts.³⁰ This is a central definition of the humanities in general and of the humanities in its analysis and interpretation of medical activities in particular. A few disciplines are mentioned in many contexts as vital components of the medical humanities and must therefore be considered the most central in the field. On their website, for example, Durham University lists history, literature, theology, anthropology and philosophy as being among the central disciplines in the field, while the scholarly journal *Hektoen International* lists the arts, ethics, nursing, history and literature.³¹ It should be noted that some humanities research does not fit with these perspectives and that this research is rarely mentioned as a part of the field of enquiry.³²

In this book, and increasingly in the Swedish context, the choice has been to name the entire field *medicinsk humaniora* as a translation of 'medical humanities', a term that emphasises that the humanities are the fundamental discipline and 'medical' its specification. The name also works well as a parallel to other terms such as the 'digital humanities' and 'environmental humanities'. There is some criticism of the descriptor, but it has become the most accepted general term even though it is, as mentioned in a new book on the subject, sometimes used for 'lack of a better term'.³³

In the following, I will cover a few important aspects of the field. Much of the research was conducted before the term 'medical humanities' existed and many studies do not place themselves explicitly in relation to the field but is nonetheless to be considered part of it. I cannot provide extensive overviews of these fields here, but only brief descriptions.³⁴

In addition to the disciplines I will be discussing here in some detail, I would like to mention that several social scientific disciplines are also relevant in this context, perhaps above all psychology and sociology, as well as political science to a certain extent

(medical anthropology is discussed below together with ethnology). In Sweden, psychologist Lars-Christer Hydén is a prominent scholar in the field, while one of the influential international figures is sociologist Arthur W. Frank.³⁵

I will be giving somewhat greater scope to the orientations related to literature and narrativity – not only because this is the field that I am most familiar with as a literary scholar, but also because they have not previously been discussed to any great extent in Sweden, and because they have an ambition to be broad descriptors that incorporate rather large swathes of the medical humanities. My guess is that this broad ambition may have to do with precisely the fact that these are relatively new research directions that do not have a long disciplinary tradition in their own subject.

Medical ethics, philosophy and religious studies

Philosophy, and particularly medical ethics, has been a key point of departure for the medical humanities. Ethics is the humanities subject that has become the most entrenched in faculties of medicine, which has led to the formation of a relatively clear and well-defined field of enquiry. Medical decision-making and medical research are two of the prime topics of discussion within medical ethics. The research often concerns questions surrounding the beginning and end of life, organ transplantation and stem cell research, patient autonomy and models for ethical decision-making. Medical ethics is an expansive field and I am unable to explore it in any depth here. It should be noted, though, that the discipline encompasses specialists from several different fields, not only philosophers but also theologians and physicians in clinical practice. Some of the most prominent Swedish scholars in the field include philosophers Torbjörn Tännsjö, Christian Munthe and Nils-Eric Sahlin, physician and medical ethicist Niels Lynöe and theologian Mats G. Hansson.³⁶

Ethics is, of course, not the only contribution to the field made by philosophy – other philosophical enquiry has also been important. The spectrum is broad here, ranging from analysis of conceptualisation and theory in various medical specialities to concepts such as autonomy, decision-making and causality. The theory of science offers essential perspectives in which medicine is analysed as a science, studying for example psychiatric diagnostics, insurance medicine, the interplay between science and various social processes and assumptions of the objectivity of evidence-based methodology.³⁷ Margareta Hallberg and Fredrik Bragesjö have studied the debate about the MPR vaccine – a commonly used childhood vaccine – that has been alleged to cause autism, an allegation that was widely communicated and led to fewer parents having their children vaccinated, even though the allegation had no scientific basis.³⁸ As Lennart Nordenfelt notes in a review, the contributions of philosophy are not limited to conceptual and theoretical enquiry, but also extend to the analysis of medicine as established practice.³⁹ Important theories in the latter context are hermeneutics and phenomenology, which Fredrik Svenaeus has continued to explore within the subject of practical knowledge.⁴⁰ Lennart Nordenfelt is a prominent scholar in the field of medical philosophy and has, among else, written books about the nature of health and theories on health and quality of life.⁴¹

Theology and religious studies are disciplines that are also engaged in several ways other than within the confines of medical ethics and the more down-to-earth nursing ethics. The theological approach is not completely unlike the philosophical, but is more often based on concrete material. There is considerable breadth to this research: quantitatively oriented empirical studies, studies of philosophical and conceptual issues, theological discussions and research on existential health within the psychology of religion. One current example of research based on concrete material comes from worldview studies, where the subject of a doctoral thesis by Wilhelm Kardemark is the perspective on humanity evinced in Swedish health magazines.⁴²

Medical history – one subject within several disciplines

Medical history is a subject with a relatively long tradition in Sweden. Medical history can be divided into three different departmental affiliations, although it does not actually exist as a separate subject descriptor. The bulk of research is conducted within the history of science and ideas, in which medical history is a large and flourishing segment. Much research on medicine, health and disease is also conducted in the field of history and, finally, there are also medical history activities within the faculty of medicine. These orientations differ; the latter area of research is largely oriented towards the professional history of the medical community and the advances of medicine. In *Medicinens öga* [The eye of medicine], Karin Johannisson calls this ‘traditional medical history’. She calls the other two branches that she identifies ‘social medical history’ and ‘critical medical history’.⁴⁴ Both of these are found in the disciplines of history and the history of science and ideas, which is preoccupied with the analysis of ideas, critical studies of power, the patient perspective, social history and how medicine has acted as a force that shapes society. While there is a certain tension between the various orientations, they are also complementary.

There are also differences in orientation and interests between the subjects of history and the history of ideas, although they often overlap. Taken as a whole, medical history research is a vibrant field of scholarship in Sweden. It studies a diverse body of material, such as patient charts, documentation of medical experiments, demographics and epidemiological statistics, medical visual media, patient narratives and physician memoirs. The field studies medical phenomena or putatively scientific orientations that were influential in the past, the practise of medicine before major medical therapeutic breakthroughs and the treatment of vulnerable groups in society – to mention only a few examples.

There are far too many scholars of medical history to mention all of them here. The most prominent representative is undoubtedly Karin Johannisson, whose many studies in medical history

are also accessible to a wide audience. For example, her studies of the body as object of medical science and the history of emotions are strongly oriented towards the human experience and the defining power of medicine.⁴⁵ The Festschrift written in her honour in 2010 displays the breadth of current research in the history of science and ideas in relation to medicine.⁴⁶ Other important contributors to the field include Gunnar Broberg, who studied eugenics and forced sterilisation in Sweden; Ingemar Nilsson, who studied the history, scientific ideals and perspective on humanity of psychology; and Roger Qvarsell, who has studied the history of psychiatry and criminality as well as advertising and health.⁴⁷

In addition to the separate spheres of historians and historians of science and ideas, I would also like to mention the interdisciplinary theme-based research settings at Linköping University. As explicitly interdisciplinary, these cannot be easily categorised in a particular subject area, but this research is often grounded in history and, not uncommonly, medical history.⁴⁸ Karolinska Institutet has established a medical history archives, the Unit for Medical History and Heritage, and runs the Hagströmer Medico-Historical Library. A comprehensive history of Karolinska Institutet was published in connection with the institution's bicentennial in 2010.⁴⁹

Medical history is thus a core activity in the disciplines of history and the history of ideas. The scholars involved have noted increased interest in how the history of medicine might be useful and participate in interdisciplinary approaches and medical education – an evolution that is imposing demands on the discipline to define its position in a new academic landscape. In response to this development, an international conference on the theme of the 'History of Medicine in Practice' was held in Uppsala in the spring of 2014.⁵⁰

Ethnology and medical anthropology

The medical orientation is also an important aspect of ethnology, even though ethnologists are not inclined to use the 'medical'

modifier, instead seeing medicine as an equally natural part of the discipline as other aspects. Ethnological studies are by definition preoccupied with a wide variety of materials and a large number of areas, and a great deal of research has been done within ethnology on health, disease, disability, ageing, care institutions and medical encounters. The discipline is wide-ranging: the ethnographic method is employed to study beliefs about issues like health, disease, life and death, as well as people's ordinary lives with disease and illness and the cultural processes that affect the day-to-day work in health care. In an issue of *Socialmedicinsk tidskrift* on the theme of 'ethnology and medicine', the editors write that by 'unveiling and describing the beliefs, norms and values that influence both patients and health care workers, ethnology can contribute to greater understanding of the cultural components of medicine.'⁵¹ They note that ethnology has drawn increasingly close to the medical field and the issue of the journal provides a good introduction to the area of research.

A current example of an ethnological contribution to the field is Susanne Lundin's book on organ transplantation, *Organ till salu* [Organs for sale], published in 2014. Lundin has also done previous research in the medical area on subjects including genetics and reproductive technology.⁵² Britta Lundgren has studied grief processes when people have lost a family member through unexpected death and examined the cultural aspects of contagion and vaccination, Lars-Eric Jönsson studies the history of psychiatry and the spaces of mental health care, while Georg Drakos has carried out research in the contexts of Sweden and Greece to examine narratives and self-understandings in relation to diseases like HIV/AIDS and leprosy.⁵³

Medical anthropology is a well-established discipline abroad, both within anthropology and in medical education. It is relegated to a less visible position in Sweden, with one important exception: Lisbeth Sachs, who has written several studies within the discipline. Medical anthropology and ethnology share the ethnographic method and often have similar research interests, such

as human belief systems and health care culture. By tradition, anthropologists are often oriented towards cultures other than their own, but medical anthropology has also become increasingly interested in contemporary western medicine. How medicine produces and communicates knowledge is often compared and contrasted to other belief systems, a relationship clearly evident in titles like *Från magi till bioteknik* [From magic to biotechnology], *Sjukdom som oordning* [Disease as disarray] and *Evil Eye or Bacteria*, all written by Sachs.⁵⁴ Scholars in the field are preoccupied with the cultural shifts in human perceptions of the body that have occurred in pace with advances in technology and diagnostics. This example shows how closely related the subjects of research can be: this interest in cultural change is shared by ethnologists, historians of ideas and literary scholars, but also philosophers like Sveinaeus, whom I mentioned in the introduction to this text.

*Literature and medicine, narrative medicine
and the aesthetic disciplines*

The constellation of *literature and medicine* denotes, one might say, the entry of the aesthetic disciplines into the world of medicine. This has not occurred as naturally as for several of the other disciplines and has therefore engendered numerous analyses of what a discipline like literature can contribute in the context.⁵⁵ Although the descriptor ‘literature and medicine’ may sound narrow, there is an ambition here to cover a large swathe of the medical humanities: both words in the name are interpreted in a broad sense, and this interpretation has become increasingly broader. For example, the editors of the scholarly journal *Literature and Medicine* wrote in 2006 about how the poles of the term are being reconceptualised: ‘the “medical” to include the work of the psychoanalyst and the trauma scholar and the “literary” to include not only film [...] but also visual representations and aesthetic products of all sorts.’⁵⁶

In this manner, the discipline is being expanded to become more of a combination of the practise of medicine in the widest sense and aesthetic expression, where literature is often taken as the most fundamental form. It is important to note that the various forms of aesthetic expression cannot be easily summarised within a perspective that is mainly textual. In this section, I will primarily discuss literature and narrativity. Unfortunately, I do not have the opportunity here to discuss the other aesthetic disciplines, such as art history, film studies and musicology in the depth they actually deserve, but I do want to stress that the discussion of literature is to some extent applicable to them and to some extent not. When literature is discussed in this field of enquiry, however, scholars are seldom exclusively interested in literary texts and there is usually a concerted effort to also include other art forms. A recent anthology, already mentioned in the introductory paragraph, *Medicine, Health and the Arts*, elects to structure its account of the Medical Humanities through four different forms of aesthetic expression: visual, performative, narrative and musical.⁵⁷ The central place of literature is thus not a law of nature, but has more to do with accepted traditions in the humanities.

Within 'literature and medicine', medical education has played a central role. One might say that literature began its medical career as a kind of 'adjunct of medical ethics', as a basis for ethical reflection in medical education.⁵⁸ Anne Hudson Jones divides the perspective on literature into two approaches, the ethical and the aesthetic. As a development from the ethical approach, centred on the content of the literary text, greater emphasis has been placed on the aesthetic, which emphasises the literary form and its capacity to develop skills such as interpretation and sensitivity to situation-dependency in narratives. A Swedish-speaking pioneer in this kind of activity is Merete Mazzarella, who has taught literature to doctors and medical students at several universities. While she is a proponent of literature and the humanities in medicine, she is critical of how demands on fiction have

grown too large and of how fiction is often used in a far too naive way in terms of literary education. She objects to the 'notion that good literature is always and in all circumstances good for everyone.'⁵⁹ She stresses the importance of not simplifying literature in teaching, but rather taking the complexity of literature into account. Like Margareta Petersson's study, which I cited above, Mazzarella's argument can be considered a challenge to professionalise this field of education in.⁶⁰

Research in literature and medicine has approached aspects of health, disease, disability and ageing through studies of literary depictions and other types of narratives. Literature functions as a space to explore human beings in all their complexity and contextuality, and to examine culture and society. The research offers textual and aesthetic perspectives as well as those of history and cultural studies. The material studied covers a wide range: in addition to fictional presentations and poetry, there is also an interest in other types of depictions of illness and disease, such as the narratives that have come to be called pathography: biographical or autobiographical narratives of personal experiences of illness and disease.

