The health humanities is a rapidly rising field, advancing an inclusive, democratizing, activist, applied, critical, and culturally diverse approach to delivering health and well-being through the arts and humanities. It has generated new kinds of interdisciplinary research, knowledge, and communities of practice globally. It has also acted to bring greater coherence and political force to contributions across a range of related disciplines and traditions.

In this volume, a formidable set of authors explore the history, current state, and future of the health humanities, in particular how its vision of the arts and humanities:

• Promotes creative public health.
• Opens new routes to health and well-being.
• Informs and drives better health care.
• Interrogates relationships between ill health and social equality.
• Develops humanist theory in relation to health and social care practice.
• Foregrounds cultural difference as a resource for positive change in society.
• Tests the humanity of an increasingly globalized health-care system.
• Looks to overcome structural and process obstacles to cross-disciplinary ventures.
• Champions co-construction, co-design, and mutuality in solving health and well-being challenges.
• Showcases less familiar, prominent, or celebrated creative practices.
• Includes multiple perspectives on the value and health benefits of the arts and humanities not limited to or dominated by medicine.

Divided into two main sections, the Companion looks at “Reflections and Critical Perspectives,” offering current thinking and definitions within health humanities, and “Applications,” comprising a wide selection of applied arts and humanities practices from comedy, writing, and dancing to yoga, cooking, and horticultural display.

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In Memoriam

Professor Ronald Carter (1947–2018)
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INTRODUCTION

Global health humanities and the rise of creative public health

Paul Crawford

Introduction

Health humanities is a fast-growing field of research, education, and practice that has generated a more inclusive, democratizing, and applied approach to arts and humanities in health care, health, and well-being. Its rise over the past 13 years represents an interdisciplinary departure from the longer-established tradition of medical humanities. However, it seeks to enjoin the medical humanities as well as fields such as arts and health, expressive therapies, community arts, and social prescribing to work more collaboratively to advance creative public health.

To date, multiple networks, research units, projects, and taught courses in health humanities have emerged worldwide. Importantly, this “burgeoning” (Purser, 2017) field has brought diverse academics, creative practitioners, and health, social care, and education professionals to work more closely with the public to find new applications and social innovations through the arts and humanities in an interdisciplinary and non-hierarchical way. As such, the field has shifted beyond medical conceptions of health and well-being, rejecting a pecking order for who controls or mandates the application of the arts and humanities to improve the human condition.

As Crawford and Brown (2020: 41) write, the health humanities offer a “superordinate evolution” that advances innovation, mutuality, and dialogue between congruent traditions. In this way, it seeks to inspire, not to control or govern innovation. Klugman (2017: 419) goes so far as to suggest that health humanities may even “stave off the decline of the broader humanities” in higher education where STEM subjects (typically defined as science, technology, engineering and mathematics/medicine) are deemed to more clearly tie in with employment opportunities. Skylar (2017) reports how health humanities is informing medical training in new and compelling ways: providing a focus on the use of arts and humanities to foreground the perspectives of patients, their families, and social conditions or environments.

Here, I present a brief overview of health humanities as an increasingly global field, outlining its origins, definitions, critical reception, praxis and creative public health. I also provide a summary of the very many excellent contributions to this important volume from new and leading voices in the field.
Origins

In 2006, I consulted with the Arts and Humanities Research Council UK (AHRC) on developing a much broader application of the arts and humanities to health care, health, and well-being than that currently available in fields such as medical humanities. The earliest field description and definition for the health humanities, a term previously only loosely applied, followed in a paper presented at the Economic and Social Research Council Business Seminar held at BioCity Nottingham, United Kingdom in 2007 (Crawford, 2007) and in the first peer-reviewed field description (Crawford et al., 2010). The latter coincided with the launch of the International Health Humanities Conference at Nottingham University, UK (August 6–8). By 2011, the International Health Humanities Network, funded by the AHRC, spearheaded multiple symposia and workshops worldwide. In 2015, the Health Humanities Consortium in the United States launched and agreed to co-produce the International Health Humanities Conference series, held every two years up to this point. The fourth International Health Humanities Conference was hosted that same year at the University of Colorado, and subsequent events have been hosted annually.

Since these early days, health humanities research units have emerged across the United Kingdom, Europe, United States, Canada, Australia, Africa, India, China, Japan, and other territories. These developments have led to a rapid growth in undergraduate and postgraduate programs in the field. Berry et al. (2016) identified 57 baccalaureate Health Humanities programs instituted in the United States alone. In 2014, the first undergraduate Health Humanities curriculum was launched in Canada at the University of Toronto Scarborough (Charise, 2017), with a Canadian Association for Health Humanities appearing in 2018. In the United Kingdom—where the focus of health humanities has been on applied, inclusive research, health and well-being innovation innovation, and activism—dedicated educational initiatives have only recently started to emerge, with a Masters in Health Humanities at University College London and the University of Edinburgh, and others in the pipeline.

Alongside the early work in field description, networking, and the formation of research units and university courses, a first manifesto for the field (Crawford et al., 2015) and a first reader (Jones et al., 2014) have been published. In addition, a wide range of articles and commentary papers have been written, debating the nature and work of the field, including approaches to or evaluations of teaching programs (e.g., Charise, 2017; Jones, 2014; Klugman, 2017; Peterkin and Skorzewska, 2018; Rubens, 2017; Skylar, 2017; Tsevat et al., 2015). In 2020, there will be a major new health humanities-led series called “Arts for Health” with Emerald and a much-anticipated Encyclopedia of Health Humanities (Crawford and Kedetz, forthcoming). Such field-defining publications mark a consolidation of relevant scholarly discussion alongside this current volume.

Field consolidation of the health humanities has also benefited from increased levels of funding from grant-awarding bodies and the support and sponsorship of multiple and high-profile institutions. In the United States, the field has found favor with OppNet and National Institutes of Health, while in the United Kingdom, health humanities has attracted the support of UK Research and Innovation and several of its Research Councils, major charities, and prominent organizations such as the British Library, the Science Museum, and the Royal Society for Public Health to name but a few. In the United Kingdom, health humanities research has featured in important government reports and been celebrated in the launch in 2020 of new national awards for both the medical humanities and health humanities, supported by the Arts and Humanities Research Council and Wellcome Trust. These more substantially funded awards replaced the earlier Health Humanities Medal which ran in 2018 (AHRC/UKRI, 2020).
For many, the shift to health humanities has been a radical and welcome move. Despite the clear collaborative approach of the field (Crawford, 2015), the development has presented a challenge to some established or more specialist movements anxious to maintain their prominence, status, or funding. For some, health humanities has provoked a kind of replacement anxiety. Yet the magic of health humanities has been its openness to all movements valuing the contribution of the arts and humanities to advancing health care, health, and well-being. In this sense, health humanities has proven to be a valuable integument for diverse individuals, groups, and organizations to make a difference in this work. As we witness above in the way that health humanities has gathered global momentum as a field, it is so much more than a switch in nomenclature. With a more public-savvy mission, the field has spurred a broadening in the scope, inclusion, or application of previously established and more narrowly configured disciplines. As Jones et al. (2017: 932) argue, the move to health humanities is not simply a matter of semantics and “splitting hairs.” Given the range of subjects, health professions, stakeholders, and practice environments it involves, health humanities is a “more encompassing, contemporary, and accurate label” (Jones et al. 2014: 6).

Since 2006, health humanities has gained traction both in re-describing, expanding, and generating a much more encompassing vision for applied arts and humanities for health and well-being. It has proposed and foregrounded the recognition of the arts and humanities as a major force for public health—as such, we might call this creative public health. In short, the field has welcomed and promoted inclusion in its work from all sectors and communities. It has challenged the privileging of professional expertise over lived experience and lay perspectives, and widened the pedagogic bandwidth for how the arts and humanities can inform multi-professional training and service development related to health and well-being. It has demonstrated how practices in the arts and humanities can act as a shadow health and social care service to any nation, albeit not necessarily led by medicine. It has pursued the development of a stronger evidence base for the application of both the arts and humanities to improve health and well-being. Finally, and importantly, it has inspired new, active communities worldwide, broadening out from Western perspectives, increasing in cross-cultural sensitivity and dynamism. It is particularly welcome to note how various scholars have begun to interrogate and deepen this move (Gutierrez and DasGupta, 2015), including (in this volume) DasGupta, El-Hadi, Crawford (A.), Boivin, and Richardson. Indeed, the salience of health humanities for diverse international health challenges has been noted by Stewart and Swain (2016: 2587) in referring to “global health humanities,” and the recent emergence of research and education networks across the African continent.