In their comprehensive study *Sykdom som litteratur* [Illness as literature] Hilde Bondevik and Knut Stene-Johansen have closely examined thirteen different diagnoses and discussed them from the perspectives of literature and cultural history. They emphasise the parallels between illness and literature: 'For just as illness is inscribed in a context that is often incalculable and multifaceted, literature itself is a complexity that is ideally suited to staging illness in a privileged manner.'⁶¹ As in my own doctoral thesis, *Litterära besvär* [Literary Ills], the focus is on fiction here, but the field of enquiry extends beyond that and encompasses, for example, a study like Petter Aaslestad's *The Patient as Text*, in which the author makes a narratological study of patient charts; Kathryn Montgomery Hunter's study of narrative in medical practice, *Doctors' Stories: The Narrative Structure of Medical Knowledge* and Rolf Ahlzén's doctoral thesis on the reading of literature and

the doctor's clinical judgement.⁶² In this context, I would also like to mention an early and comprehensive project in the Nordic region, the Norwegian *Infectio: On Illness in a Literary Perspective*, which was directed by Stene-Johansen and produced several publications.⁶³

At the centre of literature and medicine – and as a way to more clearly specify it – descriptors have arisen that focus on the narrative rather than literature. English scholars sometimes speak of ‘narrative-based medicine’, formulated as a counterpart to the classical evidence-based medicine.⁶⁴ The most well known descriptor is ‘narrative medicine’, coined by physician and literary scholar Rita Charon. Both orientations are preoccupied with bringing the narrative in medicine to the fore, which is critical in the medical profession, in the encounter with patients as well as in the acquisition of knowledge and in the professional discourse. The important role of narrative and storytelling in medicine is something that has not been previously and adequately recognised, which has given rise to these research orientations. Kathryn Montgomery Hunter's studies of how narratives and storytelling are fundamental forms of understanding in medicine is an elegant example of scholarly work in narrative medicine.⁶⁵ Narrative medicine may be regarded as part of the larger narrative turn that has occurred over the past few decades, in which narrative and storytelling have become important categories in several scholarly and scientific disciplines.

In a retrospective account, Rita Charon writes that the name visited her when she was working on an essay: ‘I realised all of a sudden that if you took the narrative out of medicine, there would be very little left.’⁶⁶ Charon also appreciated the purely linguistic kinship of narrative medicine to other sub-categories of medicine like internal medicine and nuclear medicine. Narrative medicine is thus presented as one of several medical specialities, while the medical humanities are instead an orientation within the humanities as a whole.⁶⁷ As a result, these areas have certain disparate aims and points of departure. Nevertheless, it is reasonable to re-

gard narrative medicine as a category of the medical humanities.

As Rita Charon sees it, narrative medicine picks up influences from many different directions including patient-centred care, but she takes much of the theoretical framework from literary studies. What Charon wants to offer is a speciality that is rooted in medicine and that has concrete methods for how doctors can become better professionals. She discusses the need for a holistic understanding of people and for the ability to communicate with them. But instead of consigning these abilities to the doctor's intuition – that is, something the doctor either can or cannot do – she shows that these competencies can be developed and practised. The aim is for the interest in narrative to provide 'what medicine *lacks* today – in singularity, humility, accountability, empathy'.⁶⁸ The methods she suggests are, firstly, close reading of literary texts, in which a study based on literary theory increases sensitivity to things such as the narrator's perspective, voice, context, time, character and plot. Secondly, she recommends reflective writing, in which doctors write about encounters with patients in order to better understand the patient and the disease, but also themselves.⁶⁹ In Charon's view, narrative medicine is thus primarily something that has to do with medical education and professional knowledge, but the term is also used for literary studies and other research activities.

Narrative medicine is also closely related to the field designated 'narrative ethics', an orientation that argues that ethics must work with the individual, context-dependent case presented in the form of one or more stories, rather than proceeding from a set of fundamental ethical principles. One example is an anthology edited by Rita Charon and Martha Montello, *Stories Matter: The Role of Narrative in Medical Ethics*, which discusses how understanding of stories and their narrativity can improve ethics.⁷⁰ Arthur W. Frank calls this 'thinking *with* stories', which is something other than the 'thinking *about* stories' prevalent in literary studies.⁷¹

After these quick looks at a few subject areas, I will discuss

very briefly a couple of other suggestions for unifying terms for the field in Swedish, before moving on to an overview of various activities in the medical humanities.

Humanistic health research and humanistic medicine

One term for the field previously used in Sweden is *Humanistisk hälsoforskning* (Health research within the humanities) which is also the title of a book that brings together research overviews of various sub-disciplines within this descriptor, such as ethnology, history, anthropology and philosophy.⁷² The name has since been expanded to the somewhat clumsier, but clearly inclusive, *Humanistisk och samhällsvetenskaplig hälsoforskning* (Health research within social sciences and the humanities). In the same way as *medicinsk humaniora*, the ‘medical humanities’, the name clearly illustrates the breadth of the field and is a good alternative to the term used here.⁷³ To a great extent, the name refers to the same field of enquiry and the same disciplines. One can discuss the terms based on how they include or exclude disciplines, as well as based on their effectiveness and clarity. Medical humanities has the advantage of being a relatively short and effective name, as well as being the most internationally established.

Another earlier descriptor that partially overlaps with the medical humanities is *Humanistisk medicin* (humanistic medicine). This name was used by organisations including Karolinska Institutet when it, as a pioneer in Sweden, introduced the humanities in medical education, an initiative that has since largely disappeared from the institution. A good overview of what was included in the concept is provided in a paper published in the Journal of the Norwegian Medical Association.⁷⁴ Humanistic Medicine is also the name of a development programme that has been running for a bit more than a decade at Södertälje Hospital in Sweden.⁷⁵ The descriptor is not an unmitigated success, as Roger Qvarsell and Ulrika Torell argue, because it ‘does not

primarily [refer] to the contributions of the humanistic disciplines to medicine, but is rather an ideological definition of the task of medicine, and even more so of the art of medicine' and because it thereby 'deliberately mixes the two meanings of the term humanistic – the humanities disciplines and humanism as a worldview'.⁷⁶ Owing to this ambiguity, the term is not suitable for the field and it therefore eventually gave way to other names.

ACTIVITIES IN THE MEDICAL HUMANITIES

A wide variety of activities are in progress abroad within the medical humanities and I would like to give an overview here of a few different types: research centres, journals and book publications. Naturally it is impossible to provide an exhaustive account, but the overview may at any rate serve to provide a general picture of activities ongoing in the field. English is the prevalent language in the subject area, as evident in the review, which is dominated by the United Kingdom and the United States. I will also attempt to highlight a good part of what is happening in Sweden and, to a certain extent, the Nordic region.

Research centres and networks

Major research centres that pursue a wide range of activities – something the University of Gothenburg Centre for Culture and Health aspires to – are found at several academic institutions and development has been strongest in the United States and England.⁷⁷ The research centres in the United States are in most cases affiliated with university faculties of medicine, while in England there are, in addition to institutions at faculties of medicine, independent and innovative research centres established with funding from Wellcome Trust.

Development of the medical humanities began in the United States in the 1960s. An early example is the Penn State College of Medicine, which had a Department of Humanities from its inception in 1967.⁷⁸ Another early example is the University of Texas Medical Branch at Galveston, which founded its Institute for the Medical Humanities in 1973. In 1988, they became the first in the country to offer postgraduate studies in medical humanities.⁷⁹ Many other medical schools in the United States have a centre, institution or department of the humanities. These are called by various names, such as ‘Medical Humanities’, ‘Medical Humanities and Bioethics’ and ‘Bioethics, Humanities and History of Medicine.’⁸⁰ The Program in Narrative Medicine at the Columbia University Medical Center is an important and high-profile institution directed by Rita Charon, who is both a professor of medicine and a literary scholar.⁸¹ Narrative medicine has been developed and established here as both a field of research and a subject of study. The high profile is evident, for example, in that the humanities are not optional subjects: all medical students are required to take a humanities course. Columbia’s teaching practices have also spread to several other medical schools in the country.

The development of the medical humanities has been slower in Europe. Establishment of the area did not begin until the 1990s in England and accelerated in earnest in the 2000s. The expansion was made possible in part due to support from the research funding institution Wellcome Trust, which in its endeavours to improve health care has identified the medical humanities as an important area.⁸²

About a dozen universities in England have centres for medical humanities or offer degrees in the subject.⁸³ The most distinguished are the Centre for Humanities and Health at King’s College, London, and the Centre for Medical Humanities at Durham University.⁸⁴ Both of these centres are directed by prominent representatives of the medical humanities, Brian Hurwitz at King’s College and Martyn Evans and Jane Macnaughton at Durham University. They are both independent research settings

and although they offer courses and degrees, the emphasis is on wide-ranging research activities.⁸⁵

The International Network of Narrative Medicine was launched in 2013 as an attempt to gather stakeholders in the field from the entire world – as the name indicates, primarily that part of the field interested in narrativity. The arrangers of the conference at which the network was established were the Program in Narrative Medicine at Columbia University and the Centre for the Humanities and Health at King's College.⁸⁶

There are as yet no major research centres in the Nordic region that correspond to those in the United States and the United Kingdom. What we have here are individual researchers and initiatives in research and education that, as a whole, offer a broad spectrum of medical humanities, although they do not always have extensive interactions with each other. A few Nordic networks have been established for activities in the field, which may act as a cohesive force in the future. Among else, there are the Nordic Network for Studies in Narrativity and Medicine, the Nordic Network for Philosophy of Medicine and Medical Ethics and the Nordic Network for Health Research within Social Sciences and the Humanities.⁸⁷ Examples of Swedish networks are the *Forum för medicinsk etik* [Forum for medical ethics] and the *Forum för humanistisk-samhällsvetenskaplig hälsoforskning* [Forum for health research within social sciences and the humanities].⁸⁸ Through network meetings and conferences, these networks provide meeting places for researchers who are rarely part of larger research groups at home.

As mentioned, the humanistic subject that enjoys a special status at faculties of medicine is medical ethics, which is represented at most faculties of medicine in Sweden.⁸⁹ Additionally, there are very small units oriented towards the history of medicine, such as the Medical History Unit at Lund University and at Uppsala University, Medical History, a unit within the Department of Neuroscience.⁹⁰

Journals

Thus far there are no Nordic journals dedicated to the medical humanities. There are some comprehensive international journals in the medical humanities, the most prominent of which are BMJ's *Medical Humanities* and Springer's *Journal of Medical Humanities*.⁹¹ The former was started in 2000 and publishes two issues per year. It began as a special edition of the *Journal of Medical Ethics* and has increasingly come to be a journal in its own right. The latter has been around longer and has undergone several name changes, which illustrates how the field has expanded. The journal has transitioned from names that concentrated exclusively on medical ethics (*Bioethics Northwest*, *Bioethics Quarterly* and *Journal of Bioethics*) via the hybrid name *Journal of Medical Humanities and Bioethics* before finally being given its current name in 1989. The Chicago-based *Hektoen International* is a more recent addition to the array of journals. It is a journal of the medical humanities whose underlying subjects are 'art, ethics, healthcare, history, literature.'⁹²

As the name changes of the *Journal of Medical Humanities* suggest, ethics have been one of the disciplines that have most clearly and successfully explored the meeting point between the humanities and medicine, and quite a few journals and research centres have, over time, changed their names from bioethics to medical humanities. Other journals with a philosophical orientation have maintained their subject focus. Some of the most important are *Journal of Medical Ethics*, *The Journal of Medicine and Philosophy*, *Medicine, Health Care, and Philosophy* and *Theoretical Medicine and Bioethics*.⁹³

Literature has a presence in many journals of the medical humanities, where it is often included under standing headings like 'Literature and Medicine' or 'Poetry and Prose.' The journal that has literature as its principal concern is the American *Literature and Medicine*, which began publication in 1982.⁹⁴ The comprehensive *Literature, Arts, and Medicine Database* developed at New York University also deserves mention here. The database col-

lects annotations of literature, film and art whose subjects are of medical interest.⁹⁵

Several journals are dedicated to medical history and Swedish scholars also publish frequently in forums that are not primarily oriented towards medical history. A few foreign examples are *Social History of Medicine*, *Bulletin of the History of Medicine* and *Medical History*.⁹⁶ In Sweden, we have *Svensk medicinshistorisk tidskrift* [Swedish journal of medical history] which is associated with the Swedish Society of Medicine.⁹⁷

There are also several journals oriented towards medical education in which the medical humanities are regularly discussed, including *Medical Education* and *BMC Medical Education*.⁹⁸ Journals in other fields that relatively frequently publish articles related to the medical humanities include *Sociology of Health and Illness* and the Swedish *Socialmedicinsk tidskrift (Journal of Social Medicine)*.⁹⁹

The medical humanities are also regularly represented in medical journals such as *The Lancet*, *Journal of the American Medical Association (JAMA)*, *New England Journal of Medicine*, *Academic Medicine* and *Annals of Internal Medicine*.¹⁰⁰ In the Nordic region, brief articles are seen in, for example, the Swedish *Läkartidningen* [Journal of the Swedish Medical Association] and its sister journals in the other Nordic countries.¹⁰¹

Comprehensive book publications

In addition to journals, there are naturally a wide variety of book publications in the field, especially in the form of individual research monographs. I will confine myself here to mentioning a few cardinal examples, with some emphasis on the Swedish material. Throughout this chapter, I have already given examples of individual studies relevant to the field – often published within their specific disciplines and only occasionally with a deliberate reference to the medical humanities – and I will not be discussing this type of work here.