Definitions

The health humanities adopt an interdisciplinary, inclusive, applied, democratizing, and activist approach to the arts and humanities in informing and transforming health care, health, and well-being. It is a field “engaging with the contributions of those marginalized from the medical humanities” (Crawford et al., 2010: 4). As such, health humanities has moved beyond a predominating concern with training health professionals through the arts and humanities, and a privileging of a medical, biomedical, or scientific frame or lens above that of the expertise of the public, non-medical, or non-science contributions, and challenges mechanistic or reductive routes to “injecting” the arts and humanities as a kind of treatment. Importantly, it has fractured the expert to non-expert dynamic, revealing faultlines in the project of professional “injectables,” treatments, or interventions over grassroots self- and community help and more open access to the benefits of social and cultural assets,
that is, creative public health. As such, health humanities strives to bring the public to therapeutic uses of the arts and humanities. It champions creative, non-professional, or non-expert solutions to health and well-being challenges among service users, informal carers, and self-caring individuals or groups. It values co-design, co-creativity, and co-learning over privileged direction and control in maintaining or recovering the best possible lives while living with, or having experienced, poor health. It also seeks to advance compassionate environments for health care, health, and well-being, not least for practitioners who face continual exposure to trauma (Crawford et al., 2015, 2010). As Purser (2017: 2) notes, such early definitions point to a field that “calls for a reimagining of the boundaries of health and healing, so that our intellectual and therapeutic focus might escape the physical and, perhaps more importantly, the epistemological constraints of the clinical.”

In terms of its application in education, Charise (2017: 433) confirms: “One of the innovations of Health Humanities is its radically interdisciplinary approach, which differs from conventional health education by foregrounding subjects that generally value aesthetics, social experiences, and interpretive methods over quantitative and/or biomedical modes of investigation.” She identifies health humanities as an open and diverse “undergraduate, pre- or non-health-professional field of study,” and more broadly, a “vibrant site of public learning and activism” (Charise 2017: 444). As the field develops, it is the latter—activism—which could prove the field’s greatest aspect; that is, activism for public health through the arts and humanities. The rise of creative public health seems ever more relevant as nations realize that clinical or clinically sanctioned assets are not the only route to enhancing the health of populations. In this way, health humanities loosens itself from educational and training contexts to drive noteworthy research underpinning social change. In a very compelling and powerful way, health humanities is a “free-form and viral movement” that can inform and transform ways of seeing or conceiving health care, health, and well-being (Crawford et al. 2015: 19).

Critical reception

The health humanities feature in critical discussions in the literature, for example, Jones (2014) and Jones et al. (2014). Atkinson et al. (2015) consider it a “post-disciplinary” field of study, while various commentaries have pointed to it, essentially, as the “new kid on the block” or as a competing terminology for particular kinds of research and teaching. Of course, its reception and utilization continues to evolve across different territories with diverse infrastructure and cultures for how the arts and humanities can conceive, drive, and transform health and well-being. For example, Charise (2017) notes that the health humanities may require or create different resources and approaches in unique cultures and contexts: for instance, in research funding. She flags the conventionally narrow-track, discipline-segregated research activities in the United States and Canada, where it can be challenging for any interdisciplinary field to secure funding geared to particular academic silos and rigid concepts. As a result, health humanities will always have to adapt and respond to the different cultural emphases that apply. To date, across North America the educational or pedagogic aspect remains dominant, as with medical humanities and bioethics, yet enriched by new and more open dimensions as to how education in this field is not solely focused on medical trainings and how the social aspects of the arts and humanities inform and shape new visions for health care, health, and well-being. In the United Kingdom and elsewhere in Europe, China, India and Australia, however, applied research or praxis for human benefit and democratizing and activist approaches are to the fore, with educational initiatives running alongside.
Praxis

Research in the health humanities has led to a variety of practical applications in terms of the health and well-being of the public, health care innovation, pedagogic developments, and policy influence. It is beyond the scope of this short chapter to review this work in full, but a couple of examples from recently funded programs should suffice in alerting the reader to its potential for social impact and change. In a recently completed AHRC-funded study, “Creative Practice as Mutual Recovery,” 14 separate projects examined how a selection of different creative practices in the arts and humanities can help with promoting good mental health and well-being. It explored how this is possible within and between groups of health service users, family carers, arts practitioners and health, social care and education professionals, in a shared experience termed “mutual recovery.”

One of the projects at the Royal College of Music, for example, found that a ten-week program of group drumming reduced depression by as much as 38% and anxiety by 20%, while improving social resilience by 23% and mental well-being by 16% (Fancourt et al., 2016). This is creative public health in action, adding to a raft of evidence for how the arts and humanities can promote mutual recovery without the need for a prescription as such. Importantly, mental health service users co-designed the program from start to finish. In a separate investigation of how medieval medical remedies can tackle antibiotic resistance, AncientBiotics forges new possibilities for application of historical texts to contemporary public health such as dealing with infections (Harrison et al., 2015). In the pages below, there are many other wonderful offerings of applied research and practical work to advance public health by creative means.

This volume highlights the very rich and diverse possibilities with health humanities. It comprises two parts—reflections and applications—to capture a sample of the critical thinking about health humanities and examples of how knowledge and practices in the arts and humanities can apply themselves to multiple contexts of health care, health, and well-being. It is important to acknowledge that the 65 individual chapters represent only a small part of the rich body of theory and practice in the field of health humanities worldwide. We have avoided trying to totalize in any sense this flow of activity, but hope that the current volume illuminates and points to debate, innovation, and new, exciting trends.

In Part I, “Reflections and critical perspectives,” we find several threads of the latest thinking about health humanities. Some of these chapters may reprise familiar ground, but many provoke with less familiar and by no means unitary approaches to the topic. This section features reflections on cross-cultural and indigenous perspectives (A. Crawford, Boivin, Richardson, Das-Gupta, El-Hadi); the genealogy of recovery (Brown); challenges and constraints in relation to austerity (Charise); health-care systems (Barrish); clinical settings (Joyes and Baker); and visualizing health care (Macduff); digital contexts (Banner); post-conflict resolution (Meineck); medicine within health humanities (Allsopp); graphic medicine (Squier); the sublime (B. Lewis); the role of creatives (Tischler); co-design (Macdonald); advocacy (Levy); the role of imagination (Tsaprna and Barfield); historicizing anti-vaccination (Lau); the semiotics of drug advertising (Servitje); neoliberalization and biomedicine (Neilson); sensation and culinary texts (Li); creative adult education (Lewis); zombie health care (Schlozman); and the objectified patient (Hall and Kadetz). In addition, there are critical perspectives on the potential for health humanities beyond the United States, Canada, the United Kingdom, and Europe, in terms of Japan (Huffman and Inoue), Australia (Werder and Holland), and Africa (Iféobu).

In Part II “Applications,” this volume offers a firework display of multiple, contemporary, and surprising routes for the application of the arts and humanities to health care, health, and
well-being. The tone here is a long way from “injectables,” yet it combines notice of both quantitative and qualitative evidence alongside illustrative cases. This section presents lively and inspiring accounts of how the arts or humanities contribute to health care, health, and well-being through the following: theater (Iedema, Case, Cheek O’Donnell, Tsaplina, Astles, Meineck); gallery and museum visiting (Saavedra); literature and reading (Bartel, Baker, Davis, Billington, Meineck); storytelling (Rice, Bleakley, Wilson, Allard); visual arts (Hogan, Scott, Tischler, Johnson, Czerwiec, Callender); fashion and textiles (Fleetwood-Smith, Corkhill, Atkinson, Tillotson); music (Perkins, Fancourt, Williamson, Garabedian, Baker, Bishop, Abrams); singing (Clift, Abrams); dancing or movement (Houston, Jordan, Wright, Purser, Perez-Vallejos, Haslam-Jones); architecture (Quesada-García, Valero-Flores, Moss); horticultural arts (Coope); cooking (George, Dreibelbis); paper making (Matott and Miller); history (Greenwood); biography (Cadd); ancient texts (Lee); philosophy (Carel); and law (Bracken).

In all, we have tried to live up to the inclusiveness at the heart of health humanities by inviting a selection of new writers with unique and developing voices among more established and leading practitioners, academics, and commentators committed to the application of the arts and humanities to health care, health, and well-being.

We have aimed to encourage different kinds of reflections, critical perspectives, and accounts of application without insisting upon a standard presentation of these. Such offerings are by no means exhaustive, but they do indicate the rich and diverse ways that health humanities is emerging worldwide, and how our conceptions of what we hold as belonging to the arts and humanities must remain open—not least in relation to the less privileged or obvious areas of practice such as cooking, horticulture, knitting, quilting, and so forth.