Anthologies that gather scholarly texts in order to establish or develop the field or one of its sub-fields are essential in this context. One current example is the aforementioned *Medicine, Health and the Arts: Approaches to the Medical Humanities*, published in 2014.¹⁰² Earlier examples are the two English anthologies, *Narrative Based Medicine* and *Medical Humanities* and the American *Stories Matter: The Role of Narrative in Medical Ethics*.¹⁰³ A current Swedish introductory example is *Kroppen i humanioraperspektiv* [The body from a humanities perspective] from 2013, which may be seen as a kind of declaration of intent for the establishment of the medical humanities in Sweden, especially the parts of the field oriented towards aesthetics and philosophy. The volume brings together a wide array of Swedish researchers in the medical humanities, whose home disciplines are equally divided among the humanities and medicine.¹⁰⁴ Two earlier examples of anthologies seeking to establish a field are the already mentioned *Humanistisk hälsoforskning* [Health research within the humanities] and *Kulturen och hälsan* [Culture and health].¹⁰⁵ The monograph *Medicinen och det mänskliga* [The human aspects of medicine] written by physician Carl-Magnus Stolt, also brings the intersection of the humanities and medicine to the fore.¹⁰⁶

Companions or readers are another important type of publication. One such companion is the recent *Medical Humanities Companion* published by Radcliffe Health in four volumes, whose titles are *Symptom*, *Diagnosis*, *Treatment* and *Prognosis*.¹⁰⁷ An essential aspect of establishing a field of research and education is the production of readers, and *Health Humanities Reader* was published in 2014.¹⁰⁸

THE FUTURE OF THE MEDICAL HUMANITIES

The medical humanities is a burgeoning field of research and education. In a time when medicine plays such a crucial role in social and cultural development, the field has tremendous future

potential. As noted by Ekström and Sörlin, this is humanities research that is drawing closer to medicine ‘not only to observe it from the outside – a study of – but also to work from within to produce knowledge relevant to the field – a study within and for’, and as Rolf Ahlzén wrote, it is a field that must ‘be able to alternate between the critical, analytical perspective and that rooted in insight and empathy.’¹⁰⁹

There is a relatively extensive body of research in Sweden that touches upon the medical humanities, although it has still not been shaped as a field of enquiry as it has in England, for example. In all likelihood, the evolution and establishment of the medical humanities will continue over the next few years: researchers will find additional interfaces and common interests, initiatives towards greater interdisciplinarity and collaboration will ensue; as well, education in the field is likely to become even more clearly established and coordinated in medical education. Naturally, we will also see a movement in the opposite direction, albeit to a lesser extent, in which positions are taken against the very idea of a comprehensive field of enquiry, consensus and collaboration.

I believe that an important aspect of the future of the medical humanities will be to take advantage of its diversity and breadth while avoiding any attempt to standardise the field in a way that forces the collaborating disciplines and scholars into a too-narrow furrow. The medical humanities is not a single discipline, but a multidisciplinary field of enquiry and it is something scholars can be part of without having to abandon their disciplinary affiliations. At the same time, it is important to continue establishing the confines of the field and to initiate a joint discussion of central issues, which may lead to some consensus.

That disciplines come to the medical humanities from disparate points of departure and can make diverse contributions to the field is a rich resource. The medical humanities is – to some extent already, but first and foremost potentially – oriented towards the interdisciplinary or multidisciplinary approach. It offers the opportunity to analyse important cultural and social is-

sues through interdisciplinary collaboration at two levels, first between the different humanities and social sciences – which can be difficult on its own – and then between these and the medical disciplines and medical practice. The critical mission of the medical humanities means that it is not only about collaborating with medicine, but also about subjecting medical practice to critical analysis. This is a challenge. The challenge becomes no easier in that the field is also directed outwards from the purely scientific and scholarly context towards practitioners in various medical activities and towards society as a whole.

NOTES

1. Victoria Bates and Sam Goodman, 'Critical Conversations: Establishing Dialogue in the Medical Humanities', *Medicine, Health and the Arts: Approaches to the Medical Humanities*, Victoria Bates, Alan Bleakley and Sam Goodman (eds.), New York: Routledge, 2014, p. 4.
2. The Centre for Medical Humanities, Durham University, 'Medical Humanities' (www.dur.ac.uk/cmh/medicalhumanities). This website and all subsequent websites mentioned were last accessed 1 February 2014.
3. Fredrik Svenaeus, 'The Humanities of Medicine: What Could This Be?', *En annan humaniora – en annan tid. Another humanities – another time*, Carl Cederberg and Hans Ruin (eds.), Stockholm: Södertörn University, 2010, p. 63.
4. Fredrik Svenaeus, *Homo patologicus: Medicinska diagnoser i vår tid*, Hägersten: Tankekraft förlag, 2013, p. 78f.
5. Rolf Ahlzén, 'Medicinen – en bro mellan de två kulturerna', *Kroppen i humanioraperspektiv*, Anders Palm and Johan Stenström (eds.), Stockholm/Göteborg: Makadam, 2013, p. 279.
6. Martyn Evans, 'Medical humanities: stranger at the gate, or long-lost friend?', *Medicine, Health Care and Philosophy*, 10 (2007), pp. 363–372.
7. Rolf Ahlzén, 'Medical humanities – arts and humanistic science', *Medicine, Health Care and Philosophy*, 10 (2007), p. 392.
8. This idea has been particularly central in the United States. Compare with Kardemark and Sigurdson, whose report mentions the 'so-

- cial challenge relevance' of the medical humanities as a position outside the accepted dichotomy, in which one either sees the intrinsic value of the humanities as absolute or ascribes it a value measured in purely instrumental utilitarian terms. This is a position worthy of further exploration. Wilhelm Kardemark and Ola Sigurdson, *Medicinsk humaniora vid Humanistiska fakulteten, Göteborgs universitet: En rapport*. Gothenburg: Faculty of the Humanities, 2014, p. 13 f.
9. Evans, 'Medical humanities', 2007, p. 367.
 10. Ahlzén, 'Medicinen', 2013, p. 279.
 11. Kardemark and Sigurdson, *Medicinsk humaniora*, 2014, pp. 27–29.
 12. Svenaeus, 'The Humanities of Medicine', 2010, p. 60.
 13. Anders Ekström and Sverker Sörlin, *Alltings mått: Humanistisk kunskap i framtidens samhälle*, Stockholm: Norstedt, 2012, p. 194.
 14. Ekström and Sörlin, *Alltings mått*, 2012, p. 196.
 15. I refer consistently to medical students, but these issues are relevant to all health care educations.
 16. Per Christian Jersild, *Medicinska memoarer*, Stockholm: Bonnier, 2006, p. 29 f.
 17. This is usually called adherence or compliance and it is not unusual for patients to not follow the doctor's recommendations because they are not perceived as valid. In her work *Narrative Medicine*, which is described in greater detail below, Rita Charon states that while she believes students derive emotional benefit from their writing and reading, the emotional well-being of medical students is not the primary goal. The goals are to 'enable them to recognise more fully what their patients endure and to examine explicitly their own journeys through medicine. This textual work is a practical and, I believe, essential part of medical training, designed to increase the students' capacity for effective clinical work.' Charon emphasises that this is a clinically relevant activity and part of ordinary clinical training and not some kind of group therapy for distressed medical students: 'I have come to make these distinctions for practical reasons. The death knell of any innovation in medicine or medical education is for it to be labelled "touchy-feely" or "soft."'. Rita Charon, *Narrative Medicine: Honoring the Stories of Illness*, Oxford: Oxford University Press, 2006, p. 156.
 18. Ahlzén, 'Medicinen', 2013, p. 279.
 19. There are also examples of more ambitious humanities courses that

are offered, or were offered in the past for a limited time, but they have rarely been integrated into medical education and its progression in earnest. Merete Mazzarella has, for example, taught writing courses for medical students and teachers at the Faculty of Medicine at Uppsala University, and Ingemar Nilsson has taught a course on the history of ideas of medicine at the University of Gothenburg, directed at medical students, to mention just two examples.

20. In this project, Petersson studied teaching in literature in an anonymised Swedish medical school. She followed two discussion groups led by different teachers who are both practising physicians. Petersson shows how differently the work can evolve, even at the same institution and in the same course, and how this type of activity becomes dependent on the individual teacher's approach to leading the group. Margareta Petersson and Anette Årheim, 'Läkarutbildning och litteratur', *Muntlighetens möjligheter – retorik, berättande, samtal*. Sjätte nationella konferensen i svenska med didaktisk inriktning [Sixth national conference on Swedish with a didactic orientation], Anne Palmér (ed.), Umeå: SMDI, 2009. pp. 130–141.
21. Per Vestergaard, Lise Kristine Gormsen and Karin Christiansen, *Laegers dannelse: En antologi om skønlitteratur som element i lægeuddannelsen*, Aarhus: Philosophia, 2012.
22. Ousager studied articles published in peer-reviewed journals. Four percent of the articles reported attempts to produce empirical evidence. Five percent were critical of the place of the humanities in medical education. Jakob Ousager, 'Humaniora i lægeuddannelsen: Tradition, mål og middel', *Laegers dannelse*, Vestergaard, Gormsen and Christiansen, 2012, p. 107.
23. Martyn Evans, 'Reflections on the humanities in medical education', *Medical Education*, 36 (2002), p. 512.
24. Medical education at Lund University has undergone changes in recent years, which have among else led to the movement of optional courses from one term to another. In the past, the course was therefore offered at different stages of the programme, but always during the later terms when the students had gained clinical experience. As of autumn 2013, the name of the course is 'Medicin som humaniora – litteratur, film, konst, musik' [Medicine as humanities: literature, film, art, music].
25. Compare with Jane Macnaughton, who discusses the medical humanities as a complement to the rest of medical education and as an

- opportunity to offer a kind of counterculture to it. Jane Macnaughton, 'Why medical humanities now?', *Medical Humanities*, Martyn Evans and Ilora G. Finlay (eds.), London: BMJ Books, 2001; Jane Macnaughton, 'The humanities in medical education: contexts, outcomes and structures', *Medical Humanities*, 26:1 (2000), pp. 23–30.
26. For a longer discussion, see Katarina Bernhardsson, 'Humaniora som komplement: en humanistisk kurs för medicinstudenter', *Pedagogisk inspirationskonferens för HT-områdets lärare* [Educational inspiration conference for teachers in the humanities and theology], Lund: Lund University, 2008.
 27. Several of the students' presentations were later published as essays in *Läkartidningen*.
 28. Bernhardsson, 'Humaniora som komplement', 2008, p. 6.
 29. Evans, 'Medical Humanities', 2007, p. 367.
 30. Evans, 'Medical Humanities', 2007, p. 367 f.
 31. The Centre for Medical Humanities, Durham University, 'Medical Humanities' (www.dur.ac.uk/cmh/medicalhumanities); *Hektoen International: A Journal of Medical Humanities* (www.hektoeninternational.org).
 32. One example is provided by linguistic studies that use medical technology to study the language centres of the brain, such as linguistic research at Lund University within a project where the researchers are working with MRI (magnetic resonance imaging). See *Humanities and Medicine* (www.sol.lu.se/en/project/90).
 33. 'We use the term "medical humanities" here because it is the most recognisable and widely used term to describe the field, but in the recognition that neither "medicine" nor "health" humanities fully embraces all of the subjects covered within this book: medicine, health, well-being, science and technology. [...] The field of so-called "medical humanities" incorporates a huge range of subjects and approaches, to the extent that no term will ever embrace them all. If such a term were to become possible, it would only be in consequence of an unfortunate narrowing of the field' (Bates and Goodman, 'Critical Conversations', 2014, p. 5).
 34. For longer research overviews of some of these orientations, see Roger Qvarsell and Ulrika Torell (eds.), *Humanistisk hälsoforskning: En forskningsöversikt*, Lund: Studentlitteratur, 2001.
 35. Lars-Christer Hydén, 'Illness and narrative', *Sociology of Health and*

- Illness*, 19:1 (1997), pp. 48–69; Lars-Christer Hydén and Jens Brockmeier (eds.), *Health, Illness and Culture: Broken Narratives*, London: Routledge, 2008; Arthur W. Frank, *The Wounded Storyteller: Body, Illness, and Ethics*, Chicago: University of Chicago Press, 1995.
36. See for example Torbjörn Tännsjö, *Vårdetik*, Stockholm: Thales, 1998; Christian Munthe, *Livets slut i livets början: En studie i abortetik*, Stockholm: Thales, 1992; Johannes Persson and Nils-Eric Sahlin (eds.), *Risk & Riski*, Nora: Nya Doxa, 2008; Niels Lynøe and Niklas Juth, *Medicinska etikens ABZ*, Stockholm: Liber, 2009; Niels Lynøe, *Mellan cowboyetik och scoutmoral: Medicinsk forskningsetik i praktiken*, Stockholm: Liber, 1999; Mats G. Hansson, *Human dignity and animal well-being: A Kantian contribution to biomedical ethics*, Uppsala: Uppsala University, diss. 1991.
 37. For the latter, see for example Ingemar Bohlin and Morten Sager (eds.), *Evidensens många ansikten: Evidensbaserad praktik i praktiken*, Lund: Arkiv, 2011.
 38. Fredrik Bragesjö and Margareta Hallberg, *I forskningens närhet: En studie av MPR-kontroversens bakgrund och förvecklingar*, Nora: Nya Doxa, 2009.
 39. Lennart Nordenfelt, 'Om medicinens filosofi', *Humanistisk hälsoforskning*, Qvarsell and Torell, 2001.
 40. See for example Jonna Bornemark and Fredrik Svenaeus (eds.), *Vad är praktisk kunskap?*, Stockholm: Södertörn University, 2009.
 41. Lennart Nordenfelt, *On the nature of health: An action-theoretic approach*, second revised and expanded edition, Dordrecht: Kluwer, 1995; Lennart Nordenfelt, *Hälsa och värde: Studier i hälso- och sjukvårdens teori och etik*, Stockholm: Thales, 1991; Lennart Nordenfelt, *Livskvalitet och hälsa: Teori & kritik*, Solna: Almqvist & Wiksell, 1991.
 42. Wilhelm Kardemark, *När livet tar rätt form: Om människosyn i svenska hälsotidskrifter 1910-13 och 2009*, Gothenburg: University of Gothenburg, diss. 2013.
 43. Lennart Nordenfelt, *Filosofi och medicin: Från Platon till Foucault*, Stockholm, Thales, 2012.
 44. Karin Johannisson, *Medicinens öga: Sjukdom, medicin och samhälle - historiska erfarenheter*, Stockholm: Norstedts, 1990.
 45. See, among other works, Karin Johannisson, *Melankoliska rum: Om ångest, leda och sårbarhet i förfluten tid och nutid*, Stockholm: Bonnier, 2009; Karin Johannisson, *Tecknen: Läkaren och konsten att läsa kropp*

- par, Stockholm: Norstedt, 2004; Karin Johannisson, *Den mörka kontinenten: Kvinnan, medicinen och fin-de-siècle*, Stockholm: Norstedt, 1994.
46. Torbjörn Gustafsson Chorell and Maja Bondestam (eds.), *In på bara huden: Medicinhistoriska studier tillägnade Karin Johannisson*, Nora: Nya Doxa, 2010.
 47. Gunnar Broberg and Mattias Thydén, *Oönskade i folkhemmet: Ras-hygien och sterilisering i Sverige*, Stockholm: Gidlund, 1991; Gunnar Broberg, *Statlig rasforskning: En historik över Rasbiologiska institutet*, Lund: Lund University, 1995; Ingemar Nilsson, *Själen i laboratoriet: Vetenskapsideal och människosyn i den experimentella psykologins framväxt*, Lund: Doxa, 1978; Roger Qvarsell, *Ordning och behandling: Psykiatri och sinnessjukvård i Sverige under 1800-talets första hälft*, Umeå: Umeå University, 1982; Roger Qvarsell, *Utan vett och vilja: Om synen på brottslighet och sinnessjukdom*, Stockholm: Carlsson, 1993; Roger Qvarsell and Ulrika Torell, *Reklam och hälsa: Levnadsideal, skönhet och hälsa i den svenska reklamens historia*, Stockholm: Carlsson, 2005.
 48. See for example, the following doctoral theses: Motzi Eklöf, *Läkarens ethos: Studier i den svenska läkarkårens identiteter, intressen och ideal 1890–1960*, Linköping: Linköping University, diss. 2000 and Solveig Jülich, *Skuggor av sanning: Tidig svensk radiologi och visuell kultur*, Linköping: Linköping University, diss. 2002.
 49. Karolinska Institutet, Unit for Medical History and Heritage and the Hagströmer Medico-Historical Library (intranet.ki.se/sv/medicin-historia; www.hagstromerlibrary.ki.se and intranet.ki.se/sv/om-hagstromerbiblioteket); Karin Johannisson, Ingemar Nilsson and Roger Qvarsell (eds.), *Medicinen blir till vetenskap: Karolinska Institutet under två århundraden*, Stockholm: Karolinska Institutet University Press, 2010. A review of the history of ideas in medicine is found in Ingemar Nilsson and Hans-Inge Peterson, *Medicinens idéhistoria*, Stockholm: SNS, 1998 and of the history of ideas in health care in Roger Qvarsell, *Vårdens idéhistoria*, Stockholm: Carlsson, 1991.
 50. *History of Medicine in Practice* (www.idehist.uu.se/digitalAssets/184/184565_3rd-cfp-history-of-medicine-2014.pdf; www.idehist.uu.se/forskning/history-of-medicine-in-practice/).
 51. Gabriella Nilsson and Kristofer Hansson, 'Medicin på kulturens villkor', *Socialmedicinsk tidskrift*, 88:3 (2011), p. 195.
 52. Susanne Lundin, *Organ till salu*, Stockholm: Natur och kultur, 2014;

- Max Liljefors, Susanne Lundin and Andréa Wiszmeg, *The Atomized Body: The Cultural Life of Stem Cells, Genes and Neurons*, Lund: Nordic Academic Press, 2012; Susanne Lundin, *Guldägget: Föräldraskap i biomedicinens tid*, Lund: Historiska media, 1997. The first book came out of an interdisciplinary project directed by philosopher Fredrik Svenaeus, who has studied the body as gift, resource and commodity. See Martin Gunnarson and Fredrik Svenaeus (eds.), *The Body as Gift, Resource, and Commodity: Exchanging Organs, Tissues, and Cells in the 21st Century*, Stockholm: Södertörn University, 2012.
53. Britta Lundgren, *Oväntad död – förväntad sorg: En etnologisk studie av sörjandetsprocesser*, Stockholm: Carlsson, 2006; Lars-Eric Jönsson, *Det terapeutiska rummet: Rum och kropp i svensk sinnessjukvård 1850–1970*, Stockholm: Carlsson, 1998; Georg Drakos, *Berättelsen i sjukdomens värld: Att leva med hiv/aids som anhörig i Sverige och Grekland*, Eslöv: Symposium, 2005; Georg Drakos, *Makt över kropp och hälsa: Om leprasjukas självförståelse i dagens Grekland*, Eslöv: Symposium, 1997; see also Georg Drakos and Lars-Christer Hydén (eds.), *Diagnos & identitet*, Stockholm: Gothia, 2011.
54. Lisbeth Sachs, *Från magi till bioteknik: Medicinsk antropologi i molekylärbiologins tidevarv*, Lund: Studentlitteratur, 2002; Lisbeth Sachs, *Sjukdom som ordning: Människan och samhället i gränlandet mellan hälsa och ohälsa*, 2nd ed., Stockholm: Natur och kultur, 2012; Lisbeth Sachs, *Onda ögat eller bakterier: Turkiska invandrarkvinnors möte med svensk sjukvård*, Lund: Liber förlag, 1983. Published in English as *Evil eye or bacteria: Turkish migrant women and Swedish health care*, 1983, University of Stockholm.
55. For a longer discussion, see Katarina Bernhardsson, *Litterära besvär: Skildringar av sjukdom i samtida svensk prosa*, Lund: Ellerströms, diss. 2010.
56. Rita Charon and Maura Spiegel, 'Editors' preface: Of torches, traditions, pastures, and pride', *Literature and Medicine*, 25:2 (2006), p. x.
57. Bates, Bleakley and Goodman, *Medicine, Health and the Arts*, 2014.
58. Anne Hudson Jones, 'Literature and medicine: traditions and innovations', *The Body and the Text: Comparative Essays in Literature and Medicine*, Bruce Clarke and Wendell Aycock (eds.), Lubbock, TX: Texas Tech University Press, 1990. From the outset, literature was introduced to medical education in the United States as a pathway to discussing issues of moral and values via the chaplains who worked

- at the faculties of medicine (Joanne Trautmann, 'Can We Resurrect Apollo?', *Literature and Medicine*, 1:1 [1982], p. 9).
59. Merete Mazzarella, 'Om att använda skönlitteratur', *Tidskrift för litteraturvetenskap*, 3 (2001), p. 79. See also *Den goda beröringen* in which she writes about literature and medicine. Merete Mazzarella, *Den goda beröringen: Om kropp, hälsa, vård och litteratur*, Stockholm: Forum, 2005.
 60. Text anthologies are also published that collect excerpts from fiction, mainly with reference to teaching needs. A few examples are the Swedish-language Lars-Erik Böttiger and Jörgen Nordenström (eds.), *Å herregud, mitt i semestern: en antologi. Möten med sjukdom, lidande och vård*, Stockholm: Karolinska University Press, 1999 and Lars-Erik Böttiger and Jörgen Nordenström (eds.), *Den andra verkligheten: En antologi*, Stockholm: Karolinska University Press, 2004, and the English-language Ruth Nadelhaft (ed.), *Imagine What It's Like: A Literature and Medicine Anthology*, Honolulu: University of Hawai'i Press, 2008 and the Norwegian Jan C. Frich, Edvin Schei and Knut Stene-Johansen, *På sykeleiet: Sykdom og medicin i litteraturen*, Oslo: Gyldendal, 2004.
 61. They continue: 'With its fundamental departure from the vernacular, the language of literature is aimed especially at capturing the experience of disease and its signs, understood as symptoms of deviation from a so-called normal condition. It then makes little difference whether we call the specifically literary "literariness", "poetics" or "rhetoric".' Hilde Bondevik and Knut Stene-Johansen, *Sykdom som litteratur: 13 utvalgte diagnoser*, Oslo: Unipub forlag, 2011, p. 28.
 62. Bernhardsson *Litterära besvär*, 2010; Petter Aaslestad, *Pasienten som tekst: Fortellerrollen i psykiatriske journaler. Gaustad 1890-1990*, Oslo: Tano Aschehoug, 1997; Kathryn Montgomery Hunter, *Doctors' Stories: The Narrative Structure of Medical Knowledge*, Princeton: Princeton University Press, 1991; Rolf Ahlén, *Why Should Physicians Read? Understanding Clinical Judgment and its Relation to Literary Experience*, Durham/Karlstad, 2010.
 63. Infectio (www.hf.uio.no/ilos/forskning/prosjekter/infectio/arkiv/).
 64. Trisha Greenhalgh and Brian Hurwitz (eds.), *Narrative Based Medicine: Dialogue and Discourse in Clinical Practice*, London: BMJ Books, 1998.
 65. Kathryn Montgomery, *How Doctors Think: Clinical Judgment and the Practice of Medicine*, Oxford: Oxford University Press, 2006; Montgomery Hunter, *Doctors' Stories*, 1991.

66. Rita Charon, 'Where does narrative medicine come from? Drives, diseases, attention, and the body', *Psychoanalysis and Narrative Medicine*, Peter L. Rudnytsky and Rita Charon (eds.), Albany: State University of New York Press, 2008, p. 25.
67. The descriptor 'literature and medicine', on the other hand, is distinguished by the loose conjunction 'and', which sets the two words on an equal footing, but is also vague about their precise relationship.
68. Charon, *Narrative Medicine*, 2006, p. viii.
69. Charon and her colleagues have further expanded upon the idea behind reflective writing in something they call the Parallel Chart, a project in which medical students in their clinical studies keep a parallel chart about their patients, in which they use everyday language and literary narrative to write about things that do not belong in the ordinary patient chart.
70. Rita Charon and Martha Montello (eds.), *Stories Matter: The Role of Narrative in Medical Ethics*, New York: Routledge, 2002.
71. Frank writes that '[t]o think about a story is to reduce it to content and then analyze that content. [...] To think with a story is to experience it affecting one's own life and to find in that effect a certain truth of one's life'. Frank, *Wounded Storyteller*, 1995, p. 23. Compare with the discussion of literature in the symposium proceedings, Skans Kersti Nilsson and Torsten Pettersson (eds.), *Litteratur som livskunskap: Tvärvetenskapliga perspektiv på personlighetsutvecklande läsning*, Borås: University of Borås, 2009, which largely addresses literature within the world of medicine.
72. Qvarsell and Torell, *Humanistisk hälsoforskning*, 2001.
73. There is a roughly equivalent name abroad, Health Humanities, see for example the International Health Humanities Network, www.healthhumanities.org.
74. Carl-Magnus Stolt, 'Vad är humanistisk medicin?', *Tidsskrift för Den norske legeförening*, 120 (2000), p. 3736 f.
75. *Humanistisk medicin*, Södertälje sjukhus (www.sodertaljesjukhus.se/Om-oss/Nya-sjukhuslokaler/Humanistisk-medicin). The pioneer E.A. Vastyan used the term 'humanistic medicine' (see www2.med.psu.edu/humanities/history).
76. Qvarsell and Torell, *Humanistisk hälsoforskning*, 2001, p. 16. Compare with Therese Jones's remarks on 'the use and misuse of the words "humanism" and "humanities"', which she argues is still having an impact

- on the field (Therese Jones, “‘Oh, The Humanities!’: Dissent, Democracy, and Danger”, *Medicine, Health and the Arts: Approaches to the Medical Humanities*, Bates, Bleakley and Goodman [eds.], 2014, p. 27).
77. The development is, however, broader than that and the field is also emerging in, for example, Canada, Australia and large parts of Europe, as well as Asia and South America.
 78. Penn State College of Medicine (www2.med.psu.edu/humanities/history).
 79. University of Texas Medical Branch at Galveston (imh.utmb.edu/education).
 80. University of California, San Francisco, School of Medicine (medicalhumanities.ucsf.edu); University of Rochester Medical Center (www.urmc.rochester.edu/medical-humanities) and Duke University & School of Medicine (trentcenter.duke.edu).
 81. The Narrative Medicine Program, Columbia University Medical Center (www.cumc.columbia.edu/dept/medicine/narrativemed).
 82. Wellcome Trust (www.wellcome.ac.uk/Our-vision).
 83. Medical Humanities Programmes (sites.google.com/site/edinburghmhrn/resources/programmes) provides a good overview.
 84. Centre for Humanities and Health, King’s College (www.kcl.ac.uk/innovation/groups/chh/index.aspx); Centre for Medical Humanities at Durham University (www.dur.ac.uk/cmh).
 85. In the United Kingdom and Ireland, the Association for Medical Humanities was founded in 2002 with a view to gathering the field in joint conferences. Association for Medical Humanities: (www.amh.ac.uk/about).
 86. The disciplinary and professional range of the network is evident in the following description: ‘Narrative medicine has emerged from elements of literary theory, cultural studies, creative writing and artistic practice, disability studies, narrative ethics and history of medicine, which intersect with the professional disciplines of nursing, social work, medicine and the psychotherapies.’ (www.kcl.ac.uk/innovation/groups/chh/Narrative-Medicine-Conference-/About-the-Narrative-Medicine-conference.aspx).
 87. Nordic Network for Studies in Narrativity and Medicine (narrativityandmedicine.ku.dk); Nordic Network for Philosophy of Medicine and Medical Ethics (www.imh.liu.se/avd_halsa_samballe/nnp-mme/hem?l=en); The Nordic Network for Health Research Within

Social Sciences and the Humanities (nnhsh.org) has been expanded from its previous name of Humanistic Health Research. Additional networks are also mentioned in Kardemark and Sigurdson, *Medicinsk Humaniora*, 2014.