Furthermore, this volume seeks to give emphasis to another core feature of the health humanities, that is, “appliedness.” This volume offers an entry point for many different and versatile ways that the arts and humanities can be relevant to a wide range of physical and mental health challenges.

It is particularly pleasing to see a variety of contributions that come to us, “low carbon,” from all around the globe. We welcome the focus on different social and cultural contexts for health humanities and fresh insights into how to develop new opportunities for innovation.

To sum up, we are beginning to see the maturation of health humanities as an energetic, robust, applied, and inclusive field: one that signals a more co-created and co-operative vision for how the arts and humanities can stand as an interdisciplinary, and not solely medicalized, shadow health care service to any nation. Working beyond the control of traditional hierarchies of professional knowledge and practice, health humanities is an evolving, game-changing field that attracts different arts and humanities traditions to work more closely with the public to advance health care, health, and well-being. Whether we are considering education, research, or practice, this field is opening medical and non-medical visions of how to improve human health through innovative cultural care. It continues to open up new possibilities for creative public health.

References


Introduction


NOTES

CHAPTER 9

1 I include both the terms “comics” and “graphic medicine” throughout this article because while I have been writing about comics since at least 1993, the term Graphic Medicine came on the scene in 2007, when Ian Williams MD, physician and cartoonist, coined it to refer to comics dealing with medicine, illness, disability and caregiving, and I did not encounter the term until 2010, when I participated in the first international Comics and Medicine conference in London. https://nihcrecord.nih.gov/newsletters/2018/05_04_2018/story1.htm A more extensive definition of Graphic Medicine, as well as a glimpse at the vibrant intellectual, artistic, therapeutic, and social world the field has created, can be found at www.graphicmedicine.org.

2 In an early chapter on organ donation in Liminal Lives, I used a cartoon The Times (London) set into an article addressing the global organ donor crisis to introduce a discussion of research into tissue culture. The cartoon pictures a man in an Argyle sweater swinging, pipe in mouth, from a light fixture. Below him, a woman grasping a newspaper with the headline “Pig Heart Transplants Unsafe” explains to the man beside her: “He opted for the Monkey Heart transplant instead.”

3 Since then I have written about this comic several more times, particularly in my contribution to Graphic Medicine Manifesto (2015) and in Epigenetic Landscapes (2017). What a gem it is.

4 If my memory serves me right—and it has been more than 20 years—this seminar was co-led by Kathryn Montgomery Hunter, Tod Chambers, and Delese Wear. Apologies if I have misremembered.

CHAPTER 15

1 Joseph Gone’s work is exemplary, particularly Gone (2007).

2 New efforts in the larger field of health humanities are calling for greater interdisciplinary integration across the field. See, for example, Crawford et al. (2015) and Jones et al. (2014).


4 Crawford (2014) has argued elsewhere, drawing on approaches to trauma studies in literary theory, that historical trauma can be understood as narrative. Nathanial Mohatt and his colleagues (2014) have extended this idea of the narrative structure of historical trauma to talk about the public dimensions of this narrative framework.

CHAPTER 19

Pharmaceuticalization, moreover, distinctly considers the use of medications for lifestyle, recreation, and enhancement—certainly gray rubrics—and access to them from outside licit medical channels (the internet and black market.) See Gabe et al. (2017).

In the simplest terms, GABA (gamma-aminobutyric acid) is a neurotransmitter that plays an inhibitory role in the nervous system. A GABA-agonist potentiates this system. An exception to the drugs named above is Rozerem, which is a melatonin receptor agonist. Z-drugs are technically referred of as non-benzodiazepine sedative-hypnotics.

Following Appadurai’s anthropological work on commodities and material items, Whyte, Geest, and Hardon trace the lives of drugs specifically in terms of “their production and marketing, their prescription, their distribution through intertwined formal and informal channels, and their deaths through one or another form of consumption, and finally their lives after death in the form of efficacy in modifying bodies” (Whyte et al., 2002: 13–14).

Because there are a number of different classes of medications (e.g. tranquilizers, sedatives, sedative-hypnotics), I use soporific here as the broadest term for an agent that induces sleep.

For more details on the history of DTCA, see Greene and Herzberg (2010) and Schwartz and Woloshin (2019).

1997 figure reported in 2016 dollar equivalent.


Here, Moloney references Gabe et al.’s (2017) study.