88. Forum för medicinsk etik [Forum for medical ethics] (www.imh.liu.se/avd_halsa_samhalle/forum-for-medicinsk-etik?l=sv); Forum för humanistisk-samhällsvetenskaplig hälsoforskning [Forum for health research within social sciences and the humanities] (www.isv.liu.se/nisal/forskningsnatverk-och-samarbeten/forum-for-humanistisk-samhallsvetenskaplig-halsoforskning?l=sv).
89. For example Uppsala University (www.pubcare.uu.se/forskning/etik); a collaboration between Karolinska Institutet, KTH Royal Institute of Technology and Stockholm University (ki.se/ki/jsp/polopoly.jsp?d=14785&cl=sv); Lund University (www.med.lu.se/klinvetlund/medicinsk_etik); Linköping University (www.imh.liu.se/avd_halsa_samhalle/forum-for-medicinsk-etik?l=sv).
90. Lund University, Unit for Medical History, (www.med.lu.se/klinvetlund/medicinens_historia); Uppsala University, Medical History (www.neuro.uu.se/forskning/medicinsk-historia/).
91. *Medical Humanities* (mh.bmj.com); *Journal of Medical Humanities*, (link.springer.com/journal/10912).
92. *Hektoen International* (www.hektoeninternational.org).
93. *Journal of Medical Ethics* (jme.bmj.com); *The Journal of Medicine and Philosophy* (jmp.oxfordjournals.org); *Medicine, Health Care, and Philosophy*, (link.springer.com/journal/11019); *Theoretical Medicine and Bioethics* (www.springer.com/philosophy/epistemology+and+philosophy+of+science/journal/11017).
94. *Literature and Medicine* (www.press.jhu.edu/journals/literature_and_medicine).
95. *The Literature, Arts, and Medicine Database* (litmed.med.nyu.edu).
96. *Social History of Medicine* (shm.oxfordjournals.org); *Bulletin of the History of Medicine* (muse.jhu.edu/journals/bulletin_of_the_history_of_medicine); *Medical History* (journals.cambridge.org/action/displayJournal?jid=MDH).
97. *Svensk medicinshistorisk tidskrift* (www3.svls.se/sektioner/mhi/tidskrift.html).
98. *Medical Education* ([onlinelibrary.wiley.com/journal/10.1111/\(ISSN\)1365-2923](http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1365-2923)); *BMC Medical Education* (www.biomedcentral).

- com/ bmcmededuc). There are also numerous journals with the words *Journal of Medical Education* in their names.
99. *Sociology of Health and Illness* (onlinelibrary.wiley.com/journal/10.1111/ [ISSN]1467-9566); *Socialmedicinsk tidskrift* (www.socialmedicinsktidskrift.se).
 100. *The Lancet* (<http://www.thelancet.com>); *Journal of the American Medical Association* (jama.jamanetwork.com/journal.aspx); *New England Journal of Medicine* (www.nejm.org); *Academic Medicine*, (journals.lww.com/AcademicMedicine); *Annals of Internal Medicine* (annals.org).
 101. *Läkartidningen* (www.lakartidningen.se); *Tidsskrift for Den norske legeforening* (tidsskriftet.no); *Ugeskrift for Lager* (ugeskriftet.dk).
 102. Bates, Bleakley and Goodman, *Medicine, Health and the Arts*, 2014.
 103. Greenhalgh and Hurwitz, *Narrative Based Medicine*, 1998; Martyn Evans and Ilora G. Finlay (eds.), *Medical Humanities*, London: BMJ Books, 2001; Charon and Montello, *Stories Matter*, 2002.
 104. Anders Palm and Johan Stenström (eds.), *Kroppen i humanioraperspektiv*, Stockholm/Gothenburg: Makadam 2013.
 105. Qvarsell and Torell, *Humanistisk hälsoforskning*, 2001; Gunnar Bjursell and Lotta Vahlne Westerhäll (eds.), *Kulturen och hälsan: Essäer om sambandet mellan kulturens yttringar och hälsans tillstånd*, Stockholm: Santérus förlag, 2008.
 106. Carl-Magnus Stolt, *Medicinen och det mänskliga: Vårdkonst och vardagsetik, humanism och humaniora*, Stockholm: Natur och kultur, 2003.
 107. Martyn Evans, Rolf Ahlzén, Iona Heath and Jane Macnaughton, *Medical Humanities Companion, Volume 1: Symptom*, Oxford: Radcliffe Publishing, 2008; Rolf Ahlzén, Martyn Evans, Pekka Louhiala and Raimo Puustinen, *Medical Humanities Companion, Volume 2: Diagnosis*, Oxford: Radcliffe Publishing, 2010; Pekka Louhiala, Iona Heath and John Saunders, *Medical Humanities Companion, Volume 3: Treatment*, Oxford: Radcliffe Publishing, 2013; Jill Gordon, Jane Macnaughton and Carl Rudebeck, *Medical Humanities Companion, Volume 4: Prognosis*, Oxford: Radcliffe Publishing, 2013.
 108. Therese Jones, Deleuse Wear and Lester D. Friedman, *Health Humanities Reader*, New Brunswick: Rutgers University Press, 2014.
 109. Ekström and Sörlin, *Alltings mått*, 2012, p. 196; Ahlzén, 'Medicinen', 2013, p. 279.



SCHOLARLY PERSPECTIVES ON CULTURE AND HEALTH

FROM THE UNIVERSITY OF GOTHENBURG

Daniel Brodén

CULTURE AND HEALTH is a burgeoning field of research at the University of Gothenburg. As Ola Sigurdson describes in his introduction to this book, several projects in the field are in progress at the University, but these are also included in a wider stream of endeavour related to Culture and Health.

This chapter provides a picture of the diversity of Culture and Health research at the University by presenting key researchers in various disciplines. Among them are found profiles in fields including neurology, nursing, political science, education, music theory and artistic research. As Sigurdson also explains, ‘culture’ and ‘health’ are words with multiple meanings and this chapter shows, in concrete terms, how scholars define the diverse meanings of these words based on their disciplinary horizons. Health can, as said, be understood in the strictly medical sense, but also from a more salutogenic or multidimensional perspective. Likewise, ‘culture’ may refer to artistic or aesthetic expression as well as social practises and beliefs – this may involve both music and literature and social and ethnic context. All of these researchers, however, share the ambition to expand our understanding of the prerequisites of human health and to cross traditional disciplinary lines. Consequently, the text illustrates not only the diversity of research perspectives in the field,

but also how they combine to form the contours of a greater multidisciplinary complex.

The chapter is based on a distillation of a comprehensive interview study. The presentation proceeds from the researchers' own accounts of their work and their views on the state of research in their own disciplines. The ambition is to simultaneously provide insight into distinct scholarly/scientific inputs and an overview of principal areas of enquiry within Culture and Health. It should be noted that the respondent material has been edited to create a lucid and varied text with distinct angles. The chapter has also been structured to allow readers to browse the individual arguments according to their interests.

The researchers' presentations of their personal perspectives are divided into three sections. The first, *Medicine and Health Care*, focuses on individuals working in what many regard as the central discipline within the field. The scholars and scientists are:

**Thomas Lindén*, associate professor of neuroscience

**Björn Vickhoff*, musicologist and director of the 'BodyScore' project at Sahlgrenska Academy

**Helle Wijk*, registered nurse and associate professor of care sciences

**Peter Fröst*, artistic professor, and *Henric Benesch*, project developer, at the Chalmers Centre for Healthcare Architecture

**Henry Ascher*, associate professor of paediatrics and chief physician with the refugee children's team at Angered Community Hospital

**Lauren Lissner*, professor of epidemiology and director of the EpiLife research centre

The second section, *Society and Living Conditions*, puts the spotlight on another important sub-field: the study of Culture and Health in a wider social context. These research voices are:

* *Sören Holmberg*, professor of political science, and *Lennart Weibull*, professor of mass media research, both with the SOM Institute

* *Marie Demker*, professor of political science and co-director of the Religion, Culture and Health research programme

* *Johannes Lunneblad*, senior lecturer in education, communication and learning

* *Peter Korp*, associate professor in sport science

* *Johan Wedel*, social anthropologist

The third section, *Humanities, Art and Culture* focuses on researchers who study cultural beliefs and aesthetic expression with linkages to health within the framework of the humanities and human sciences. The representatives are:

* *Margareta Hallberg*, professor of the theory of science

* *Lars Lilliestam*, professor of musicology

* *Yvonne Leffler*, professor of comparative literature and co-director of the Religion, Culture and Health research programme

* *Johan Öberg*, research secretary at the Faculty of Fine, Applied and Performing Arts

It should be noted that this division into sections was not made to demarcate any fixed boundaries between scholarly domains, but only to clarify various spheres of interest within Culture and Health. The chapter ends with a section titled ‘A multidisciplinary future?’ that distils the joint reasoning of the researchers presented concerning the challenges faced by the field. Many of the respondents agree about the potential of multidisciplinary collaboration in Culture and Health, but they also address existing structural problems that need to be resolved.

MEDICINE AND HEALTH CARE

As we know, the modern view on health has strong roots in Enlightenment thought and the advent of medical science. A main characteristic of this emerging worldview, especially in the 19th century, was ebullient optimism regarding the possibilities of the

medical sciences to objectively understand and explain humans, primarily as biological beings. But even as science made enormous strides and successively found cures for many diseases that had plagued humanity, the strictly rationalist view of health left little room for the cultural and social dimensions of life.¹ Modern medical science has however increasingly begun to seek an expanded view on human health, as reflected not least in the emergence of the field of care sciences.²

One may regard the Culture and Health-oriented research at the University of Gothenburg as characteristic of this continued movement. Initiatives are being taken that expand the perspective on medicine and health care in neurology, epidemiology, person-centred care, the care setting and healthcare architecture and paediatrics, as well as music as a mode of rehabilitation. As this section will show, most of these are based on various forms of innovative thinking within existing disciplines, but also multidisciplinary collaboration between Sahlgrenska Academy and other faculties at Gothenburg University and Chalmers University.

Healing the brain in an enriched environment

THOMAS LINDÉN, associate professor of neuroscience at Sahlgrenska University Hospital, maintains that biological interventions are not the only way to cure injuries to human cognition and intellect. Lindén has participated in several research projects affiliated with the Centre for Brain Repair and Rehabilitation (CBR), where patients with various types of brain injuries, such as those caused by stroke and Parkinson's disease, participated in rhythmic exercises and music listening and the effects on healing and functional recovery were studied.

There are many well-founded studies that show that patient healing can be affected through measures that fall outside accepted medical frameworks.³ Lindén emphasises that the human brain is characterised by plasticity, which means that the tasks

of neurons can be through human interaction. Groundbreaking studies at Sahlgrenska have also shown that the brain can form new cells throughout life.⁴ There is intensive research ongoing that involves how such processes ('neurogenesis') can be stimulated and neural function changed. Scientists are studying the effects of drugs and chemical substances, as well as how physical activity, sensory stimulation and social interaction affect the brain.

In the context, scientists speak of research on the effects of an 'enriched environment'. It is possible, for instance, to enhance the rehabilitation process by allowing patients to participate in various physical and social activities. Another avenue is to create more stimulating spatial environments in the hospital. These include a much-noted study of a hospital ward in which half the patients lay in beds facing a brick wall, while the other half had a view of a forest. The study clearly showed that the patients with the more pleasant view required fewer painkillers, could be discharged earlier and were in generally better condition when they left the hospital.⁵

Lindén relates that there are many exciting and promising research results that clarify how innovative approaches can affect patients' physical and mental recovery, but that much remains to be done. Although the research plainly shows strong effects, we still do not fully understand what all of this means for healthcare. As well, the new findings have been put into practice only to a limited extent. There is a plethora of collected data and exciting research results, but few models for how this knowledge should be applied in clinical practice.

Choral singing as a mode of rehabilitation

Musicologist **BJÖRN VICKHOFF** is an unusual voice from the humanities in the world of medical research. He is part of the multidisciplinary 'BodyScore' project at Sahlgrenska Academy. The other members of the research group are from disciplines including neurology, psychology, philosophy and musical performance. Body-

Score studies the biological effects of music and choral singing on the body and human health. The aim is to find ways to use music for rehabilitation and wellness programmes. One working hypothesis is that singing calms breathing, which affects the heart and has positive health effects. The group recently published a paper, which garnered international attention, on how choral singing stimulates cardiac variability, which is a health-related variable.⁶

Vickhoff emphasises that while the project is on the leading edge of current research, it has been an unorthodox element in the medical setting.⁷ In order to be taken seriously, the group has had to apply the same rigorous methods used in drug development, which entailed proving biological effects in randomised, controlled studies. Nevertheless, the project focuses on people in social interaction. New technology has made it possible to study what might be called the ‘neurophysiology of cooperation’ and to compare brain activity in several brains in a natural setting.

The research conducted within BodyScore points to health effects that are both of a biological nature (singing strengthens the diaphragm, which increases lung capacity) and an existential nature (self-esteem is improved through the interaction with other people). If we understand health from a wide cultural horizon, Vickhoff emphasises, the interplay between lifestyle, mental health and physical complaints becomes apparent. Medical science has not traditionally been interested in social interaction and connections between quality of life and physical health have been overlooked. Instilling motivation is an important element of rehabilitation. In addition, people who have been isolated due to their illness are able to experience fellowship and joy.

But Vickhoff stresses that it is also important to counteract instrumental attitudes that reduce music to a simple health tool and to prevent the formation of unsubstantiated notions that certain aesthetic expressions are more health-promoting than others. The supposition that the music of Mozart is particularly beneficial is a notion based more on outmoded hierarchies of taste than on science. Nor does BodyScore aim to prescribe choral singing

as a particularly ‘benign’ form of culture, but rather to carry out a pilot project to study biological functions that may in the long run enrich people’s lives and choices of cultural experiences in the healthcare context.

*The significance of the health care setting
to human being and doing*

HELLE WIJK, registered nurse and associate professor of care sciences at Sahlgrenska Academy, studies the significance of the care setting to human well being and quality of life. Wijk is primarily interested in the interaction between the physical and psychosocial environments and is currently working with intervention studies in various care contexts, including homes for the aged, within the IPA project (Influence, Participation and Autonomy). The aim is to study the impact on patients’ perceptions of their life environments of new architectonic solutions, furnishings, changes in colour schemes and lighting and access to participation in cultural activities based on personal preferences.

The care sciences have demonstrated longstanding interest in methods related to Culture and Health, such as studying the effects of activities involving song and dance. Research that aims to track the effects of these activities are characterised by a systematic and interdisciplinary approach. Wijk is the editor of the anthology *Vårdsmiljöns betydelse* [Significance of the care setting] (2014), in which researchers in the care sciences, architecture and design present arguments related to the linkages between enriched physical and psychosocial conditions.⁸ The Faculty of Health Sciences in Gothenburg also collaborates with the Centre for Healthcare Architecture at Chalmers University (see the next presentation) and the two share an interest in evidence-based design – a method of integrating knowledge from different disciplines to arrive at quantifiable relationships between the physical setting and its various effects.⁹

The ability to apply findings in a concrete care situation is an

important concern to Wijk. It is one thing to draw up theoretical guidelines for working in a salutogenic or person-centred way and quite another to put these guidelines into practise. It can also be difficult to apply successful concepts in other contexts and it is thus essential to simultaneously identify transferable success factors and prepare concrete instructions.

Interpersonal social culture plays a significant role in whether it will be possible to implement various concepts in practise. Wijk argues that stakeholders should examine the atmosphere and not only the physical setting. The internal culture and atmosphere in the care setting has by tradition been perceived as vague and difficult to influence, but more sophisticated methods have recently been developed to estimate the effects of an explicit or tacit care philosophy and its impact on work performance, leadership and staff attitudes.

Designing the healthcare buildings of the future

PETER FRÖST, artistic professor, and **HENRIC BENESCH**, project manager, are both with the Centre for Healthcare Architecture at Chalmers. They emphasise that care settings reflect a certain social perspective on health. Healthcare buildings and settings are not expressions of universal ideas, but rather products of a social understanding of the nature of healthcare. Fröst and Benesch subscribe to the view of architecture as ‘a built image of ourselves’, which we can always reassess and improve. By problematising historical processes and existing practices, we can with greater acuity express our vision for the care settings of the future. Seen from this perspective, we are far from having exploited the full potential of enhancing healthcare through innovative planning and novel architecture.

According to Fröst and Benesch, there is a tradition in Sweden, unique by international comparison, of involving healthcare workers in planning care settings in order to enrich care provision in various ways. They believe it is essential to open this

arena to patients and their families as well. In light of today's complex healthcare system and multicultural society, this presents both great opportunities and great challenges. How do we involve everyone who uses these care settings, based upon their various circumstances and interests?¹⁰

Fröst and Benesch argue that well-designed healthcare architecture can prevent stress in both patients and staff, but also improve efficiency in care provision. Numerous studies show that architecture can promote healing processes and the work of the Centre for Healthcare Architecture is based on the concept of the 'evidence-based supportive care setting'.¹¹ The vision is one of architecture as an active part of healthcare through more qualitative elements of natural light, spatial environments, moods, colour and sound. Another concrete point of departure for the Centre is research in the field that assures the integration of organisational development and process efficiency improvements in relation to various innovative design processes.

Fröst and Benesch argue that it is essential for research in healthcare architecture to maintain the tension between the qualitative and the quantitative, especially considering that architecture is a sociomaterial and sociocultural artefact whose every dimension is impossible to measure.¹² The research is sure to further develop instruments for measuring that which can be measured, but Fröst and Benesch stress that the field is highly dependent upon multidisciplinary studies of aspects that cannot be determined quantitatively. As they see it, much of the strength of healthcare architecture research springs from its ability to combine creative and evidence-based work with critical reflection.

A more human approach to healthcare

HENRY ASCHER, associate professor of paediatrics at Sahlgrenska University Hospital and chief physician with the refugee children's team at Angered Community Hospital, is known for his

advocacy of humanistic healthcare. Ascher was involved in starting the Centre for Children's Right to Health at the Queen Silvia Children's Hospital, which is working to integrate a children's rights perspective in healthcare in accordance with the UN Convention on the Rights of the Child. More recently, Ascher has researched and published on subjects including asylum-seeking children, children with severe withdrawal syndrome ('apathetic children') and undocumented refugee children who, as a result of their vulnerable position, repress much of their anxiety and their needs in the encounter with healthcare.¹³ His work at Angered Community Hospital is aimed at improving cooperation with Sahlgrenska Academy and the rest of the University of Gothenburg concerning research and education with focus on health disparities among different socioeconomic groups in the population.

According to Ascher, healthcare oriented towards empathy is important in general. As a paediatrician, he also believes it is easy for doctors to presume, in their capacity as specialists, that they know what is best for the patient, but actually they can never be sure of that. Children may perceive their situations very differently than the adult expert. Good healthcare is dependent upon a participatory perspective that proceeds from equal and empathetic communication with the patient.

While Ascher emphasises the value of a broad perspective on health, he has also dealt with the various meanings of the word 'culture' in his work. As a doctor at the Queen Silvia Children's Hospital, he was early to see the opportunity to reach and activate even seriously ill children through play therapy and theatre. But Ascher also feels a palpable need for better approaches to interacting with people with various cultural backgrounds and beliefs about the body and health. To ensure that all patient groups are treated humanely, healthcare must not be based only upon medical assessment, but also openness, responsiveness and empathy.

Ascher underlines the need to reflect about how we use the word 'culture'. It is not only ambiguous; it can also be used in var-

ious directions. When for instance we use ‘culture’ to refer to art, we tend to concentrate on how literature or drama can expand ingrained perspectives. But when the same word is used in relation to people’s various cultural backgrounds, it can be confining or static, as when we talk about ‘African culture’ or ‘immigrant culture’. Usage of this kind can block the insight that human cultures are dynamic and in a state of constant change.

Public health through a wide-angle lens

LAUREN LISSNER is a professor of epidemiology and director of a comprehensive research centre that studies physical and mental public health from a lifetime perspective. EpiLife is made up of a network of epidemiological researchers with various specialities including cardiology, nutrition, obesity, psychiatry, psychology, primary care, statistics and clinical laboratory studies, who are collaborating to further develop research perspectives in areas such as nutrition, dementia and obesity. EpiLife bases its work on population studies that have been ongoing at the University of Gothenburg since the 1960s and which are still followed up today. The studies have however been adapted to social changes, such as accelerating globalisation and new problems in public health.

Obesity, which increased dramatically in Sweden during the 1980s, is Lissner’s personal area of research. Obesity is generally associated with several chronic diseases like diabetes and cardiovascular disease, as well as various types of cancer and dementia. It seems however that the negative impact of obesity on general quality of life is most severe in children. The lifetime-based research at EpiLife also shows that obesity at a young age can have major consequences upon physical and psychosocial health later in life.¹⁴ Lissner argues that we should concentrate primarily upon children in order to most effectively prevent future health risks.

Lissner argues that a successful fight against obesity will be dependent upon understanding the underlying cultural factors. Although the spread of obesity has slowed, the incapacity rate remains high from a historical perspective, which depends upon factors including socioeconomic inequities. It is thus vital to deepen our understanding of the culturally conditioned factors that control health-related eating habits and lifestyles in various population groups.

In this respect, public health research on obesity is based on striking a balance, according to Lissner. It is important on the one hand to ask culturally specific questions in relation to various social groups while avoiding stigmatisation and simplification on the other hand. One possible happy medium would be to involve the people included in the studies to a greater extent in several aspects of the research process. For epidemiological research to be health-promoting while remaining sensitive to cultural context, its points of departure should be clearly defined and supported by the group it is studying.

SOCIETY AND LIVING CONDITIONS

Social and cultural perspectives are certainly recent elements of medically oriented health research, but we can also basically describe modern healthcare as a social project. Ever since the rise of nation states in Europe, especially in the 19th century, governments have had overall responsibility for the health of their citizens and one of the aims of the institutionalisation of healthcare was to strengthen society as a whole.¹⁵ The Swedish word for public health, *folkhälsa* (derived from the German *Volksgesundheit*) became part of the Swedish language in the early 20th century, which evinces a blending of the scientific and social perspectives.¹⁶ Historical public health work laid the foundation for modern public health studies, which are thus aimed at strengthening the health of the population by counteracting physically,

mentally and socially unhealthy lifestyles. However, the linkage between civil well being and social planning also figures in the background for various socially oriented disciplines.

Efforts within these disciplines at the University of Gothenburg have concentrated primarily on problematising human well being as a social phenomenon. Researchers across the spectrum from political science, mass media studies, social anthropology and sport science to education share an interest in illuminating and evaluating various cultural and social discourses in the field.

No simple connection between culture and health

In their project 'Culture, Health and Personality', **SÖREN HOLMBERG**, professor of political science, and **LENNART WEIBULL**, professor of mass media studies, have analysed statistical data on the connection between citizens' health and cultural habits, such as reading, choral singing and cinema and theatre-going. Holmberg and Weibull are with the SOM Institute ('Society, Opinion and Media'), which carries out comprehensive annual studies of the attitudes and behaviours of the Swedish population, with national as well as regional and municipal focus groups.

Holmberg and Weibull have empirically tested the hypothesis of the beneficial effects of culture, which may figure in discussions of Culture and Health, but their analyses showed no significant positive correlations between people' cultural habits and self-reported physical or mental health.¹⁷ Holmberg and Weibull have also factored in variations between people's personality traits, which are usually ascribed importance in public health contexts.¹⁸ Here as well, the results were negative. The correlation between cultural habits and health is equally weak independent of individual personality traits.

Holmberg and Weibull emphasise that the hypothesis was tested on a large sample of the population. This distinguishes the study from health studies outside Sweden that have smaller sam-

ples and more limited variables. The SOM studies are based on wide population data collected over a long period of time, which makes it possible to make complex comparisons of various habits among population groups with a high level of confidence.

While Holmberg and Weibull argue that their analysis should put a wet blanket on the uncritical enthusiasm about the positive impacts of culture on health, they also point out that it does not provide a final answer. SOM carries out representative population studies with limited opportunity to demonstrate the subtleties of that which deviates from the average. Based on the study, one cannot preclude a positive correlation between cultural habits and health in, for instance, particularly voracious readers, active choir singers or avid cinema/theatre-goers. Likewise, their quantitative study cannot say anything about the therapeutic effects of culture in the same way that qualitative research can do. Nonetheless, their work should engender healthy scepticism towards overly simplistic and unsubstantiated notions about the beneficial effects of culture.

Shared norms in a multicultural society

MARIE DEMKER, professor of political science and co-director (with Yvonne Leffler and Ola Sigurdson) of the Religion, Culture and Health research programme, argues that discussions of linkages between culture and health can enrich the understanding of what constitutes a good society. There is an established area of enquiry in political science related to how good governance can be achieved. Numerous quantitative analyses have shown that interpersonal trust and impartial institutions are essential to achieving good healthcare, high average lifespan and level of education, but Demker also says that new studies are providing more sophisticated analyses.¹⁹ For example, in *Född 1953: Folkhemsbarn i forskarfokus (2013)* [Born in 1953: Children of the people's home in research focus], Sten-Åke Stenberg explores in

depth the connections between health and home environment, childhood conditions and schooling.²⁰ Interestingly enough, Stenberg shows that people seem to be more resilient in the face of deprived living conditions than previously assumed, while it seems to be more difficult to compensate for certain social and personal circumstances.

According to Demker, political scientists have been discussing factors related to culture and health as more or less universal products of nature for far too long. There is every reason for current researchers to critically reflect upon their presuppositions. For instance, that young people are reporting increasing ill-health is perhaps not an obvious trend. How do the respondents define health and well being today compared with 1950? How are perceptions of well being connected to changing patterns in families, work and political participation? And what degree of individual deviation is tolerated today compared with society in the past?

Demker believes there is far too little interest among scholars of political science in normative questions in the field with cultural linkages, such as religion and family ties. She maintains that it is important to understand that beliefs about good health and poor health are culturally conditioned. The multicultural society is truly made up of many cultures and there is risk that the frames of reference of dominant groups will obscure or exclude other traditions.

Demker's own research focuses on the role of religion in government, as well as how the view on national and cultural identity affects social welfare and well being in society.²¹ One fundamental question is whether a liberal society should encourage or discourage the practise of religion. Another is whether family values concerning religion, culture and language take precedence over a norm promoted by the government. Such questions call for both philosophically oriented analyses of the role of government and empirical studies that include national comparisons. It is also relevant to study the significance of religious convictions on social

participation and personal well being. Although there is copious evidence that religious and cultural affinities have impact on individual well being, this does not mean that all such affinities are necessarily good for society as a whole.²²

A more complex understanding of public health

PETER KORP, associate professor in sport science, concentrates his research on beliefs about the nature of health and how health should be promoted. Korp's doctoral thesis, *The promotion of health*, (2002), has to do with confrontations and antagonisms between the perspective of clinical medicine and 'new' forms of health promotion.²³ The medical perspective primarily understands health as the absence of disease, which usually entails strategies to remedy clinical problems and possibly prevent disease. The health-promoting perspective, on the other hand, understands health in terms of well being and is more oriented towards strategies to strengthen the resources people need to manage everyday life and achieve good quality of life. In short, these are two paradigms with disparate norms on what health is and how health work should be pursued.²⁴

One serious antagonism between the paradigms concerns, according to Korp, the assessment of what is a health problem. The medical paradigm requires an objective assessment by medical experts, but if health is understood more holistically as quality of life, the matter is not equally self-evident. Thus far, the health-promotion paradigm problematises the objective diagnosis and underlines the importance of people's own perceptions of their health.²⁵

Korp is interested in problems related to public ambitions to influence people's lifestyles in a healthful direction. The assumption of the critical importance of lifestyle to human health shifts focus to what people do and do not do in their everyday lives and their attitudes towards various risks. Lifestyle is a complex phe-

nomenon though, and experiences of public attempts to control citizens' habits through information, advice and moral strictures are hardly universally positive.²⁶ There is no straightforward relationship between the advice meted out by medical science and how individuals ordinarily behave. For example, people listen to what the experts have to say to various extents or they forget the advice and find their own alternatives. If we add cultural differences among social groups to this mix – such as how people think and behave, their capacity to assimilate various kinds of information, how they interpret the information based upon their frames of reference and what importance they ascribe to a healthy lifestyle – the matter of influencing lifestyles becomes very complex indeed.

Deeper critical discussion is thus essential, according to Korp. In the contexts of medicine and public health studies, lifestyle is used with a striking lack of critical thought to describe people's individual health-related habits, with no analysis of what this lifestyle is, how it is created, reproduced and changed. Consequently, it is difficult to formulate strategies for health-promotion that can seriously influence people's culturally impregnated lives. If we truly want to change health-related habits, it is important that we choose strategies based on solid understanding of the conditions underlying people's lifestyle choices.

The social justice perspective

JOHANNES LUNNEBLAD, senior lecturer in education, communication and learning, argues that focus on social injustice and structural problems is important in the field of Culture and Health. In the 'Best Interests of the Child' project, Lunneblad has studied the reception of recently arrived refugee children, which is a subject that concerns health in both the medical and the social senses.²⁷ International research shows that government agencies that work with refugees concentrate their efforts more on clinical

problems than on psychosocial health work.²⁸ According to Lunneblad, it is obvious how national and local governments can work to support and strengthen refugee families in their day-to-day lives. Many families have experienced traumatic events that affect their capacity to take care of their children and it is thus important that society can offer parents various forms of health support and social safety nets without stripping them of their parental role.

In this context, Lunneblad cannot ignore the ongoing deregulation and dissolution of the public sector. While his project was in progress, responsibility for the introduction of recently arrived refugees was transferred from local authorities to the Public Employment Service, which eliminated vital functions like cooperation among introduction units, doctors and paediatric health centres. As well, there was no longer anyone who had coordinating responsibility or even an overall view of where recently arrived refugee children lived in the municipality. As a result of the reform, important medical and social knowledge that had been previously amassed was thus lost.

In his research, Lunneblad generally applies a social justice perspective to conditions for children and young people living in Angered, a suburb of Gothenburg. Growing ethnic and social segregation affects young people's well being and the opportunities they are given in life. The statistics show that inequities between rich and poor are significant to a wide range of life choices, from whether or not to take exercise to whether or not to take drugs. The schools also contribute to shaping the self-images of young people and one of the effects of the educational environment in Angered is to reproduce low expectations among both students and educators.

Lunneblad stresses the importance of a holistic perspective on the connection between social structures and human health. He believes that researchers are currently expected, to a significant extent, to find fast answers to questions such as how to get people into the labour market or improve academic performance

in the schools. But more complex studies of social structures and how individuals perceive their own lives are important. Personally, Lunneblad combines statistical analysis with cultural theory approaches and an ethnographic method, meaning that he follows and studies people in their everyday lives. Such research can both shed light on present segregation between rich and poor and bring to light the counter-narratives that people create about their living conditions and their place in society.

Alternative thinking about health

Social anthropologist **JOHAN WEDEL** specialises in medical anthropology. Anthropology generally studies how people relate to and interpret their worlds in order to produce knowledge about the complexity of human society and increase the understanding of ‘foreign’ cultures. One might also say that a holistic approach is inherent to the discipline in that it relates human beliefs and expressions to economic, political and social contexts.

To a great extent, medical anthropology revolves around critical examination of Western medicine (biomedicine), while concurrently seeking to describe the connection between biological processes related to health and disease and social and individual beliefs.²⁹ Medical anthropology challenges conventional medical discourses in many ways and has become a central node of research in the field of Culture and Health (see Chapters 1 and 3). The discipline is also having increasing impact in healthcare and public health contexts and anthropologists are currently being engaged to train healthcare professionals and public health workers in ‘cultural competence’ and ‘cultural sensitivity’ in their interactions with people.

Wedel notes that the complex interplay between cultural beliefs and health has also become apparent in medical circles through studies of placebo – deliberate treatment with medicines that have no effect – that show how thinking affects the body and

vice versa. Such results not only upset an accepted scientific distinction between body and mind, but also put alternative methods of therapy and healing in a different light.³⁰

Wedel has studied for instance the religious healing of disease and ‘cross-cultural psychiatry’, which are both central sub-fields of medical anthropology. His doctoral thesis, *Santeria Healing* (2004) is concerned precisely with non-Western religious healing.³¹ Its vantage point is the anthropological production of knowledge concerning how magic, witchcraft and healing rituals can strengthen social bonds and affect human beings physically and emotionally. Cross-cultural psychiatry, in turn, focuses on cultural beliefs about mental illness. Anthropologists employ a broad comparative perspective to examine how Western psychiatry is shaped by social, cultural and political forces, but also how people in other cultures deal with mental illness that falls outside generally accepted categories.

Wedel clarifies that medical anthropology not only studies alternative explanations for illness, but also how global health disparities are dependent on structural inequities, such as the distribution of economic and political power.³² Anthropologists have for instance contributed to broadening the scientific debate concerning HIV/AIDS. Shifting focus from individual behaviour and ‘at-risk groups’ to the significance of poverty and social marginalisation has created a basis for new policy discussions about AIDS and other global public health issues.

THE HUMANITIES, ART AND CULTURE

Research in Culture and Health is currently being pursued within the humanities and artistic disciplines at the University of Gothenburg against the backdrop of traditional thought in the humanities, which revolves around the study of the human condition expressed in language and history, art and aesthetics.³³ A view of art crystallised in the 19th century in which certain artis-

tic expressions were considered elevated above mundane utility to a symbolic sphere of imagination and sensuousness. People spoke of the 'fine arts' and the potential of aesthetics to change people's perceptions of the world. Although such high-flown words became somewhat anachronistic, from this aesthetic horizon it remains common to understand culture in the form of artistic expression, including literature, the visual arts and music.³⁴

Consequently, humanities studies in the field of Culture and Health at the University of Gothenburg are concerned with both cultural beliefs and aesthetic expression. While scientific theorists concentrate on systematic reflection about the former, scholars in aesthetically oriented disciplines like comparative literature, musicology and artistic research at the Valand Academy are also preoccupied with art and popular culture as an exceptional source of knowledge about the conditions for human well being.

Controversies among various perspectives in medical science

MARGARETA HALLBERG, professor of the theory of science, studies the cleavages between points of view in a variety of fields including medicine. From the perspective of 'controversy studies', Hallberg analyses antagonisms in science where knowledge is uncertain and scientists represent conflicting positions. Controversy studies focus less on the objective issue than the social, political, historical and religious factors that are critical to the parties' position-takings and polarised argumentation. Hallberg also applies a meta-perspective to examine disputes about the current state of knowledge in light of sociocultural contexts.

Hallberg has studied conflicts about subjects as diverse as sexual abuse of children and multiresistant bacterial strains in patients. Her first study in the health field concerned the introduction of brain death as a new concept of death in Sweden in the

1980s.³⁵ At the time, various authorities were arguing about the question of when death occurs – when the heart stops beating, or when brain activity ceases? If the answer is cardiac death, transplantation of the organs of a person dependent upon a respirator would be murder in the legal sense. If brain death, on the other hand, is the critical issue, it becomes possible to declare a person dead whose body is being kept alive by technical devices. The proponents of brain death as the deciding factor had evidence on their side, for brain function is essential to life, while the proponents of cardiac death relied on historical, social, religious, down-to-earth beliefs that death occurs when the heart stops beating. In this way, brain death emerged as ‘scientific death’ and cardiac death as ‘cultural death’.

In another study, Hallberg examined how medical knowledge can be scrutinised and criticised not only ‘intra-scientifically’ but also by the public, the media, politicians and various special interest organisations.³⁶ Scientists and hospitals can be forced to take a public position on issues that lack clear-cut answers or sufficient evidence. One controversy concerned the issue of a link between the measles vaccine and autism, which was suggested in a paper published by a reputable medical journal. Empirical support for the assumption was weak, but the paper was given considerable attention in the media and engendered widespread debate and a decline in vaccination rates in much of the Western world. Hallberg was struck by how countries responded to the issue in such different ways, as well as how various sociocultural circumstances shaped the medical controversy and efforts to resolve it.

Hallberg believes that some of the most intriguing questions in the theory of science can be formulated specifically in relation to various health problems and their cultural and social contexts. Medical work may have content that engenders both engagement and concern. This does not mean that every issue within Culture and Health will be controversial or the subject of debate, but that it is nevertheless a highly topical field of enquiry for research in the theory of science.

Contemporary fiction about illness

YVONNE LEFFLER, professor of comparative literature and co-director (along with Marie Demker and Ola Sigurdson) of the Religion, Culture and Health research programme stresses the importance of a broader concept of health. In parallel with the emergence of the medical humanities as a field of enquiry in Sweden and other Nordic countries (see Chapter 3), discussion within the field has largely emanated from the traditional understanding of health prevalent in medical science.³⁷ Leffler argues that we are living in a society in which various psychological and lifestyle-related conditions account for a substantial portion of what we can call the illness of our time. Within the field of Culture and Health, it is thus important to establish that health is something that involves more than the absence of disease and which touches upon a person's entire existence.

Religion, Culture and Health is a multidisciplinary programme that brings together political scientists, theologians, historians of religion, literary scholars and film scholars. On the overarching level, the programme studies various kinds of beliefs and stories that create meaning in people's lives. Leffler herself studies how popular literature confirms and challenges established views on well being. Chick-lit – romantic stories about 'women in crisis' – is one example. The chick-lit genre is to an extent shaped as 'self-help books in disguise' that give modern women suggestions about how they can manage their personal problems and turn adversity into success in their careers. Leffler offers the chick-lit genre as illuminative of how various diseases and health conditions have particular currency at different points in time. While TB and syphilis were the 'major' literary diseases of the late 19th century, today's literary health conditions are most likely to be depression, stress and feelings of powerlessness.³⁸

Leffler argues that literature not only reflects contemporary beliefs and problems, but also helps readers manage their lives. Even as novels make connections to social discourses, they also

improve the reader's ability to see the world from other perspectives. The opportunity to participate in events through the eyes of a fictional character allows readers to imagine something that they need not experience personally. The reading of literature is a risk-free way to enrich our lives with new thoughts and experiences of what it is like to suffer severe depression, for instance.

Leffler maintains that the most interesting literary research in the field of Culture and Health is the study of the significance of fiction to meeting people's existential needs. There is generally higher interest within the discipline in readers' cognitive and emotional development, but researchers have also begun to work specifically with 'rehabilitative reading' or bibliotherapy.³⁹ Emphasis is on how reading can help patients manage life crises or psychological distress. While this concretely shows the benefit of literature according to the 'culture by prescription' principle, Leffler stresses the value of studying not only the instrumental function of literature, but also how it challenges accepted notions of the meaning of health and well being.

Music as existential healthcare

LARS LILLIESTAM, professor of musicology, is interested in the connection between everyday musical experiences, well being and existential health. People can affect their mood and well being by listening to music for relaxation, pleasure and comfort or to feel a sense of roots, home and community. In their book *Musiken och jag* [Music and me] (2012), which is based on interviews with people of various ages, Lilliestam and his colleague Thomas Bossius discuss how people use music to cope with both minor problems and major life issues.⁴⁰ It is obvious that music is connected with our life course and identity, who we are or who we want to be. In short, music enhances people's existential health by stimulating perceptions of meaningfulness, context and hope. This can occur in a kind of everyday self-therapy when people listen to music of their own choice, play musical instruments, or sing.

There is an interface between Lilliestam's research perspective and music therapy, which is a clinical discipline that has developed a comprehensive body of practice and research since the Second World War. In parallel, musicology in recent years has, through coining terms like 'health musicking', deepened the understanding of music as an everyday enricher of human well being. But although research on music and health is well established in countries including the US, the UK, German, Denmark and Norway, research initiatives have thus far been limited in Sweden.⁴¹ Lilliestam has primarily worked within the framework of 'Music, Culture and Health', a Nordic research network that has produced several books in the field.⁴²

Lilliestam notes that there are many dubious or weakly supported notions about the beneficial effect of music. Critical scrutiny and the search for science-based explanations are particularly important considering that unsubstantiated stories have also been perpetuated within research. Many questions need to be refined and time-honoured notions must be re-examined.

Lilliestam believes music and health is a pressing area of research in an era characterised by constant and dramatic change. Managing people's feelings of worry, stress and resignation is not only an issue for medicine and healthcare. It is important to understand how people think and react to these problems and how they look for ways to overcome them. How, for example, do people interrupt negative thinking patterns and feelings of depression and pessimism? How do people cope with and attempt to overcome problems and hardships? How do we influence people's behaviour to achieve sustainable development in the future? Such questions call for a humanities perspective and collaboration across disciplinary lines.

Recalcitrant art for the good of society

JOHAN ÖBERG, research secretary at the Faculty of Fine, Applied and Performing Arts and director of literary composition at Val-

and Academy, is interested in the problem with the instrumental view of art and culture that lurks in the background of some Culture and Health initiatives: Is the primary function of art truly to be 'useful'? Öberg does however see the ambivalence: it is important on the one hand to uphold the autonomy of artistic expression but on the other hand it is difficult to ignore that art is part of a social context. No one wants an arrangement in which artistic work is set apart from all social contexts, including those of cultural and research policy.

Öberg notes that ever since Culture and Health was launched as a policy area in academic research and government, questions have been raised about its connection to the arts. According to him, all artistic work of any substance chafes against social norms in one way or another.⁴³ In simple terms, it essentially does not fit into society as it is. The arts and fiction – and their kin, religion, ritual, mystery – have always constituted a space in which human beings have been able to experiment with questions of profound importance. For example, political norms may be questioned or reversed and notions about the supposedly alien may be disrupted and dissolved. The benefit and the power of art for society and citizens reside in its seeming uselessness.

But art has also and forever been linked to religious, political and economic systems that supported it and attempted to control it. As an example, Romantic art in the 19th century was integrated into the ideological framework of the nation state – here in Sweden, we usually speak of 'national romanticism'. With its aggressive radicalism and non-conformism, modern art constituted a force in not only the resistance but also the shaping of various modern social projects – liberalism, communism, fascism and so on.

It is therefore, according to Öberg, not only understandable but downright good that artists invited to participate in new ideological projects – and Culture and Health is indisputably one such – ask critical counter-questions: 'is it not true that what you are describing as Culture and Health is something art has always

been involved in and only stands to lose by when it is framed instrumentally and politically?’ But in this context, Öberg considers an attitude along the lines of ‘just give us a generous arts and culture policy and leave us alone’ toothless in the context. It is, after all, impossible for artists to work outside their time and its ideological and material conditions. And one of these conditions is the dismantling or reshaping of the welfare state and the new forms of prevention that are arising as a consequence. The question of Culture and Health then appears, not least, as urgent in light of the biopolitical theories that are also topical in art theory and art debate.⁴⁴ Here, health is undeniably part of a power discourse in which the government and the market exert significant rights of co-determination over the bodies and lives of individuals. There is also a meeting place here for contemporary art and public health work in the late modern age.

The most immediate question is how the meeting of artists and social actors should be arranged in a fruitful way. Öberg notes that the currently popular client-provider model is hardly to be recommended. It seems more reasonable to imagine a meeting place where scholars, politicians and artists can stand as equal partners with latitude allowed for friction and criticism. Such a meeting place would require careful preparation. Time must be allotted for genuine dialogues so that the parties can gain insight into each other’s intentions and points of departure. The meeting place must, in short, be *curated*, to borrow an expression from the contemporary art scene. The word in Swedish is *curera* – a term that also brings to mind a ‘healing’ process to create a relationship between policy and art.⁴⁵

A MULTIDISCIPLINARY FUTURE?

Following this account of the breadth of research perspectives in Culture and Health, there is reason to end by harvesting shared ideas about the future of the field from among the scholars and sci-

entists presented in the chapter. There is considerable consensus on the potential of research based on a more complex understanding of human health and an evolution of interdisciplinary collaboration. The presentation itself illustrates the fluid boundaries and overlaps in perspective among the three major traditional faculty groups of the arts and humanities, science and the social sciences. Indirectly, the field of Culture and Health points to how discipline-specific, compartmentalised understanding of human well being is really a historical construction (see Chapter 1), which is now being re-examined for good reason. At the same time, most of the scholars who have contributed to the chapter argue that strengthening the field of research on a national level will be highly dependent upon changed structural conditions for the creation of fruitful multidisciplinary syntheses and collaborations.

The opportunity to obtain research grants is a central problem for many in the field. There is some fear that support of multidisciplinary research in Culture and Health will remain nothing more lip-service on the part of policymakers. When push comes to shove, the research councils tend to reward projects that stay within traditional disciplinary boundaries and which produce fast, quantifiable results. Likewise, most of the participants in this chapter emphasise that the medical discourse is strong and it can be difficult to garner support for research that moves outside these accepted frameworks. Culture and Health are words that sound alien in clinical and scientific contexts. They are also words burdened by a degree of complexity in such a way that their ambiguity not only opens the door to an expanded perspective on humanity, but also makes it difficult to pithily communicate what the research is actually about. Researchers in the field thus may be subjected to higher demands than others to define and legitimise the premises for their work.

One concrete complication is that projects that bring medical researchers together with scholars from other faculties grates against accepted rules and procedures for research grant applications. The competition for grants is fierce and those who are assessing applications must comply with their directives and existing dis-

ciplinary categorisations. In general, the norms for what science is vary drastically among the scientific, humanities and socially oriented disciplines and it is difficult for assessors to evaluate competencies within various disciplinary traditions on equal terms. The conventions for what constitutes good qualifications differ markedly between medicine and the humanities, for instance.

Consequently, many of the scholarly voices heard in this chapter argue that the opportunity to realise projects in Culture and Health depends on strategic initiatives at the national level that take multidisciplinary complexity into account and eliminate existing structural barriers.

At the same time, several participants point out that there is a challenge for researchers in Culture and Health to work for the long term, to be committed and, so to speak, to mobilise themselves from the bottom up. If it is difficult to gain support for research that breaks new ground and challenges traditional ways of thinking, being able to show the relevance and strength of the field becomes a matter of urgency. To some extent, the ball is in the court of the research collective, since they must personally move outside their 'comfort zones' and come together across disciplinary boundaries to a greater extent than has thus far been the case. As much as upon the given structural frameworks, the flourishing of Culture and Health as a field of enquiry will be dependent upon increased dialogue among disciplines and interest in other scientific and scholarly horizons. To establish a foundation for future multidisciplinary research, scholars must have the courage to work together, make their voices heard and – not least importantly – pursue studies that are hard to dismiss.

NOTES

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 16. See *Svenska Akademiens Ordbok* (Dictionary of the Swedish Academy).
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EDITOR'S AFTERWORD

Ola Sigurdson

CULTURE AND HEALTH is a fascinating field of enquiry. Even as it is undergoing rapid change and growth, it is providing an opportunity for innovative collaboration among various academic disciplines. Likewise, the field has obvious social relevance.

This book presents the field of Culture and Health research by addressing fundamental questions like the import of the words 'culture' and 'health', how the field has emerged in Sweden, how scientists and scholars are pursuing research in Culture and Health and how we can and should avoid instrumentalising culture and the arts. The aim is to provide an introduction to the field that is both accessible and provides deeper understanding, directed at researchers, policymakers, students and practitioners. For readers who want to further explore and learn more about the field – for the sake of their own research, their organisation, or out of personal interest – the extensive references in the book provide a gateway to researchers, academic articles and books, Swedish and foreign research centres and digital resources. *Culture and Health: A Wider Horizon* provides a map that interested readers can use to navigate the field.

Although the aim is to provide a well-informed and multifaceted picture of the field, this book makes no claims to being exhaustive. The chapter authors are all scholars in the humanities,

but this fact does not limit their ability to describe something that will also be recognisable at faculties of fine art or medicine. Nevertheless, there is reason to complement the book with points of view formulated from an artistic or medical horizon. The Centre for Culture and Health is planning two additional anthologies that will focus on artistic and clinical practice, respectively. Presenting Culture and Health not only as a multidisciplinary field but also from a multiplicity of scientific and scholarly perspectives is a matter of urgency.

This book could not have been written without the contributions of a number of individuals who are mentioned here in no particular order: Annica Sjölander, research coordinator at the Centre for Culture and Health and discussion partner concerning most of the book; Daniel Brodén, not only the author of one of the chapters, but also someone whose indefatigable interest in details I share; Katarina Bernhardsson, Gunilla Priebe and Morten Sager, superb authors of individual chapters who respect and understand deadlines; Bengt-Ove Boström, deputy vice-chancellor of the University of Gothenburg, chairman of the advisory board of the Centre for Culture and Health and a constant source of encouragement and valuable suggestions; Anders Franck and Eva Staxäng at Jonsered Manor, which offers an unusually high number of programmes relevant to the field; Pam Fredman, vice-chancellor at the University of Gothenburg and a great friend of Culture and Health; Martin Hellström, pro vice-chancellor at the University of Borås Högskola who dropped the introductory mediaeval example of Culture and Health into my lap when we met at Visby Airport; Margareta Hallberg, dean of the Faculty of Arts, University of Gothenburg, and a driving force in the medical humanities; William Kardemark, critical reader and scholar and, in other contexts, co-author; Ingrid Elam, dean of the Faculty of Fine, Applied and Performing Arts, University of Gothenburg, with her many viewpoints on the role of the arts in the context and the source of Sartre's remarks about health; Johan Öberg, with his critical sense of everything; Olle Larkö, dean of

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DIGITAL RESOURCES

(All accessed 6 February 2014)

1. University centres, networks and projects

Association for Medical Humanities

www.amh.ac.uk/about

Centre for Humanities and Health, King's College, London

www.kcl.ac.uk/innovation/groups/chh/index.aspx

Centre for Medical Humanities at Durham University

www.dur.ac.uk/cmh; www.dur.ac.uk/cmh/medicalhumanities

Centre for Culture and Health at the University of Gothenburg

www.ckh.gu.se

Duke University & School of Medicine

trentcenter.duke.edu

Physical activity in the prevention and treatment of disease

<http://www.fyss.se/fyss-in-english/>

Centre for Person-centred Care at the University of Gothenburg

<http://www.gpcc.gu.se>

Forum för humanistisk-samhällsvetenskaplig hälsoforskning

[Forum for health studies in the humanities and social sciences, Swedish only]

www.isv.liu.se/nisal/forskningsnatverk-och-samarbeten/forum-for-humanistisk-samhallsvetenskaplig-halsoforskning?l=sv

Forum för medicinsk etik

[Forum for medical ethics, Swedish only]

www.imh.liu.se/avd_halsa_samhalle/forum-for-medicinsk-etik?l=sv

History of Medicine in Practice, Uppsala University

www.idehist.uu.se/digitalAssets/184/184565_3rd-cfp-history-of-medicine-2014.pdf; www.idehist.uu.se/forskning/history-of-medicine-in-practice

Humanistisk medicin, Södertälje sjukhus

[Humanities in medicine, Södertälje Hospital, Swedish only]

www.sodertaljesjukhus.se/Om-oss/Nya-sjukhuslokaler/Humanistisk-medicin

Humanities and Medicine, Lund University

www.sol.lu.se/en/project/90

International Health Humanities Network

www.healthhumanities.org

Infectio, research project

[Norwegian only]

www.hf.uio.no/ilos/forskning/prosjekter/infectio/arkiv/index.html

International Network for Narrative Medicine

www.kcl.ac.uk/innovation/groups/chh/Narrative-Medicine-Conference-/About-the-Narrative-Medicine-conference.aspx

Karolinska Institutet, Hagströmer Medico-Historical Library

www.hagstromerlibrary.ki.se; intranet: internwebben.ki.se/sv/om-hagstromerbiblioteket

Karolinska Institutet, Unit for Medical History and Heritage

internwebben.ki.se/en/unit-medical-history-and-heritage

Karolinska Institutet, KTH Royal Institute of Technology and Stockholm University, collaborative ethics Centre for Healthcare Ethics

ki.se/ki/jsp/polopoly.jsp?d=14785&l=sv

Kokoro Research Center, Kyoto University

<http://kokoro.kyoto-u.ac.jp/en/AboutUs/greetings.html>

Kultur Skåne: Kultur och hälsa - Kultur i vården

[Skåne Office for Culture: Culture and health – Culture in healthcare]

http://www.skane.se/sv/Webbplatser/Kultur-Skane-samlingsnod/Kultur_Skane/Kultur_i_varden/

Swedish Arts Council

<http://www.kulturradet.se/sv/verksamhet/Kultur-och-halsa/>

The Cultural Brain: On culture, learning and health

<http://www.kulturellahjarnan.se/us/the-cultural-brain/>

Linköping University, ethics

www.imh.liu.se/avd_halsa_samhalle/forum-for-medicinsk-etik?l=sv

Literature, Arts, and Medicine Database

litmed.med.nyu.edu

Lund University, Unit for Medical History

[Swedish only]

www.med.lu.se/klinvetlund/medicinens_historia

Lund University, ethics

www.med.lu.se/klinvetlund/medicinsk_etik

Medical Humanities Programmes, compilation sites.

google.com/site/edinburghmhrn/resources/programmes

Humans Making Music (Swedish only)

<http://www.musicerandemanniskan.se>

Nordic Network for Philosophy of Medicine and Medical Ethics

www.imh.liu.se/avd_halsa_samhalle/nnpmme/hem?l=en

Nordic Network for Studies in Narrativity and Medicine

narrativityandmedicine.ku.dk

Nordic Network for Health Research within Social Sciences and the Humanities
nnhsh.org

Penn State College of Medicine
www2.med.psu.edu/humanities/history

The Program in Narrative Medicine,
Columbia University Medical Center,
www.cumc.columbia.edu/dept/medicine/narrativemed

University of California, San Francisco, School of Medicine
medicalhumanities.ucsf.edu

University of Rochester Medical Center
www.urmc.rochester.edu/medical-humanities

University of Texas Medical Branch at Galveston
imh.utmb.edu/education

Uppsala University, ethics
www.pubcare.uu.se/forskning/etik

Wellcome Trust
www.wellcome.ac.uk/Our-vision

2. Journals

Academic Medicine
journals.lww.com/AcademicMedicine

Annals of Internal Medicine
annals.org

Arts & Health
http://www.tandfonline.com/toc/rahe20/current

BMC Medical Education

www.biomedcentral.com/bmcmededuc

Bulletin of the History of Medicine

muse.jhu.edu/journals/bulletin_of_the_history_of_medicine

Hektoen International

www.hektoeninternational.org

Journal of the American Medical Association

jama.jamanetwork.com/journal.aspx

Journal of Applied Arts and Health

<http://www.intellectbooks.co.uk/journals../view-Journal,id=169/>

Journal of Medical Ethics

jme.bmj.com

Journal of Medical Humanities

link.springer.com/journal/10912

Journal of Medicine and Philosophy

jmp.oxfordjournals.org

The Lancet

<http://www.thelancet.com>

Literature and Medicine

www.press.jhu.edu/journals/literature_and_medicine

Läkartidningen [Journal of the Swedish Medical Association]

www.lakartidningen.se

Medical Education

[onlinelibrary.wiley.com/journal/10.1111/\(ISSN\)1365-2923](http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1365-2923)

Medical History

journals.cambridge.org/action/displayJournal?jid=MDH

Medical Humanities
mh.bmj.com

Medicine, Health Care, and Philosophy
link.springer.com/journal/11019

New England Journal of Medicine
www.nejm.org

Social History of Medicine
shm.oxfordjournals.org

Socialmedicinsk tidskrift [Journal of Social Medicine]
www.socialmedicinsktidskrift.se

Sociology of Health and Illness
onlinelibrary.wiley.com/journal/10.1111/(ISSN)1467-9566

Svensk medicinshistorisk tidskrift
www3.svls.se/sektioner/mhi/tidskrift.html

Theoretical Medicine and Bioethics,
www.springer.com/philosophy/
epistemology+and+philosophy+of+science/journal/11017

Tidskrift for Den norske legeforening
[*The Journal of the Norwegian Medical Association*]
http://tidsskriftet.no/Innhold/The-Journal-of-the-Norwegian-
Medical-Association

Ugeskrift for Læger [The Journal of the Danish Medical Association]
ugeskriftet.dk/english

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