On a taxonomy of common this kind of figurative language, see Scott et al. (2004: 23).

Although Gabe et al. (2017) draw data from a sampling of the UK’s population, there is quantitative and qualitative evidence of at the very least resistance to or reluctant acceptance of medicalization, if not a more concentrated process of de-pharmaceuticalization in the United States. See Moloney et al. (2019: 5).


Indeed, if we are thinking paratextually, side effect warnings are part of drugs as consumable objects. Because the FDA requires that prescription drugs are dispensed with package inserts, whether we read them or not, drugs have a textual, media component. In fact, the very fact that we are so quick to throw away the 40-page, 1000-line document that includes everything from chemical structure, pharmacokinetics, and clinical trial information on top of side.


The authors understand the dilution effect as an “effect [that] occurs whereby those who assess the mixed set of diagnostic and non-diagnostic information arrive at less extreme predictions in comparison with those who assessed only diagnostic information. That is, the nondiagnostic information—information of little value and consequence for outcome prediction—dilutes the value and importance of the diagnostic information in our prognostication” (797).

I am indebted to my colleagues Suzanne Edwards and Mark and Alyssa Volker that were generous in sharing their extensive knowledge of musicology to substantiate this reading.


CHAPTER 20

In this instance, and in the rest of the chapter, I define the “biomedical epistemology”—usually shortened to just “biomedicine”—as the idea that all human physiology and consciousness can be known and modified via laboratory experimentation because it is material. As Nikolas Rose (2007: 4) writes: “It is now at the molecular level that human life is understood, at the molecular level that its processes can be anatomized, and at the molecular level that life can be engineered.” Rose adds (and I agree) that according to this basic orientation of science to humanity, “it seems . . . there is nothing mystical or incomprehensible about our vitality—anything and everything appears, in
principle, to be intelligible, and hence to be open to calculated interventions in the service of our desires.”

2 A list of these cuts can be found in “Update: Mounting Healthcare Cuts” from the Ontario Health Coalition. To get a sense of the neoliberal flavor of the government’s discourse, see Health Minister Christine Ford quest for “efficiencies” in the following CBC News Online article: “What we are looking at is improving patient efficiency. We are restructuring the system in many respects, moving people into different positions within that structure, because the way things are operating within the LHIN structure, it’s not working right now. And providers are operating in silos. We want to break down those silos” (Draaisma, 2019).

3 If faculties of medicine require a “humanities elective” from their students, what does this really mean? For one thing, it predicts the present: the humanities within the institution of medicine is not considered central or essential, but is conceived of as a value-added or ancillary commodity. Trying to change this is hard because medicine knows what it wants and the table is tilted from the beginning. The humanities can be said to “have a place” but are also “put in their place” at the same time.

4 One of the ways to do this is to have dual-trained scholars collaborating with humanities faculties to show that medicine has another life.

5 As explained by Bennett et al. (2018: 1342), “personal skills training, and complementary, mind-body (e.g., mindfulness, meditation) interventions to mitigate stress perception have shown promising results in allowing individuals to recover following the PTE and to develop new coping skills.”

CHAPTER 21

1 Liao lived in the district of Tongzhou, one-hour east of Beijing’s city center.


3 Later in the article, I will argue for different version of *xin* 心. For instance, literary scholars place it in the chest and in the mind. Medical scholars place it in the lungs and in the heart. And if we look at the character itself, it offers yet another pictographic clue of potentially invoking the brain.


5 For the remainder of the chapter, I will no longer include the Romanization of 心 as *xin* to appreciate its multiplicity of meanings and pronunciations.


8 Wragge-Morley grounds his definition in early modern European history of science where most natural philosophers considered metaphors with great suspicion, but relied on them regardless. For


10 For the full podcast episode with Alex Wragge-Morley and our interview with Dr. Guangming Li, see our episode “Multiple Organs: 心 as Heart-Mind-Brain” at https://cargocollective.com/mind-metaphors/THINKING-ORGANS.

11 More on this possibility in “Multiple Organs: 心 as Heart-Mind-Brain” at https://cargocollective.com/mind-metaphors/THINKING-ORGANS.

12 For a catalogue of mingtang tu reproductions into the twentieth century, see Huang, L. (2003).

13 This is a rough translation, the original reads: 髓海至陰之在通尾骶。The suihai髓海 or “bone marrow sea” is one of the “four seas” listed in the Huangdi neijing lingshu haiyun pian 33. The others include xuehai 血海, qi hai气海, and shuigu zhihai 水穀之海, or very roughly the sea of Blood, Qi, and Water/Millet each located very roughly in the meridians, chest, and abdomen.


16 This was the case with naming nerves as shenjing 神經, which scholars borrowed from the Japanese shinkei that was coined in the eighteenth century. See Shapiro, H. (2003). How Different Are Western and Chinese Medicine? The Case of Nerves. In: H. Selin, ed., Medicine Across Cultures: History and Practice of Medicine in Non-Western Cultures. Dordrecht: Springer Netherlands: 351–372.


18 Coke was not invented in 1928, but it was the year that Coke was first trademarked in China. Nevertheless, Coke was Liao’s favorite drink. Her son-in-law often stocked dozens of mini Coke bottles in her mini refrigerator.

19 The link to the short film can be found here: http://lan-a-li.com/on-aging.


21 While Kant has written at length about the aesthetics of ethics, I follow landscape architect Ron Henderson’s concern for the ethics of aesthetics.

22 I use the case of body maps to compare the movement of medical theories and clinical practice. More on this in my forthcoming book, Intimate Cartographies: Body Maps and the Assembly of Medical Imagination.


CHAPTER 31

1 An example of an arts-based research project is www.derby.ac.uk/media/derbyacuk/assets/research/research-groups/documents/65835-The-Birth-Project.pdf.

2 This is an abridged list which originally appeared in further detail in Pink et al.’s edited volume Theoretical Scholarship and Applied Practice (2017) in a chapter entitled Working Across Disciplines Using Visual Methods in Participatory Frameworks. This in turn, was based on a list produced by Weber (2008: 44–47). As I felt Weber’s categorisations lacked sufficient distinction, I used her list as a starting point and acknowledge her work as the initial inspiration.
CHAPTER 33

1 For example the Program in Narrative Medicine at Columbia University. www.narrativemedicine.org/about-narrative-medicine/ (accessed October 20, 2018).
2 Plato Minos 231a; Isocrates Evagoras 2.10 and 2.49; Aristotle Poetics 1450b. 16–21.
4 www.warriorchorus.org/ (last accessed November 11, 2018).

CHAPTER 36

1 Arts and Humanities Research Council study, Cultural Value (AH/P014356/1), in which Shared Reading groups were filmed and sound-recorded (see Longden et al., 2015). The study was conducted according the University of Liverpool research ethics protocols, including informed consent by participants. Pseudonyms are used.
2 For information on The Reader’s Read to Lead training courses and a suite of online training films, developed by CRILS and funded by Arts and Humanities Research Council (AHRC), see: www.thereader.org.uk.

CHAPTER 37

1 The literature on professional and pre-professional dancers’ health is much more extensive, but deals with a population that has significantly different issues than the recreational dancer. The literature tends to focus on studies investigating the impact of intensive dancing, for example effects of over-training on the body, injuries and injury prevention, and psychological effects. The pursuit of dancing as a professional occupation has brought with it unhealthy working practices, such as bullying, dancing through injury, as well as mental illness, such as anorexia nervosa and bulimia (Buckroyd, 2000; Jola and Calmeiro, 2017).

CHAPTER 48

1 See www.nlm.nih.gov/exhibition/graphicmedicine/index.html

CHAPTER 49

1 Gary’s case study is explored in Vardakoulia (2013: 19–21).

CHAPTER 51


CHAPTER 63

1 See also the International Convention on the Elimination of All Forms of Racial Discrimination of 1965, Article 5 (c) (iv) and the Convention on the Elimination of All Forms of Discrimination against Women of 1979, Articles 11.1 (6) and 12.
2 The World Health Organization notes that “law is not always an unmitigated social good, but can actually stand in the way of progress in health and human rights.” See World Health Organization (2017: xvi).
3 For example, in many parts of the United States, anonymous donations are legally permitted.
5 For example, the School of Law at the University of Limerick engages with the community through various initiatives such as Advanced Lawyering Projects, UL Engage practicums and community law lectures. See, for example, https://ulsites.ul.ie/law/node/18261 (accessed 2/2/19).
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For an overview of the role of music in health and well-being, including from community, therapeutic, educational, and everyday contexts see:
For an overview of the use of music and wider arts in health, including how to develop and evaluate music interventions in health care, see:


