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Aesthetics and Body Experiences in Health Care

Britta Møller and Falk Heinrich

Studies in health and health care comprise a broad field encompassing medical treatment, prevention, and care for older and permanently sick people. The area includes many healthcare practices and practitioners: doctors, nurses, care workers, alternative practitioners, etc. Thus, health studies are subject to a broad and interdisciplinary area that has different ways of understanding what health is and how health is studied (Naidoo & Wills, 2015). Drawing on various scientific fields, discourses of biology, medicine, cultural studies, psychology, social policy, and sociology are all intermingled in health studies. Traditionally derived from natural science, an objective biological construction of health has dominated health studies and health care in the West (Naidoo & Wills, 2015). Here, the body is considered a collection of matter-based functions, where dysfunctional bodies can be restored by repairing or replacing broken parts. Likewise, medicine dealing with physical and mental health aspects and dysfunctions relates to the body as a means—or obstacle—for performance. One of the consequences of the medical approach is that the body can never be strong and effective enough, as shown by the intricate relationship between medicine and elite sports. In this case, body work and bodily health are understood as performance machines, and the body's training is valued as something done (Aldridge, 2004). In health care, bodies are seen as targets of daily care in terms of personal hygiene, medical treatment, exercise, proper nutrition, and medication. Bodies are treated as almost mechanical objects of care in the sense of concern and worry. This is considered low-ranked and even dirty work performed as paid bodywork on the bodies of others (Twigg, 2000).

Only recently have aesthetic artifacts and practices gained attention within health studies and health care. Aesthetic dimensions are often seen in beautifying hospitals and nursing homes' spatial interiors and surroundings (wall colors, mural art, posters, paintings, sculptures, recreational parks, etc.). Likewise, the benevolent effect of aesthetics is seen with cultural experiences (theater, music, poetics, and narratives) and aesthetic experiences in and with nature. Evidently, there are good reasons for this. However, we argue that the aesthetic dimensions of the lived body are an important and valuable addition and sometimes even a substantial means for a good or better life (Shusterman, 1999), especially for people with permanent health conditions and older people. Somaesthetic practices are also a means of healing.

Somaesthetics surpasses external beautification and aestheticization because it posits aesthetic attention within our somatic self as the center of healing and improvement. Somaesthetic practices focusing on bodily awareness and experiences can be benevolent and supporting in health questions, and this has several reasons. First, somaesthetics questions

the predominant thinking that sees the body as an object to be manipulated and enhanced. In contrast, somaesthetics proposes the experiencing of one's own body as an integral part of well-being and meaning-making. Second, somaesthetics suggests a more fluid continuum between health and sickness that focuses on acceptance and improvement through somatic aesthetic practices and awareness. Thus, somaesthetic practices can support healthcare by emphasizing the aesthetic experience and awareness of the situated body and its actions. Likewise, the theoretical dimension of somaesthetics can contribute to an altered and ameliorative understanding of health, sickness, and situated well-being.

This issue about aesthetics and body experiences in healthcare presents three articles that deal with different aspects of healthcare, attending to human lives from the cradle to the grave. The first article, 'Crafting Atmospheres for Healthcare Design,' is authored by Esben Skouboe (architect and researcher) and Iben Højholt (composer and sound studies researcher). It addresses the healing and empowering agency of a somaesthetic design of delivery rooms for both parents and midwives at work. The article sheds light on a design process that considers the aesthetic preferences and somatic associations of prospective users of the delivery room. The chosen methodology is reflected in the interactive components of a delivery room that offers various aesthetic atmospheres through visual projections and soundscapes. This allows users to create a very personal and aesthetically rich atmosphere as the context for one of the most critical situations in life. The second article, 'Breathing in Mortality: Demedicalization of Death in Documentary Films,' is written by Outi Hakola and explores how cinematic narratives in documentaries represent death and the dying body. The somaesthetic focus is on breathing as life's most basic sign and function. Breathing is either hindered by medical technology or set free in a demedicalized natural death. The third article, 'Care Practice as Aesthetic Co-creation: A Somaesthetic Perspective on Care Work,' by Britta Møller, focuses on the somaesthetic communication between care workers and elderly people in nursing homes.

The three articles study different care locations: a delivery room at a hospital (Skouboe/Højlund), intensive care units and hospice units (Hakola), and care practices in nursing homes (Møller).

All three articles stress that (medical, cinematic, and welfare) technologies have appeared as signs of modernity that standardize and make healthcare practice more efficient. This also heightens the status of the field as an essential part of a technologically advanced society. Hakola describes how cinematic media has built an image of scientific technology as something with authority and sociopolitical importance. Møller points to welfare technology as something that gives status by enabling a distanced position to the body in care work. Skouboe and Højlund stress that medical technologies in functional and institutionalized delivery rooms assimilate machine rooms to which patients are alienated. However, Skouboe and Højlund also stress that this type of technology is necessary and life-securing; new additional technologies to create a somaesthetic hospital room design might be considered "unserious hippie-like initiatives conducted by management."

Hakola finds that the medicalization of death and dying freezes embodied time, as it can prolong life and give time for relatives to make decisions about life and death. However, these technologies also override the agency and subjectivity of the patient. Hakola argues that, at least temporarily, technology overtakes patients' subjectivity, as patients are left unable to breathe for themselves. Medical technologies create a blurred and unstable image of the person (Hakola) and passive hospital patients (Skouboe/Højlund). Medical instruments can dehumanize and isolate patients at the moment of death and force them to let go of their agency (Hakola).

In response to this situation, Skouboe/Højlund stresses that hospitals need to be conceived as more than just spaces for efficient and secure physical treatments; hospitals are also places for significant life events and memories for life, such as giving birth. Hakola's and Skouboe/Højlund's studies highlight the embodied process of dying and giving birth emphasized by demedicalization, and in Skouboe/Højlund's case, enforced by a technological somaesthetic design of the delivery room. Attention must be given to the embodied relations between human experience and technology. Technology—medical and cinematic (Hakola) and medical and atmosphere-generating instruments (Skouboe/Højlund)—can also create a potential for body awareness for the actors (viewers, parents, midwives) to experience various perspectives on the medicalization of death and dying (Hakola) or empowerment, stress reduction, pain management and more active and self-reliant patients (Skouboe/Højlund). Hakola and Skouboe/Højlund study desires and intentions to de-medicalize the acts of giving birth and dying. Skouboe/Højlund emphasizes homelike decor and familiar local nature moods as positive distractions and downplays the functional and institutionalized things and sounds in the delivery room. Hakola conducts studies of documentaries in hospice and palliative care, where the patient's agency is related to breathing and where all traces of medicalization and technology are almost erased. The focus is on the dying body's breathing movements and sounds, in contrast to the machine sounds and the after-death stillness. Hakola stresses that the demedicalized cinematic focus in documentaries affects the viewer to respond to the on-screen representations effectively, as their bodies will mimic those of the breathing characters and hence potentially create a bodily awareness of the status of one's own body. These embodied experiences of the breathing body create embodied knowledge of dying and death.

A focus on rhythms is prominent in both Hakola's and Møller's studies. While Hakola stems from the visual rhythm of breathing in and out as a form of engagement with the world, Møller stresses a similar point related to the rhythm of interaction between caretaker and patient. Both authors argue that, in each intake (of breath or impressions), people take something of the world into themselves. With each outgiving (of breath or expression), they release something of themselves with which they participate in a shared world. Møller explores this rhythm as an aesthetic interaction based on impressions and expressions performed in relations between a care worker and an older person. Based on a micro-situational analysis informed by Dewey's and Shusterman's concepts of aesthetic experience, Møller zooms in on the somatically understood communication that forms the basis of a care relation. Møller describes the bodywork in care practices as aesthetic co-creations, a communicative process where both actors and the practice are constantly shaped and reshaped.

The three articles present some somaesthetic perspectives on healthcare and care work. However, there is still more to understand about the somaesthetic perspective in healthcare practice and research. Skouboe and Højlund argue for a shift from evidence-based medical design to research-based design that includes aesthetics and experiential validation criteria and more diverse interdisciplinary theory and methodology, allowing alternative qualitative methods as part of clinical trials. Hakola challenges the idealization of modern medicalization processes and argues that focusing on the stages of breathing can help overcome the sensory limitations of representing dying as a process. More could be known about the educational potential of care professionals in studying the embodied experience of breathing as an impression that resonates in and with the observer's body. Similarly, as stressed by Møller, more knowledge is needed about how to learn to care and improve care practices through the aesthetics of interaction and dialogue.

Apart from the mentioned articles, which focus on the body's function and significance in healthcare situations, this issue also contains a paper written by Jiyun Bae. It deals with the aesthetics and pedagogical purposes of *hwarang*, a system involving groups of young men in early Korean history. The ideology and pedagogy of the *hwarang* are analyzed and interpreted in light of the philosophy of somaesthetics. However, the paper also shows that Eastern practices and understandings inspire the ideas behind somaesthetics. The aesthetic practices of these groups of youngsters entailed singing, body practices, and entertainment aimed at experiences of joy and pleasure. Core notions such as "play," "travel," and "self-cultivation" and their inner relationships serve as examples of *pungryudo*, the practice-based aesthetics of the *hwarang*. This aesthetic ideology concerns a specific part of life, such as art or entertainment, and has repercussions in all life domains, including ethics, politics, and sexuality. The paper shows that the *hwarang* promotes the insight that one's intellectual and practical life is integrated into one's lifestyle and that the lifestyle is very much based on somaesthetic experiences of different kinds of pleasures, including sensory, intellectual, spiritual, and practical pleasures. This seems very much forgotten by modern education and pedagogy, which focuses mainly on acquiring knowledge.

Crafting atmospheres for Healthcare Design

Esben Bala Skouboe and Marie Højlund

Abstract: *This work contributes to the growing body of work, conducted on the vicinities between well-being and biomedical treatments in health design. The article presents and discusses the design of the new delivery rooms at a Danish hospital in Hjørring, including the multi-sensory artwork: Nordjyske stemninger (Moods of Northern Jutland). The authors are both artists, architects, and researchers in this project, thus it is not the purpose of his article to report evaluation results. However, it is our intention to share and discuss contemporary healthcare design strategies and point to the importance of considering the interplay between cultural, social change, and environment in order to bridge the know-do gap in healing architecture. Based on our work we give a concrete example of a case aimed at re-introducing art in healthcare environments, supporting the caregiver, the laboring mother, and her companion in the existential and life-changing moment. The article includes descriptions of the design process including interviews, observations, and reflections. In this case, we want to argue that the gap between visions and implementation in evidence-based design and healing architecture, must be understood as a symptom of a deeper epistemological and philosophical challenge concerning the dichotomous and demarcating understanding of the relation between the human and its surroundings, obstructing ecological coherence and validity and silo stacking of results not utilizing the rich potentiality of interdisciplinarity synergies. As it is difficult to convey a bodily and sensory experience in only words and images, we hope that the reader will use their imagination while reading the descriptions of a situated experience throughout the article. The Ukrainian sculptor Alexander Archipenko described the cause and impulse of creative motivation as seeing the absence of a thing. With this lens we invite the reader behind the scenes in the creation of somesthetic design of the new delivery rooms, now being the background of more than 1.000 births a year in the Northern part of Jutland. The argument of this article uses artistic practice to explore a new potential healthcare practice, with overseen and neglected potentialities in a supportive somesthetic healthcare design. The article is structured in four parts: Healing environments, Somesthetic design framework, The sensory delivery room, and Reflection.*

"It is not exactly the presence of a thing but rather the absence of it that becomes the cause, and impulse for creative motivation" Alexander Archipenko, (Nichols 2003).

1. Introduction

This work contributes to the growing body of work conducted in the vicinities between well-being and biomedical treatments in healthcare design. The article presents and discusses the design of the new delivery rooms at a Danish hospital in Hjørring, including the multi-sensory artwork: *Nordjyske stemninger* (*Moods of Northern Jutland*). The authors are both parents, artists, architects, and researchers in this project, and it is not the purpose of the article to report evaluation results. However, it is our intention to share and discuss contemporary healthcare design strategies, and point to the importance of considering the interplay the between cultural, social change, and environment in healing architecture. Based on our work we give a concrete example of a case aimed at re-introducing art in healthcare environments, supporting the caregiver, the laboring mother, and birth companion in the existential and life changing moment.

The article includes descriptions of the design-process including interviews, observations, and reflections. As it is difficult to convey a bodily and sensory experience in only words and images, we hope that the readers will use their imagination while reading the descriptions of a situated experience throughout the article. The Ukrainian sculptor Alexander Archipenko described the cause and impulse of creative motivation as seeing the absence of a thing. With this lens, we invite the reader behind the scenes in the creation of the somaesthetic design of the new delivery rooms, now being the background to more than 1,000 births a year in the northern part of Jutland, Denmark.

This article's main contribution is to explore how a somaesthetic approach to healthcare design opens a series of ethical perspectives and ideas useful in creating healing healthcare atmospheres. The existing clinical paradigm is known and accepted as a “normal” and “neutral” interior space, where there is a dominant focus on functionality, security, and efficiency. However, seen from a somaesthetic perspective, no space is neutral, and traditional healthcare aesthetics have rendered an inhumane environment for people to experience their most private, extreme, and valuable moments – during the birth of their child. One can argue that the brutal lack of sensitivity to the sensing body and its context is a lack of care. Most often the birth ends with a happy moment, however babies are also stillborn, which renders another set of emotional needs. These two birth situations are radically different, even though the bio-mechanical process is similar. In this experiment, the team has been focused on the healthy birth; however, further research is currently being conducted into stillborn cases in somaesthetic delivery rooms by the authors. Designing for life and death demands a highly skilled, collaborating design team that includes users and expertise from many domains (midwives, doctors, nurses, architects, composers, cinematographers, painters, software engineers, etc.). All technical solutions must be extensively tested and known in depth by the team. The artistic expressions must be developed to support the healthcare personnel’s act of care, and address the patients’ deep emotional needs, and use state-of-the-art research as a foundation for their work. Somaesthetic healthcare design is serious design that will shape the most important memories, and the art will help people in their most vulnerable moments when they experience the life or death of a baby.

2. Healthcare setting

Figure 1 *Delivery room in Hjørring before the artistic intervention, Spring 2020*

In Spring 2020, the North Denmark Regional Hospital in Hjørring, Denmark, opened their four new delivery rooms (37 sqm), as seen on images above. The design of the rooms was based on knowledge from *healing architecture* (HA), e.g., using large windows for optimized daylight, ideally an outlook to green areas, intelligent lighting systems to support the circadian rhythms, and wellbeing of patients and staff. However, the complex building process hindered an outlook to green areas, and the idea of large windows clashed with the need for privacy and intimacy in the birth situation. The vision of homelike décor was reduced to a chair for the patients.

In Spring 2021, fieldwork was conducted by the authors to follow a couple's birth from beginning to end. The focus was to understand the effect of the delivery room as a birthing and working environment, including a soundscape analysis. This fieldwork analysis informed the design decisions, and allowed the team to establish a mutual understating of social, functional, and emotional needs during a labor process. This analysis includes phenomenological, as well as procedural and empirical demands, such as: during a caesarean section, 18 specialists need to have access to the mother and all equipment, and everything needs to comply with clinical cleaning regulations, etc. The functional needs are well known by the healthcare staff and extensively described; however, the element of emotional and social needs is lacking, which motivates the following phenomenological analysis.

The environment in the delivery room was dominated by functional and institutionalized things and sounds, such as air conditioning, clock ticking, sounds from different hospital equipment and alarms, noises from furniture in other rooms being moved, doors slamming,

footsteps, tapping on the computer keyboard used by the midwife, ambulances outside, and alarm sounds from equipment in the room. A sound system in the room for personal music choice was used for a short period in the beginning of the birth. The only non-functional sounds were conversations between people in the room. There was an overall lack of background sounds, and on the muted background functional and signal sounds stood out, taking foreground attention.

The room was divided in four zones: entrance, bath, birth, and toilet. The entrance was placed next to a sliding door to a toilet, a coat rack, and four cabinets for staff use. A ¾ hospital bed divides the delivery room into a bath and birth zone. In the bath zone there was a bath top, chair, table lamp, height adjustable computer workstation, phone, stainless-steel rolling table, rolling bin, sink, mirror, and plastic glove dispensers. In the birth zone, there was a birthing bed, radiant warmer, suction machine, CTG, oxygen, nitrous oxide, aspirator, whiteboard, and lots of visible technical pipes and infrastructure. The walls were covered in white glazed tiles, off-white paint, and one wall was painted with a matching color to the petroleum-colored linoleum floor. A reflective, framed poster with breastfeeding training information, laminated lists with phone numbers, handwashing techniques, and waste-handling guides decorated the walls. From the ceiling were a red emergency line, ventilation, a surgery lamp, dimmable ceiling light, smart blind system, and integrated loudspeakers.

> *The overall experience of the room is that it seems dull and muted with an absence of sensory stimulation. After some hours, a slight sensation of pressure on the ears as if listening under water. During the whole birth process there are no natural sounds entering from the outside, and thus no sensation of having a connection to circadian rhythms and weather changes. The window shutters are closed, so there is almost no natural light to indicate time of day, and from the celling a homogeneous office-like lighting secures good institutional working light. The ticking of the watch often takes the foreground of attention, also for the couple giving birth. The slamming of the door. A feeling of a 'presence of absence', and a sense of losing track of time and place – it is like being guests in a machine room.* (Field notes taken during a delivery)

Overall, our analysis of the birthing environment points to the everyday difficulty of applying generalized guidelines of HA in practice. The delivery rooms are dressed up as spaces ready for emergency, and the white hospital rooms still risk becoming yet another non-place (Augé, 1992). The rooms did not offer people a space that empowers their identity, and did not build a rich, common reference of a group of people. Finally, these non-places were not popular places to live or work, rendering people as anonymous patients or white-coats. Emergency has become everyday life in the hospitals, and the sensing body has been forgotten despite the holistic visions behind HA (Folmer, Mullins, & Frandsen, 2012; Ulrich, 1984).

Based on the extensive review of art and culture's effect on health and well-being by Fancourt and Finn (2019), and practical design knowledge from previous experiments in sensory delivery rooms in Herning, described by Lorentzen, Andersen, et al. (2021), the design team was invited as leading designers in the design of the four new sensory delivery rooms. The team consisted of an interdisciplinary group of experts, including architect and researcher Esben Bala Skouboe (author), nature photographer Morten Hilmer, composer and sound studies researcher Marie Højlund (author), painter Henrik Godsk, chief midwife Helle Høy, and doctors Anya Eidhammer and Lars Burmeister.

3. Healing Architecture, and Sensory Delivery Rooms

To frame the creative process, and transform the new birthing environment into sensory delivery rooms that resonate with the visions behind HA, the article dives into the status of HA, and research on birth environments. Based on this analysis, it is argued that there is a need to break with the reductionist idea of expert knowledge and generalized design practice, and facilitate a holistic approach to both the environment and the body adopting a somaesthetic approach. This shift calls for a deeper epistemological and methodological reflection, before moving on to the concrete design transformation.

During the last century, there has been a movement towards HA that focusses on how hospitals may accommodate healing environments to maintain personal integrity. The American professor Roger Ulrich led one of the first systematic studies in evidence-based healthcare design (Ulrich, 1984). The experiment demonstrated how the architecture and its surroundings could affect the recovery of patients, and help lower the workload on personnel. This study is one of the first examples of evidence-based healthcare design, and has shaped a new holistic and stimulating approach to hospital design, emphasized by Dirckinck-Holmfeld & Heslet (2007) and the extensive literature review *Healing Architecture* (Folmer, Mullins, & Frandsen, 2012, p.4; Frandsen et al., 2009).

The review became a dominant reference for legitimizing HA as the guiding concept used in the design of new Danish hospitals. HA focuses on how new hospitals can be built with the patient's experience of the environment in focus, and at the same time aim at improving the overall experience of staff and visiting relatives. This expands the holistic and integrative vision, and goes beyond traditional act of building, because it addresses the healing agency of space, which had for long been subjected to a mechanical and efficient ideology. HA architectural design was to be supportive and promote wellness, and healthcare environments should be designed to foster patients, personnel, and relatives coping with stress, by building spaces that stimulate a sense of control with respect to both physical and social surroundings. Essential to the concept is a deep connection to deeper qualities in nature, further elaborated by Browning and Ryan in *The Biophilic Design Guide Nature Inside* (Browning and Ryan, 2020).

Giving the patient access to social support from family and friends has been found to be an important factor to reduce the experience of stress in the environment. Lastly, HA describes the use of integrated art as a potential tool for positive distractions (Ulrich, 1991). The concept of positive distractions is defined as, "an environmental feature that elicits positive feelings and holds attention without taxing or stressing the individual, thereby blocking worrisome thoughts". Positive distractions come in many forms, including visual images, songs, music, animals, digital media, etc. The distractions re-establish a link between music, art, ornamentations, architecture, and the sensing body. The need for the positive distraction must be context specific, e.g., in the case of the last phase of birth, a wave on the local beach with periodic rhythms would help the woman giving birth to steer her breathing patterns and help pain management. Positive distraction can also involve building ornamentation (Sussman & Hollander, 2021) and decorative detailing, which will attract attention more than a blank wall.

Overall, the paradigm of HA envisions a future hospital where the interplay between the experiences of the sensory, competent human and the environment takes the center of attention. A healing environment is characterized by meeting the need to feel both protected and secure in a hectic healthcare environment, and like an integrated part of this environment, empowering the patient to be able to actively choose privacy or to engage in the environment at different

times. The environments become an instrument that support clinical as well as social activities.

Research in healthcare design of birthing environments emphasize at least three primary knowledge fields: a good and healthy treatment (surgeon), a strong and good nursing relationship between people (nurse), and a well-tuned space for recreation (sensed space). The interplay between these domains is experienced by the patients and their relatives on the sensed journey through the hospitals. During the last decade, extensive research has been conducted in the field of good treatment, causing major improvement across the sector. In the case of treatment, the birth mortality rate fell from 27,711 deaths per 1,000 live births in 1953 to 2.5 deaths per 1,000 live births in 2020 in Denmark (United Nations - World Population Prospects). This impressive result is a result of a systematic collaboration between nurses and doctors, which is not to be neglected. The design of the birthplace has been associated with health outcomes, including the number of caesarean sections, maternal pain ratings, satisfaction with care, and the ability of staff to perform their duties (Setola et al., 2019). In the study, Goldkuhl et al. (in press, 2022) engaged in ethnographic fieldwork to explore the influence and meaning of the environment in regular birthing as well as in sensory-birthing rooms (with new furniture, natural-colored fabrics, lighting, and nature scenes projected on the walls, combined with nature sounds, which reminded some of the women of their home or of previous experiences).

The study showed that the *regular institutional* room was dominated by an institutional décor and birth philosophy, causing the women to adapt to the role of the passive hospital patient, asking for permission to change body position and difficulty in initiating their own activities. In contrast, three parameters related to the sensory-birthing room helped enabling an experience of a *personal room*, signified by the birthing women's active involvement and agency (self-determination and ownership over the room, process, embodied knowledge, and informed decisions):

> 1) Sensory-birthing room shaping the whole experience positively by giving the woman a welcoming feeling, symbolizing tenderness and care in the otherwise unfamiliar hospital atmosphere, reminding some of women of their home or previous experiences. The rooms furthermore enabled the women's adaptability, spatial mobility, and feelings of familiarity by providing possibilities of modifying the room, taking initiative, and showing ownership over the room; agency was enabled when they experienced a sense of control over the room.
>
> 2) The care-provider experienced an ability to put the standardized institutional birth manual in the background, and foreground "an approach and care that conveyed a calm, equal, and trusting atmosphere" (Goldkuhl et al., 2022, p.7). The care enables the women's feeling of agency, and their intuitive bodily sensations were allowed to guide the birth.
>
> 3) Devoted involvement of an active and supportive birth companion, initiated by the care-provider's invitation for them to take part and find their place in the welcoming room.

Based on this review, and the descriptions from leading midwives and doctors on the team, it is concluded that an optimal birth environment involves not only meeting the needs for medico-technical safety, but also ensuring a physiologically and emotionally *safe space* or *birth territory*, signified by a permissive atmosphere where birthing women have a sense of agency, safety, and satisfaction - contributing to a sense of familiarity and calmness. In other words, it is

not enough to design a calming setting if the overall hospital birth culture with its institutional authority permeates the atmosphere (ibid., p.8).

The *birth territory theory*, described by Fahy and Parratt (2006), outlines that a less familiar environment makes labor feel fearful and uncertain. Therefore, there is a need to support a birth territory as a *sanctum* similar to the *personal room* in being "a homely environment designed to optimize the privacy, ease, and comfort of the woman", and enhance the "embodied sense of self" and agency (ibid., p.46). Downe et al. (2018) reported women's positive childbirth experience, apart from having a healthy baby, also included giving birth in a safe environment.

Anthropologist Birgitte Folmann did a phenomenological study about the father's role during birth in a comparative study of a standard and a sensory delivery room at Regional Hospital Herning (see image). The study showed how the sensory delivery room offered the birth companions with possibilities to engage in practices of attunement, resulting in a more explorative and active role during birth. Furthermore, they described their sensory experiences in a more nuanced way afterwards, when remembering the experiences. "Since action can modify perceptions, the fathers' more active participation in the birth ended up changing the way they perceived their experiences" (Folman, 2020, p.129) as they felt they could easily adjust and remain calm in the process of attunement. Designing multi-sensorial birth environments is therefore not only a matter of designing nice surroundings, but equally a focus on inviting the users to attune through concrete practices of place-making. Despite the stress of the birth process, and the life-changing event of being a first-time father, the newly designed birthing room made them "feel right" (ibid., p.129) by "actively co-constituting the atmosphere, generating autonomy, enabling the subject to better attune to the space precisely because their attentiveness to the atmosphere was heightened" (ibid., p.130).

Figure 2 *Sensory delivery room in Herning, 2017*

In the same sensory delivery room, Nielsen and Overgaard (2020) explored how women's positive experiences of the sensory delivery rooms were connected to the welcoming atmosphere through positive distractions, and the room's adaptability to the women's needs, as most of the women found that the ambience of the room gave them a sense of empowerment in actively and autonomously exploring the room and its facilities. The sensory delivery room thus signaled respect for the family's needs through supporting the interaction between woman and birth companion (Nielsen & Overgand, 2020, p.1). Similar to the findings of Goldkuhl et al. (2022), the role of the midwife affected the experience of the room so that "the effect of the midwife and the room appeared inseparable" (Nielsen & Overgand, 2020, p.5). Hammond et al. have looked at the midwife's experience of the work environment in birth environments, concluding that: "We propose that the design and aesthetics of hospital birth rooms, including the objects and structures within them, act as generative mechanisms sending messages to midwives about what is possible and permissible in the birth room. These messages elicit emotional and cognitive responses from midwives, and such responses can shape the activities and behaviors that constitute individual midwifery practice" (Hammond et al., 2014, p.93).

Taken together, it is highlighted that an aesthetically pleasing environment, with many possibilities to change and meet shifting needs for safety and agency, is important.

The Know-Do Gap

> *"We know very much about how to save lives and build strong social relations during the birth, however working focused with the healing architecture and the multi-sensory experience is new to us"*, Obstetric specialist surgeon Lars Burmester.

The "Know-Do" gap between what we know and what we do in healthcare practice was first presented in 2006 by WHO as "one of the most important challenges for public health in this century" (WHO, 2006, p.1). Current research in healing architecture and birth environments invites and equips practitioners to design comforting and healing delivery rooms. However, as stated in the quote above by obstetric specialist Lars Burmester from Hjørring, translating knowledge into practice might neither be easy nor obvious. If it was only a matter of translating the knowledge into practice to bridge the *Know-Do gap*, why does the newly renovated delivery room in Hjørring only present minor changes, and why is knowledge from music, art, and architecture not present in the renovation?

Becker et al. described how the field of HA struggles to move beyond research for either justification or incremental change and is incapable of rethinking and innovating (Becker et al., 2011). In the quest to legitimize itself as a valid approach, the primary goal of research is to justify design proposals by employing evidence-based models (experimental and quasi-experimental, comparative research design) focused on outcomes to convince stakeholders of the causal relationship between specific interventions and outcomes (Becker et al., 2011, p.116). This method is designed to deliver results in a closed environment detached from its contextual noise. Hence it is obvious that while every part of a healthcare design is understood and studied in detail, the broader contextual, cultural, and somatic dimensions are often left outside the comforts of most healthcare personnel. It might be useful to consider the body and the space as containers isolated from one another in research for justification. However, in situations where there is a need to rethink the foundational premises of a field, it is crucial to develop and encourage research for innovation demanding a "deep understanding" and asking new questions (Becker et al., 2011, pp.119-120).

Additionally, an engagement in research for innovation practitioners must be guided by a conceptual framework and ecological theory that reflect the complexity of the problem being approached, but also new methods that combine scientific knowledge with, for example, artistic and design knowledge (Lawson, 2010, p.97). It is evident that addressing in-situ situations demands a bottom-up approach, cross-pollinating theory with practice-based work to secure a higher ecological validity to acknowledge the contextual dimensions. This demands a different interdisciplinary approach than the stacking of different research results. Within the sociology of science and technology, Matthew David has proposed that the entrenchment within forms of reductionist and relativist epistemology can, and should be overcome by adopting reflexive epistemological diversity (David, 2005, p.22). Introducing reflexive epistemological diversity in the field of HA would demand taking its starting point in an interdisciplinary attunement to create a common ground from which to work.

Existing research in the field of HA points to the importance of interweaving the active and sensory competent human, and considering the room as a sensory instrument, where **the space is a carefully crafted multisensory composition that can be played by skilled practitioners to support the act of care.** For this we need a new inclusive framework that can bridge the world of treatment, efficiency, and utility with the world of feelings, emotions, and understanding, approaching the space from a multi-sensory and somatic position. We therefore seek to test a model to start bridging the *Know-Do* gap for the design of sensory delivery rooms based on interdisciplinary attunement with artistic and design knowledge, and a conceptual somaesthetic framework and ecological atmosphere theory to engage in needed research or innovation.

4. Atmosphere, somaesthetic tool for interdisciplinary attunement in healthcare design

Approaching the creative process of crafting a perceptual experience in a complex healthcare domain demands a common theoretical and conceptual framework, which allow doctors, architects, musicians, nurses, actors, midwives, cleaning personal, patients, etc. to meet on common ground, speaking the same language despite the obvious different epistemological traditions. To establish a common ground and avoid the danger of silo thinking, the authors suggest establishing an ecological common ground using the concept of *atmospheres*. The concept unites the creative, social, and clinical disciplines in a shared embodied "language" of sensory experience. The concept of *atmospheres* was used as a tool to access a shared language of sensed somatic qualities, described by each individual discipline. Approaching the concept of atmosphere as a universal property of space is described by the German philosopher Gernot Böhme as a metaphorical "cloud" hanging in any space, affecting any passersby (Böhme, 2011). A wide range of external forces and stimuli continuously transform the cloud; the color of the wall, the placement of the window, the trees, the stainless table, or the sound from the mouse and keyboard, the smile and tone of voice, etc.; anyone and everything affect the atmosphere and shape the appearance of the cloud (Overholt & Skouboe, 2017). According to the Gernot Böhme (2017), atmosphere surrounds felt spaces where objects, forms, and colors are distinguished. The aesthetics of an artwork is a response to certain aesthetic needs, feelings, and desires; hence this is very familiar to us, and we have a rich language when we are presented with a description of the felt surroundings.

People not only perceive the world on the basis of atmospheres, but they also perform activities and practices, and thus transform atmospheres in order to attune themselves to new

and unfamiliar settings and situations (Folmann, 2021, p.129). Through the lens of atmospheres, it is evident that we adopt an approach to meaning-making as an active and embodied dynamic relation between perception, action, and meaning. Perception is thus not a passive one-way process but a relation between meaningful affordances in tuned spaces and human capabilities, and capacities to attune and resonate with them. These capabilities can be empowered and developed by making possibilities to "tune" the space as well as being "tuned" by the space physically available (Edensor and Sumartojo, 2015). In this way, the space can offer itself as a supportive element in the complex experience of bringing a new child into the world, whereas entering a white-walled hospital environment, with its highly visible medical equipment, can be counterproductive for attunement and active engagement in the situation (Folmann, 2021, p.130). Objects in the room orientate themselves not only towards the staff but also toward the couple, counteracting the feeling of being in a calming place, and the practice of attunement counteracts the absence of attentiveness to felt atmosphere.

The felt atmosphere becomes a common social interface of space; it is in this cloud your feelings are affected, and it is in this social dialogue you engage when visiting the delivery rooms. The cloud connects the first-time mother with the healthcare staff in a delicate dialogue with space. The artist Olafur Eliasson uses the term *felt meaning* of spaces to differentiate intuitive sensibility from our more primitive animal nature. A felt meaning is something we sense without the conceptual grid, or architecture, or words to attach to it. (Eliasson and Bukdahl, 2015, p.17). It is in this description of felt meanings we find the important connections between the disciplines of art and health. Working in the domain of existential sensed space remains the core of both healthcare and artistic practice, not to state that these domains are not addressed in traditional healthcare science of the white clinical and professional atmosphere described in the beginning. This article attempts to establish an argument that feelings in healthcare spaces have existential value, and the felt space is more than an efficient white container; stepping into a hospital means taking a step closer to life rather than stepping away from the world. Through the sensorial experience, art can become a central tool to communicate things that words and brochures cannot express or capture. It becomes an act that establishes an existential bridge to a new version of oneself through bodily experience.

The American philosopher, Richard Shusterman, introduced the concept framework of somaesthetics as a philosophical framework to combine body and mental dimensions of human beings into inseparable parts, in opposition to the "body-mind" dichotomy. This tradition is "devoted to explaining the nature of our bodily perceptions and practices, and their function in our knowledge and construction of the world" (Shusterman, 2003, p.112), advocating for the importance of creative and active engagement over traditional aesthetics. In the case of a birth situation, each human body is going through very different experiences but must meet in the end as a whole family - in minds and bodies at the same time. As atmosphere is multisensorial by nature, a key activity in the space is to develop our knowledge and construct the knowledge of a new world – a world where I become, and where we become actively and creatively part of a larger society in a particular place with a particular language and cultural richness. By separating mind and body in white voids we oppositely understand the body as a passive living machine; however, according to Shusterman (2000), we are missing very important existential parts of what it means being a human.

It is with this mutual understanding that the interdisciplinary team used the concept of somaesthetic felt meaning and atmosphere - as tools to establish a common ground moving into the unknown territory of the design experiment. If we are to unfold the vision to gain a higher

ecological validity, the design process would need to conduct a multi-sensorial and multi-disciplinary practice. This shift demands a novel focus on the interaction between multiple interacting elements at once: the mindset of the woman giving birth, the feelings of the surgeon, the physical décor, the interplay of the senses, the felt atmosphere, and the activities in the delivery room, etc. In design theory, this is termed a *wicked problem*. Wicked problems have no clearly defined problems to begin with, and design researchers construct a future where "results do not come in the form of knowledge about things at hand, but in the form of suggestions for a change of a present state" (Hallnäss & Redström, 2006, p.128). With this mutual understanding, the interdisciplinary team enters the design process for four delivery rooms in the Northern part of Denmark.

5. Case: Somaesthetic approach to delivery room design

Based on the above-mentioned somaesthetic framework, a design process was conducted from January 2020 to January 2021. The interdisciplinary team involved midwife, obstetric surgeons, architect, composer, painter, and a nature photographer. The team holds six years' experience in sensory delivery room design, including scientific and artistic contributions in sound design, responsive lighting, art, and healing architecture. The design process builds on the following hypothesis:

> *By approaching the delivery room design as a somaesthetic instrument, and moving familiar local nature moods inside the delivery room as positive distractions, combined with the home like décor, we can empower the parents and midwives to reduce stress, help parents be more self-reliant, help pain management, create more active partners that will support family-building dynamics, support the midwives' relational work, and in general build better and more memorable environments for the midwives, birthing women, and their companions, without compromising safety.*

In the following section, we will describe the design process to help share knowledge from behind the scenes of making a somaesthetic delivery room. The process was developed in three phases. Each phase informs the others, and the design process is a product of several iterations back and forth to match the visions of the perceptual stimuli and the physical hardware setup to the atmosphere in the space. In the following section we will describe the three phases: concept design, building an interactive instrument, and crafting atmospheres.

Concept design: Atmosphere as interdisciplinary mediator

In the concept design phase, the interdisciplinary team used the theoretical framework mentioned above to establish a common ground. As a conceptual tool, the team used the concept of the performing atmosphere as a conceptual vehicle/framework to establish a common ground. The common ground was rooted deep in each member's sensed and embodied memories and experiences; this abstract common ground enabled the group to describe the somaesthetic gap in the existing delivery rooms. This enabled a shared critique of the existing practice and a mutual understanding in the design team, which was essential in moving forward in the design process. Using the concept of the sensed atmosphere as a conceptual vehicle allowed the staff to see their world in another view, and describe the emotional, functional, and social needs from the perspective of an expert. Such as,

> *"It is important that the atmosphere is welcoming and calming to all families because that will affect their birth process positively and stimulate the building of trustful relations to the midwife and doctors. It is also important that the occupants can customize the space to their needs and wishes, this will stimulate the feeling of self-empowerment, and ultimately stimulate self-confidence at the critical moment of birth."; "It is also important that the atmosphere is in the background, leaving the stage to the couple's experience of the birth, and the building of social relations. At the same time, the atmosphere should support pain management and breathing frequency during birth"; "It is important that new procedures or hardware does not compromise safety"; "It is important that in case of emergency the atmosphere is easy to switch off".*

These observations create demands to the spatial atmosphere and create a range of interdisciplinary aesthetic and social ripple-effects into the formulation of a design concept. For example, a calming and welcoming atmosphere was made by using homelike décor and moods specially crafted to support circadian rhythms and bring calming moods from local nature into the delivery rooms. The team agreed to see the space as a somaesthetic instrument using décor, room lighting, projectors, and loudspeakers to shape the atmosphere of the space.

This decision was motivated by research promising a series of positive health outputs, evolving by moving nature inside healthcare environments, which include improved physiological response, improved cognitive functioning, improved emotions and moods, improved physiological response, improved cognitive functioning (Browning and Ryan, 2020, p.242). In the literature review, the authors also found that video screens placed in the windows of the hospital showing images of nature were found to lower blood pressure, lower heart rate, and had positive psychological benefits for workers in windowless spaces (Kahn et al., 2008), which opens the possibility of using digital screens. Also, nature sounds can have a positive impact on heart rate, blood pressure, and sympathetic nervous system activity (Ulrich et al., 1991), hence the interest in the local natural sounds. Furthermore, there is evidence of how listening to calming music can lower anxiety and experienced pain during labor (Chuang et al., 2019). Listening to music can increase positive emotions and patient satisfaction, and decrease negative emotions and perceived threat for women undergoing a caesarean section (Kushnir, Friedman, Ehrenfeld & Kushnir, 2012). Music also decreases the associated anxiety (Eren, Canbulat Şahiner, Bal & Dişsiz, 2018), motivating the demand of being able to play your own music during labor, and working carefully with musical compositions, mixing natural sounds with music compositions.

Lastly, a series of more functional demands were included as, e.g., an easy-to-use tablet interface, a wall switch enabling the modes start, stop, and trigger emergency scenarios, and a general understanding of the birth practice and protocol in the space. Based on the theoretical framework, the sensory delivery room should furthermore heighten patients perceived safety to support the feeling of home and sense of belonging, by making the installations site-specific, attuning with their everyday, known environments.

Crafting Atmospheres

To create a welcoming multisensory atmosphere that supports the existential situation and stimulated a strong sense of place and time, the team decided to capture meaningful and familiar local moods in nature. The hypothesis was:

> *If we can stimulate memories of positive calming nature experiences, we can stimulate a sense of belonging, consequently triggering the women's conscious and sub-conscious somatic response systems to help them perform in the different phases of the birth. The embodied memories will help them support the feeling of belonging, safety, and pain management.*

Figures 3 and 4 *Left: Maps of meaningful sites; right: from on Recordings in Toldne.*

To understand and capture the important situated atmospheres from nature, 30 semi-structured interviews were conducted with local pregnant women across the region. In the questions, they were asked to describe an important calming memory from their local nature, and to mention meaningful local places (quotes from the interviews are used as image text below). To some, these questions were abstract, and the interview was supported by: *Can you describe the experience from nature that you would love to pass on to your child?* This question triggered all couples to long, detailed reflections on experiences from their childhood, and detailed descriptions of sensed experiences. The interview was structured with 15 questions and conducted via phone calls; this gave an informal and friendly conversation of 15-30 minutes, and delivered a range of high-density situated information about the important, situated nature experiences. Any place named in the interviews, was plotted into a map as *Landmarks* (see above). Together with the description of personal experiences in nature, the interviews served as input to the creative process of 'chasing' moods.

Figure 5 *Image from the mood Home: "The sound of Nordjylland to me is the sound of calming waves hitting the beach", Woman 28 years*

During the period 2021-2022, the artistic team traveled the northern part of Denmark chasing local moods described in the interviews. A prerequisite for recording the moods was an understanding of the technical output in the immersive spatial instrument described above. The room was designed to make a ten-meter continuous video and omni-present sound, which required the sound recordings to be recorded by a Ambisonic field recording system, and the video to be 8K resolution to get the quality needed (Canon EOS R5 & DJI Maveric II drone).

Figures 6 and 7 *Images of the field recordings setups. Left: video and sound recordings at Toldne. Right: Morten Hilmer working in the white landscape.*

The details of the specific design practice were messy, intuitive, and beyond this paper to unfold in more detail. It builds on artistic knowledge, technical skills, intuition, creativity, curiosity, and the ability to work closely together. As a guiding tool the artist group used the somatic atmosphere descriptions from the interviews. The compositions were developed by the individual artists and assembled in a 1:1 test setup, consequently leading to discussions compromises and changes, see image below. The test was highly pressured because it rendered a common understanding of the felt experience; the specialist could then detail the final compositions. The 100+ hours of recordings were cut into 4 one-hour moods; each cut is played for a minimum of 5 minutes, stretching from morning to night. This rhythm enabled the room to tune into the present state of mind. Hence, if the couple entered the room in the morning, the

algorithm could trigger the morning in video, sound, room lighting, etc.

The team worked with two types of moods: *ambient* and *birth*. The *ambient* moods were the calming, known, and welcoming moods of morning, midday, evening, and night. In these, specific known local signature locations were included, based on the interviews. It is important that this deep, local connection to nature is present in the visual environments, because it may render good and calming memories. For the installation, three *ambient* moods were developed: *Drømme* (*Dreaming*), *Ro* (*Peace*), and *Hjem* (*Home*). *Dreaming* was recorded in the spring, *Peace* in winter, and *Home* in autumn; this allows for a vivid image of the local nature moods. The *birth* mood was more intense both visually and aurally through rhythms of ocean waves to support breathing rhythms and pain management. The results were four moods: *Urkraft* (*primordial force*) where sound and videos from the local Westcoast during a storm supported the more active atmosphere in the space and the supporting breathing rhythm.

Figures 8 and 9 *Images of the test setup. Left: 1:1 studio installation. Right: Spatial representation of sound.*

Based on the interviews, we could see a very diverse taste of music; however, natural soundscapes have a specific calming role for most women. Therefore, the team works with a new type of musical composition using field recordings as a means to make soundscape generated music. The music resonates with the recorded sounds to create music from the existing tonality of, e.g., birds. These choices were based on the existing research explained above, and interviews together with research in soundscape assessment that suggest how soundscape quality most often matches perceived quietness. The soundscape in the delivery rooms is therefore designed based on Andringa and Lanser's qualitative cognitive model for soundscape design, highlighting the role of ample safety indicators mediated by proximal situational awareness and subtle sounds, to enhance a pleasant quiet environment that promotes health (Andringa & Lanser, 2013, p.1440). On the other hand, an unpleasant environment forces one to attend to particular sources, promoting reactivity and reduced options to relax, and other forms of proactive self-selected behavior. As such, pleasantness and the absence thereof is an indicator of whether we exhibit proactive or reactive behavior. A calm soundscape is therefore characterized by the absence of disturbances and pressing situational demands.

As a delivery room is also a workplace with functional sounds that cannot be removed, we therefore aim instead to introduce ample safety indicators in the background to both mask and

remove awareness of the functional sounds. It is established in research literature on soundscape assessment that, to achieve a high level of tranquility, the perceived loudness of natural sounds (e.g., nature, wind, water, natural elements, countryside, rain, birds, and music) should be higher than human and mechanical noise (Gustavino, 2006; Pheasant et al., 2008; Andringa & Lanser, 2013).

Another strategy we use to promote safety is through heightening the feeling of control over the environment, by being able to choose the moods and the volume of the soundscape. The relation between our core affects and state of the environment is therefore one where individuals are not forced out of safe mind-states by annoying sounds, as pleasant sounds that they feel they can control allow them to stay in a calm mind-state, and therefore also allow them control over their mind-states. Calmness and perceived safety are results of a holistic assessment of the meaningful relation of the individual to the environment, where there is a presence of meaningful sounds supplemented by other sensory impressions, so that there is a meaningful whole and few "foreground" percepts stand out (Andringa & Lanser, 2013, p.1441). Visually presented landscape vegetation can amplify this effect (Yang et al., 2011). The more we can connect to a quiet ambiance, the more we can experience a feeling of quietness. An ambient soundscape helps our proximal monitoring because our omnidirectional sensitivity is activated, easily promoting a feeling of safety. Therefore, we use 6 speakers – 5 spread out, and integrated into the ceiling - plus a subwoofer. With this system, it is possible to play natural soundscapes at low volume without losing perceived sound quality.

Building an interactive instrument

Inspired by previous experiments in Herning (Nielsen & Overgaard, 2020), the sensory delivery room was designed as a welcoming space, using home like furniture, table lamps, and cabinets to hide the clinical hardware. Furthermore, the room is stripped of the laminated guidelines, and the white tile on the wall is replaced by a digital projection. The overall space was divided by an acoustic screen, with a painting resonating the colors and landscape of the region, and separating the technical domain from the more home-like space.

Figure 10 *Image of delivery room. Divided by a decorated mobile acoustic, the delivery room has a home-like space with media-art installation to the left and a birthing section to the right.*

Building a space that can attune to circadian rhythms, and help welcome the mother and her companion in a mood that resonates with their state of mind, is important. When the couple enters the room at night, the atmosphere of the space should resonate the circadian rhythm, supporting a coherent atmosphere, and boosting a sense of belonging. Another important demand to the instrument was the multisensory and immersive experience being inside a nature-like mood, the perceived intensity should be calming and stay in the perceived background, leaving room to the social situation of the birth. The natural moods should become a positive distraction in the background during labor. However, in the last stage of birth, the atmosphere should increase in intensity, supporting the woman's pain management and performance, like dance music can support the dancer. In order to talk to the senses, the space was upgraded to an immersive spatial instrument using a 10-meter digital projection, integrated with lighting, and a 5.1 sound system. The result is a delivery room setup, which can change the atmosphere radically, according to the situation. It is controlled by a switch on the wall, or a tablet placed on a cabinet in the birth environment.

Building a welcoming space, which is attuned to the temporal atmosphere shaped by the circadian rhythms was important. Another important dimension is the social and personal empowering actions that include people's personal choice. This could be to customize the space, by choosing between different atmospheres, fine tuning light intensity or volume, or enabling a favorite music playlist. The delivery room is an instrument for the couple to feel at home, and it is when the space intuitively interviews their needs new social dimensions of empowering are observed.

The principal participation strengthens the dialogue between the woman and her companion, and supports the family building dynamics. The interactional dimension is the staff, who need a fast interface, hence there are 3 switches on the wall: "On" activates the circadian algorithm, and chooses the best matched atmosphere. "Off", all hardware turns off. "Cleaning" (or emergency), all lights full power for cleaning and emergency mode. Altogether, these three interaction dimensions are important when approaching welcoming, and inclusive interactive spaces for healthcare design.

Figures 11 and 12 *Images of the delivery room. Left: The birthing section include a chair to the father and cabinets for technical equipment. Right: Image of the home-like media-art installation in the mood "Hjem" (Home)*

6. Reflection, and future work

"Cure Sometimes, Treat Often, Comfort Always" Hippocrates 400 BC

We must acknowledge that hospitals are both working places for staff, and at the same time are surroundings for the most important moments in our life. The hospitals are a background for life-changing events, such as the birth of children, the death of a loved one, or a life-changing diagnosis. Hospital spaces are more than spaces for efficient and secure work, they are places for some of our most important events from which come memories for the rest of our lives. In ancient cultures, many of these events were accompanied by rich spiritual and ritual practices, including music, dance, special objects, poetry, spiritual sculptures, and spaces. These rich cultural artifacts shaped our understanding of ourselves to help us navigate our own social life. Art is not only relevant as existential comments in museums, but it belongs in the heart of our self-understanding; somaesthetic health practice can serve as an instrument of care, and present a rich alternative to the clinical environments. We are not asking for a new golden standard for randomized clinical studies, or faster, and more efficient births; however, we are interested in using somaesthetic practice to support the act of human care.

The concept of atmospheres, and attention to the 'felt meanings' of a space, can serve as a conceptual framework to bridge the know-do gap in healthcare, because bodily feelings can be our common reference point despite specializations. Designing the experience, cannot be left to the architect alone, because of its multisensorial nature. Bridging the different artistic domains allows teams to open to a much richer sensorial experience. In the case presented in this paper, the delivery room was designed as an instrument, firstly presenting a calming and homelike décor, and secondly being equipped with digital technologies that allow the space to adapt to time of day, and the personal wishes of the users. Giving the users the choice to shape the atmosphere of the room gives them the feeling of having control over the situation; user customization delivers a dimension of social empowerment that is highly important. Realizing this vision would not always rely on complex technological innovations, but to the sensitivity of the 'existential space' described by the theoretician Christian Norbert-Schultz (1968). Various biophilic, low-tech design strategies can also function as an alternative, however, within the clinical context of a delivery room, the hygienic standards are very strict, often challenging the aesthetic visions of bringing nature inside (Browning & Ryan, 2020).

Effects and side-effects need to be well understood before a surgeon can change practice. Through systematic trial and error in controlled environments, a rich curiosity and healthy academic skepticism has moved the healthcare practice into a credible research-driven practice. The authors feel privileged to work in this domain with curious and critical healthcare staff. It is with this attention to details and curiosity for new scientific methods we need to build evidence for a new existential healthcare design paradigm. It is clear that we need to move away from evidence-based practice to research-based practice (Frandsen et al., 2009, p.3) to address the novelty of this approach. This would also include alternative qualitative methods in the clinical trials. However, the process of including such new criteria for validity poses problems for evidence-based design, as the increasingly diverse interdisciplinary theory and methodology put pressure on the comparability of evidence-based design to evidence-based medicine, which has been an important part of its legitimization in the healthcare industry (Højlund, 2017, p.31).

The authors of this paper have both been involved in other healthcare environment transformations. In all projects, there has been a wish to measure the clinical effect of each

intervention. However, the clinical data have until now not proved a significant effect that can be causally explained by the sensory delivery rooms. This has led to frustrations, and statements from staff and users such as "the numbers do not show what we experience (hear, feel, etc.)". The evidence is lacking – however evidence is a specific knowledge form in the hospital, based on specific, legitimized research methods, such as the randomized control trial, whereas other forms of research knowledge such as ethnographic studies do not count, or have the same weight.

Instead of only chasing singular clinical evidence, we want to end the article by suggesting two areas that we believe calls for future work and research, based on mixed methods across quantitative and qualitative research:

> 1) Comparative studies that seek to answer if a video of a postcard-like coast with peaceful waves without specific familiar locality would be as effective as the local beach from your childhood memories? *If* and *how* the localness matters to enhance the perceived calmness and familiarity in the room.
>
> 2) Research that focusses not only on how moving from the institutional aesthetics to the new type of integrated décor matters in "itself", but equally important it is our experience that this must go hand in hand with a cultural change and full commitment from the health staff on all levels. Our experience is that the full potential of these interventions goes beyond the experience in the room; music, beautiful nature videos, integrated paintings, homelike décor, high quality wooden furniture, and attention to details. The striving for excellence through experimental work has caused a new, positive cultural change in the maternity ward.

Figure 13 *Image taken during a water birth in the Winter mood "Silence" at the North Denmark Regional Hospital*

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Breathing in Mortality: Demedicalization of Death in Documentary Films

Outi Hakola

Abstract: *The 20th century saw a strengthening of medicalization processes, which included a medicalization of death where dying and death came to be handled primarily as medical challenges. For their part, cinematic technologies participated in this by utilizing film technology to standardize medical processes, by using films for educational purposes, and by representing medical technology and knowledge in an authoritative sociocultural manner in film narrations. As a side effect, cinematic narratives have often portrayed death as a medical failure that people can and need to be saved from. Toward the end of the 20th century, criticism toward medicalization has increased among healthcare personnel and hospice and palliative care movements, for example. At the same time, as documentary films have continued to try to capture and understand the dying processes, in at least those films dealing with so-called natural death (due to aging or terminal illness), their tone has started to emphasize demedicalization aspects. I argue that this change in tone is recognizable in how the cinematic technology represents and utilizes breathing in the films' narratives. Breathing—and particularly difficulty breathing—audibly and visibly embodies the fragility of the human body before death. At the same time, it conveys a sense of agency: Are you able to breath on your own? Is medical technology needed to do breathing for you? And how is the use of technology for dying individuals justified or not? I analyze the documentary films* Dying at Grace *(2003),* Frontline: Facing Death *(2010),* Love in Our Own Time *(2011),* Extremis *(2016),* ISLAND *(2018), and* Covidland *(2021), and through them I argue that 21st-century documentary films are joining in the efforts to demedicalize death and, as such, they are shifting the long relationship between cinematic and medical technologies.*

Introduction

Cinematic technology has explored whether a camera can reveal and document what death is, as an event (medically speaking) and as an experience. Yet, the recording of death has proven to be problematic. The medium has limits on how to reach beyond cinematic representation, and death refuses to be fully communicated through narrative, aesthetics, and the affective options that cinema offers (Malkowski, 2017; Sobchack, 1984). Despite the limitations of the medium,

filmmakers have continued their attempts to capture the moment of death and, in this process, breathing has become an important narrative tool for both cinematic and medical purposes.

An absence of breathing and a heartbeat (or respiratory and circulatory arrest) served as the medical definition of death well into the 20th century (Saeed, 2018). Since the 1950s, the invention of mechanical respirators and other life-supporting technologies has led to the current practices of measuring brain function to define death (Maguire, 2019; Saeed, 2018). Yet, changes in breathing, such as difficulty breathing and lack of breath, continue to serve as diagnostic tools in several illnesses and the moment of impending death, and these can be perceived as image and sound by film audiences. Closer to death, difficulty breathing can shift to agonal breathing, where the automated process of breathing becomes difficult and a conscious effort, a medical sign that the person is getting weaker (Fletcher, 2018). Finally, the final stage of dying can often be detected by a death rattle, which can develop during the last hours of life when the patient is too weak to swallow and the airway secretions produce gasps in breathing (Campbell, 2019; Wee et al., 2006). These stages of breathing communicate the medical conditions of the patients, and in documentaries they can be used as ways to overcome the sensory limitations of representing dying as a process.

In medical research, breathing has been discussed in relation to diagnostics, several long-term and acute illnesses, and life support and death (Bausewein et al., 2007; Dorman et al., 2007; Hutchinson et al., 2017). While part of this research focuses on symptoms and treatments, the research has also placed importance on the experiences of breathlessness. Research has shown that people experiencing difficulty breathing can feel failure or an otherness of their bodies, which affects their sensations, thoughts, feelings, and behavior (Malpass et al., 2019). Breathlessness not only limits their lives physically, but also socially, psychologically and existentially, and it can create a sense of loss or hopelessness and an awareness of mortality and the temporality of life (Górska, 2016; Hutchinson et al., 2018; Macnaughton & Carel, 2016; Malpass et al., 2019; Malpass & Penny, 2019). Thus, while breathing serves as a medical diagnostic and observational tool, it also puts the focus on the patients, their experience of loss, and an oft-related fear of death—an affective experience that cinematic media and storytelling are capable of conveying for viewers. After all, cinematic experience can transform the viewers' understanding of issues they have not experienced themselves, for example, to give insight into death and dying.

Yet, in film studies, breathing has received limited attention. Quinlivan (2012) argues that breathing can be a powerful instrument for narration, visual and audio effects, meaning-making, and embodied experiences. When made the focus of a film, breathing has intense emotional and visceral impact, not least because of viewers' tendency to respond to on-screen representations mimetically or affectively. Thus, in moments where breathing is the focus of narration, viewers not only become sensitive to the on-screen breathing bodies, but their own bodies can start to mimic those of the breathing characters, creating an embodied experience and bodily awareness (Fahd, 2019; R. Gibson, 2013; Quinlivan, 2012). This potential for bodily self-awareness and an embodied connection with dying people invites viewers into affective experiences of the dying process in a way that can overcome the limitations of cinematic (and medical) technology.

In this article, I discuss how health-related documentaries with a focus on end of life utilize breathing as narrative and an embodied tool to explore the potential and limits of communicating death and dying through cinema. The discussion is related to my research project on end-of-life documentary films. After watching over fifty documentaries on the topic, I started to notice the role of breathing as a signifier of dying. For this article, I chose examples that give prominence to this narrative solution and highlight the complexity of meanings that are embedded to this

signifier. My analysis will show that breathing as a signifier of death has also cultural and political goals. When the documentaries represent a contrast between independent breathing and breathing with respiratory devices, they discuss the practices of medicalization of death, where death and dying have become defined and handled primarily as medical challenges (Conrad, 2007; Sadler et al., 2009; Tabernero, 2018).

Both medical and cinematic technologies have appeared as signs of modernity from the beginning of the 20th century. Medical professionals have used film technology to document and standardize medical procedures and to serve for educational or verification purposes within the field (Dijck, 2005; Ostherr, 2013). In addition, the cinematic media has eagerly participated in building images of scientific technology as something that should have authority and sociopolitical importance (Tabernero, 2018). Both documentary and fictional film and television representations of the medical field have imagined and conceptualized medical knowledge and technology as a kind of salvation, and consequently, they have portrayed death from natural causes as a (medical) failure that people need to be rescued from (Dijck, 2005, pp. 14, 33–34; Hetzler & Dugdale, 2018, p. 767; Ostherr, 2013, pp. 168–169). However, when it comes to mediating death as a transformative moment in human life, cinematic expressions have faced difficulties in capturing the totality of the dying experience. These difficulties are similar to those of the medical field, where definitions of death remain controversial, for example due to coma and brain death. Similarly, no matter how much the images of the dying process are slowed down in cinematic representations, realizing the exact moment that could be studied for modern (medical) gaze can remain out of reach.

In recent documentaries of natural death occurring due to age or illness, the cinematic medium continues in its attempts to mediate death as an experience, but instead of medicalization purposes, these tend to aim to demedicalize death, to define it as a normal part of life in a way that highlights the person, not the medical issues or death as a failure. In particular, I pay attention to how breathing narratives help to justify the demedicalization of death. With a combination of cinematic and medical perspectives, I illustrate the twofold connections that on-screen dying bodies have with technology. Both medical technology, such as ventilators, and cinematic technology, such as cameras, create the embodied potential for viewers to gain perspectives on the medicalization of death and dying in contemporary societies. While cinematic technology has added to the medicalization processes in the 20th century, I argue that documentary films of the 21st century challenge the idealization of modern medicalization processes.

Narrative Aspects of Intensive Care and Hospice Care Documentaries

I approach the role of breathing in demedicalization narratives through theoretical and methodological practices of narratology, which studies structures and functions of narratives. Specifically, I focus on two constitutive building blocks for both stories and human experiences: space and time. The narrative events take place in various environments and locations, whether real or imagined, and they enable contextual and metaphorical depth for stories (Ryan, 2012). Similarly, narration takes place in a temporal setting that gives the stories a sense of direction and tempo (Parker, 2018). Together, space and time situate both the characters and the viewers in the stories.

Two different care locations define the end-of-life documentaries that I analyze in this article. First, I study medical documentaries about intensive care units (ICUs), which provide critical care, life support, and constant surveillance for patients whose lives are at immediate risk.

I study the hour-long television documentary *Frontline: Facing Death* (Navasky & O'Connor, 2010), the Netflix documentary *Extremis* (Krauss, 2016), and a topical short documentary *Covidland* (Teitler, 2021). Second, I analyze documentaries about hospice and palliative care where the focus is on comfort care and the experiences of the dying patients. The following three documentaries also include the last breaths of the dying people: *Dying at Grace* (King, 2003), *Love in Our Own Time* (Murray & Hetherton, 2011), and *ISLAND* (Eastwood, 2018).

Both ICUs and hospice spaces provide spatial frames with patients in their hospital beds, surrounded by staff and family members. Yet, medical (and cinematic) technologies play different roles in these spaces. In the ICU, the medical technology, particularly ventilators, occupies a key spatial role, and the film camera maintains some distance from the patient. In comparison, the home-like environment of hospices marginalizes medical technology and brings film cameras close to the patient.

Differences in settings bring forward differences in the medical and sociocultural contexts of care. The medicalization of death has been connected to highly technologized intensive care, even when many ICU professionals (and others) have raised concerns about the dehumanizing aspects of the overmedicalization of dying (Hetzler & Dugdale, 2018, p. 767). Overmedicalization includes an aggressive aim to prolong life through medical interventions, such as ventilators, which arguably turns patients into isolated medical objects, whose individual autonomy and social and emotional wellbeing are marginalized (Field, 1994; L. K. Hall, 2017; Hetzler & Dugdale, 2018; Zimmermann & Rodin, 2004). In comparison, the rise of hospice movements appears as an alternative for medicalized death and as a transition toward demedicalized dying (L. K. Hall, 2017, p. 235). Hospice care and palliative care focus on holistic end-of-life care, where medical care treats symptoms and aims for comfort care (instead of a cure), and which is complemented with psychological, social and spiritual care to increase the level of quality of life (Loscalzo, 2008; Radbruch et al., 2020). Similarly, in the documentaries, the ICU films give the central role to the medical technology, whereas the hospice films tend to avoid technological aspects and focus on the patients' experiences.

In addition to setting, the framing of images adds spatial aspects to film narration. The framing defines which elements, such as breathing, are given focus and visibility on screen. Quinlivan (2012) has observed that breathing shows itself through cinematic place—it is something that is made visible (and heard) particularly through breathing bodies on screen. Because documentaries about natural death put special focus on the breathing of the dying main characters, who are either breathing independently or with a ventilator, these films also construct the spatial potential for an embodied connection. Thus, by looking into the images and sounds of breathing, I analyze how viewers are invited to pay attention to breathing, and how this direction of attention can challenge medicalization processes.

Time serves as another important motivation, both in the narratives and in end-of-life care. Medicalization, with its medical interventions and technology, aims to either prevent or slow down dying and to increase one's lifespan. The demedicalized death is often embraced if there is no longer hope for other results. Thus, the ethical dilemmas of end-of-life care lie in the uncertainty of the prognosis: the best course of care decisions—curative versus palliative care—can often be realized only in hindsight. Thus, the ambivalence of temporality of life muddies the waters for medical staff, patients, and their families.

In contrast, documentaries have a built-in hindsight to evaluate medicalization of death due to the editing and post-production practices where filmed events are turned into a narrative. Heidegger's metaphysics of "being-toward-death," according to which death gives perspective to

all experiences and guides our (temporal) way of being in the world (Heidegger, 1978), serves as a starting point for Ricoeur, who argues that the temporal structure of human experience is comparable to the temporality of narrative, where events are both projected toward a certain future and informed by the past. This structure of "having-been, coming-forth, and making-present" gives the narrative a circular form where the end is anticipated in the beginning, and the beginning is included in the end (Ricoeur, 1980, p. 181). In end-of-life documentaries, the viewer is aware of impending death from the beginning, and thus the narration is burdened with anticipation of death, a strong attitude of "being-toward-death." Breathing, changes in breathing, and lack of breathing mark this anticipation, the passing time, and progressing dying process.

Along with the passing of universal time, breathing marks the embodied time in these documentaries. Instead of universal (or clock) time, embodied time refers to the experience of time, and its importance is recognized by both the medical and cinematic fields. Studies of hospice and palliative care have emphasized the patients' experience of time becoming embodied: terminally ill people mark outer universal time as less important than their inner time, and their end of life is defined by changes in their bodily functions and lived experiences (Lindqvist et al., 2008), where "it is not the clock that stops ticking, but the heart that stops beating, when lifetime is ended" (Ellingsen et al., 2013, p. 170).

Similarly, in phenomenological philosophy, time is often seen as a "dimension of our being" instead of a universal object (Merleau-Ponty, 2002, p. 438), and in film theory, Deleuze has argued that while images move within a certain time, they can relate to time also indirectly or virtually in ways that underline experienced, not universal time (Deleuze, 1985, pp. 24–44). When on-screen breathing characters experience time through their bodies, they mediate an embodied potential for the viewer to connect with their experiences.

In addition, "being-toward-death," or anticipation of death, creates non-linearity in the narration, making the experience of time fluid. The fluidity of time that is connected to lived body experiences gives depth to the cinematic expression. According to Sobchack (2004, p. 121), temporal simultaneity also expands the space of presented images, and as such, the temporal aspect of the images includes and affects the spatial and material bodies in them. In the following analysis, I utilize this idea that the spatial and temporal aspects related to breathing serve as narrative tools to visualize and embody dying processes in a way that can reveal these documentaries' relationship to ideas of (de)medicalization. I start the analysis with the ICU documentaries before discussing the hospice and palliative care documentaries.

Breathing and Agency in Intensive Care Documentaries

The contemporary medical documentaries that narrate the daily lives of intensive care units are influenced by the traditions of cinma vrit and observational documentaries, where events take place in front of viewers with no voice-over commentary, added music or sound effects, often being filmed with a hand-held camera as if to emphasize a "real" feeling (J. Hall, 1991; MacDougall, 2018, pp. 1–2; Nichols, 2017, pp. 132–135). This style was eagerly utilized in early medical documentaries, where viewers were invited to witness hospital life behind the scenes; ambient sounds, such as beeping and machine sounds, as well as images of medical technologies, such as a dialysis machine, ventilators, and heart monitors, provided an impression of unmediated reality, and the institutional feeling of rushing doctors gave a sense of authenticity (Ostherr, 2013, p. 157). All three ICU documentaries—*Facing Death*, *Extremis*, and *Covidland*—utilize this tradition at least partially by highlighting the sense of being present,

offering observation, and witnessing the practices, potential and limitations of intensive care. By placing the care practices under scrutiny, the contemporary films also turn a critical gaze toward the medicalization of death.

In *Extremis*, a short documentary that depicts the ICU of Highland Hospital in the U.S., the challenges related to medicalization of death become visible through two patients, Selena and Donna. In both cases, their families face a conflict about whether they should be maintained on a ventilator or allowed to die by being removed from life support. In the end, Donna's family decides to remove the tubes, and Donna says goodbye to her family before passing away a day later. Selena is surgically attached to the ventilator until her death about six months later.

Because Selena is unable to communicate or respond to stimuli, the family needs to make care decisions for her. Consequently, there is very limited on-screen time for the patient, and the narrative focus is on the family, which is struggling with a sense of loss and care choices. For them, the high-tech medical technology equals life, the decision to remove the ventilator equals murder, and death equals failure in medical care. Thus, medicalization provides hope and a prolongation of life (and time); the roots for these kinds of expectations have been sought from media narratives. Medical programming, where trauma patients can be "fixed" and life-sustaining treatments are emphasized at the expense of long-term outcomes of medical interventions or benefits of palliative care, has been argued as giving families misguided expectations of ICU care (Hetzler & Dugdale, 2018; Houben et al., 2016). Although Selena's family's (unrealistic) sense of hope is merely observed, not openly criticized, the choice to leave the patient as part of the background, not the central focus, questions whether the medicalization of death is in the interest of the family, not the patient.

The desire for demedicalization is further highlighted with Donna. The viewer is introduced to her when she is strapped to a hospital bed and breathing with the help of the ventilator. The beeping sound of the EKG machine and the whooshing sound of the ventilator make the medical technology spatially present through audio and visual imagery. This introduction highlights the role of medical technology, and mechanical breathing seems to replace Donna's agency. The sounds diminish when her husband starts talking to her soothingly. The husband even confesses being worried that the ventilator is the only functioning thing. Later on, Donna is able to respond to the doctors and her family, and she signals that she wants to have the breathing tube removed. Her part of the film finishes with her own words, when after the removal of the tube she smiles and tells everybody to calm down. She regains her own breathing, and her own voice, and she and her family choose to accept the impending death. The medical treatments or technology no longer intervene in the goodbyes and communication. At the same time, her death is not portrayed as failure, but as a rite of passage. In subtle ways, the documentary compares these two end-of-life care choices in a way where mechanical breathing prolongs life yet also relieves the patient from agency.

The connection between agency and breathing is highlighted in the Public Broadcasting Service's documentary *Frontline: Facing Death*, which features an emergency care unit at Mount Sinai Hospital in New York City. The film introduces doctors dealing with intensive care and aggressive medical interventions, and patients and their families who are dealing with various terminal diagnoses. Here, too, the focus is on care choices, and the documentary discusses conflicts between the hopes related to medicalization and the fears of overmedicalization, where invasive and aggressive treatments can affect quality of life and sometimes even shorten life. While the filmmakers seemingly present both sides of the argument, the spatial and temporal narration challenges the outcomes of overmedicalization. Spatially, the dependence on medical

technology becomes a focal point. Mechanical ventilation plays a particularly significant role, as it assists or replaces the breathing of the patients. The ventilators also marginalize the patients, who become almost unrecognizable beneath tubes attached to medical devices.

For example, one scene starts with a close-up of the illuminated screen of the medical device that measures oxygen levels and breathing. Slowly the camera pans to the breathing tube and follows its movements in the regulated rhythm of breath. The camera focuses on this movement in an almost hypnotic way. The rhythm of breathing in and out is also a form of engagement—with each intake of breath, people take something of the world into themselves, and when breathing out they release something out of themselves and participate in the shared world (Quinlivan, 2012, pp. 104–105). Thus, when patients are unable to breathe for themselves, technology, at least temporarily, overtakes their subjectivity. In *Facing Death*, where the patients die despite medical interventions, the visual allegory of borrowed breathing asks whether the medical options provide meaningful life. In this scene, the image continues to refocus, from the breathing tube to giving a glimpse of the patient at the end of the tube. Even here, their face remains out of focus, unrecognizable. This image contrasts with the medical technology, the breathing mask, and its timely and precise movements, which are in focus, with the blurred and unstable image of the person.

While the spatial aspect of breathing questions the limits of human agency in connection to medicalized death, temporal aspects raise questions of being-toward-death. Respiratory machines give time for families to make decisions about end-of-life care and to come to terms with loss. The medical staff highlights that this treatment should be temporary, but for many families it is hard to decide when to stop it, as intensive care can give false hope that modern technology could prevent dying. In many ways, medical technology freezes embodied time, yet by extension it also freezes the agency and subjectivity of the patient. In *Facing Death*, none of the patients get better, and at the end of the documentary, only one patient—who is permanently hooked to a breathing machine—continues to live. The question whether the patients can breathe on their own gives narrative structure and tension to the film, and the removal of the breathing technology becomes the closing scene of the documentary. This implies that unless you can breathe yourself, you have neither agency nor meaningful life, and the question raised is how the relatives are going to deal with this loss.

Whereas *Extremis* and *Facing Death* question the suitability of medicalized ICU care for terminally ill patients at the end of their lives, the COVID-19 pandemic discusses impending death in the context of acute illness—the primary function of ICU care—where difficulty breathing is a sudden, and unwelcome, reminder of mortality. *Covidland*, where ICU doctor Megan Panico cares for COVID-19 patients at Hartford Hospital, witnesses how COVID emergency care affects both healthcare personnel and the patients. While emotional strain comes to the fore, medical technology represents hope to save lives amidst the pandemic. As a respiratory disease, COVID-19 affects lungs, and in severe cases coronavirus can cause acute respiratory distress syndrome, a life-threatening lung injury, where oxygen cannot get into the body, and which often requires intensive care with oxygen or a ventilator (World Health Organization, 2020). The care aims to support the patient so that the body has time to heal. In *Covidland*, medical technology is presented as an option to freeze embodied time.

This short documentary also starts with images from an ICU corridor filled with monitors and medical technology. Mechanical beeping sounds and close-ups of blood pressure monitors and IV therapy bags surround the staff as they put on their personal protective equipment. While the contextual images highlight the need for medical technology for life support, the images

of the staff reference the threat of infection. Here, breathing acquires dangerous undertones. Participation in the world through breathing becomes both a blessing and a curse, when every intake of breath can expose one to a virus, and every outbreath can cause danger to others. In this context, breathing carries both positive and negative connotations. The opening ends with the staff members looking into a patient's room through a glass window. Thus, before the viewer is allowed to meet the patients, the need for protection is introduced, highlighting the isolation of patients.

The short film tells the story of a patient, Brian, who according to the closing credits died from COVID. He is introduced through medical technology: the camera pans from the machines by the bedside to Brian, whose face is hidden beneath an oxygen mask. Similarly to other ICU films, the image does not linger on Brian, but cuts to the staff's discussion of his medical status. When the camera finds Brian again, the only movement is his chest, as he struggles to breathe even with the mask. The medical technology hums in the background.

Later on, when Brian is involved with discussion of his care, the medical technology—both visual and auditory spatial cues—also fades into the background, and low-key background music is introduced. It covers the sound of the machines and gives priority to the agencies of both the patient and the caretaker. When Dr. Panico discusses Brian's views on having to be intubated, and potentially dying with a breathing tube, distress and the inability to decide are visible in Brian's facial expressions. At the same time, his difficulty breathing highlights his deterioration. The doctor explains for the viewer that it is heartbreaking to lose people, and while medical technology can provide hope, aggressive interventions, such as sedation due to intubation, can also dehumanize and further isolate the patient at the moment of their death. In the last image we see of Brian, he states: "Whatever will be… it's okay" (Teitler, 2021). These last words can hint at his desire to avoid a medicalized death, but just as well to his trust in healthcare professionals to make the right choice, and such, these words can also hint to willingness of letting go of agency.

While *Covidland* brings forward how ICU technology has helped to save patients from acute illness, even these kinds of COVID-19 documentaries include critical views toward medicalization of death. Similarly to *Extremis* and *Facing Death*, *Covidland* refuses to turn to the trope of heroic recovery stories; instead, medicalization processes appear in all these ICU stories as temporary for patients with the potential to get through aggressive care, not as something that can eliminate death. The films' "being-toward-death" orientation represents deaths of patients as inevitable, even when stories include insights into challenges of making (right) care choices. Thus, the benefit of hindsight invites viewers to criticize medicalized practices, and in many cases, ventilators appear as a dehumanizing option for person-oriented care at the end-of-life.

Hospice Documentaries and the Last Breath

Documentaries about hospice and palliative care erase almost all traces of medicalization. Occasionally these films show how patients are provided with medication or additional oxygen—but high-tech machines, such as ventilators, are missing from the narratives. In these films, agency is connected to breathing, yet the question is what time is left, not what a machine can provide. In the context of hospice, time arguably has special meaning because comfort care aims to appreciate the time that is left when one is faced with the lack of a future (Pasveer, 2019). In the Australian documentary *Love in Our Own Time*, the family of Jutta (the dying patient) talks about her breathing. Her daughter wonders: "She is lying there, breathing, but who

is she, where is her personality?" Here, the patient's weakening consciousness and presence are connected to bodily functions, such as breathing, and while it anticipates the imminent loss, it is also comforting, as the husband confirms: "the only movement is the breathing … that is a good sound" (Murray & Hetherton, 2011). Here, the role of breathing is directly connected to the dying process.

In these films, breathing is used to give updates on how each character is doing. For example, in the Canadian documentary *Dying at Grace*, situated in the palliative care unit at Toronto Grace Health Centre, the camera peeks into the patients' rooms to show and listen to them still breathing. Carmilla is the first patient to die, and her death is shown in a sequence at night. She is surrounded by concerned family, who witness her labored breathing, while a lightweight nasal cannula helps to increase oxygen flow. After the family leaves, the camera visits Carmilla's bedside a few times, together with nurses who are doing their rounds. The first time, a medium shot shows Carmilla's chest moving with the rhythm of each hard breath. The second time, a close-up of her hollow face cuts to an extreme close-up of her hand resting on her moving chest before returning to a close-up of her terminal breathing. The last scene of Carmilla is after her death. In the middle of the night, in a medium-long shot, the camera shows two nurses entering the room. They check her breathing, and when they cannot detect it, they take away the tubes and caress her skin. With one last close-up of her now immobile face, a voiceover shares a nurse calling Carmilla's daughter and telling about her very peaceful death. In this sequence, the troubled sound of breathing and the close-ups of the breathing body communicate aliveness as a contrast to the stillness and quietness at the end. Also, close-ups invite the viewer near to the dying person, creating a visceral impact.

In the hospice documentaries, the spatial aspects of breathing are empathetically visceral. The breathing bodies evoke embodied connections to the materiality of dying bodies, and because the embodied breathing invites consciousness of mortality (Fahd, 2019; Quinlivan, 2012), these moments invite viewers to experience the temporality of life. The sections of the films where the main characters' breathing is easier tend to include medium shots and medium-long shots that introduce the hospice space and people in it. When main characters' breathing gets difficult, the camera comes closer. In the deathbed scenes, the filmmakers tend to use medium close-ups and close-ups of dying people, creating a sense of intimacy. By bringing the camera, sometimes even a handheld camera, close to the dying person, the films leave no escape route and give no potential for distancing oneself from the moment of death. Particularly when there is no medical technology that stands in the way of gazing at the dying person, the access is immediate and affective.

Affectivity is emphasized in *Dying at Grace*'s closing scene, where Eda dies in front of the camera. The scene lasts for almost three minutes with a hand-held camera shooting a close-up of her face resting on the pillow. Her eyes are half-closed, her every breath difficult, gasping, almost as if it were an automatic, unwanted action. The breathing is visible through her slightly open mouth, movements of the cheeks, a slight bobbing of the head, and often difficult swallows. The sound of her difficulty breathing, or the death rattle, diminishes all other sounds. Breathing as the main visible and audible element in the scene invites the viewer to become aware of their own breathing, to compare their body with the dying body. This consciousness makes the viewer pay attention to the automated process of breathing, its rhythm, and its necessity for the lived experience and for continuation of inner, embodied time. The long-shot duration, hand-held yet rather immobile camera, and close-up of Eda's difficulty breathing emphasize the witnessing of the delicate moment of the last breath. During the scene, the gasps and gaps between breaths

increase, interspersed with silence, until there are no further breaths. When Eda stops breathing, the sound of the background noises returns, and the beeping sound from medical technology can be heard; yet at the moment of death, the focus is on the person, Eda.

In other deathbed scenes, the role of the last breath and the absence of medical technology are similar, highlighting the embodied, even natural process of dying. In *Love in Our Own Time*, the sound of dying is mixed with labored breathing from childbirth. In the montage, two women in labor use different breathing techniques to help with the pain, and these sounds are edited together with the death rattle of Jutta. The sound comparison continues even after the women have given birth and Jutta has died. From the sound of the new mothers crying with happiness, the film shifts to the sounds of desperate crying; soon viewers are shown how Jutta's family is crying around her deathbed. As Greene (2016) reminds, the sound of breathing draws attention and this conscious choice in cinematic narration always carries cultural meanings. In the case of *Love in Our Own Time*, the comparison between the defining moments of birth and death reflects the cyclical pattern of life. The first and last breaths become the same, yet different, highlighting individual experiences as part of nature, marking death as a natural instead of medical phenomenon.

While hospice documentaries focus on the person and the natural aspects of dying, the narration turns away from the promises of medical technology and the medicalization of death. However, at the same time, another aspect of technology comes to the fore—the role of cinematic technology. The ethics of filming the last moments of people highlights the camera's role as a witness, the filmmaker's and viewer's motivation to see death, and the medium-related relationship between the viewer and the dying individual (M. Gibson, 2001; Sobchack, 2004).

Sobchack argues that the typical cinematic choices in deathbed scenes—the carefully framed, focused, long, slow, immobile, and intimate images used in Eda's deathbed scene—indicate planning and permission to film death, and as such they serve as a promise of the "humane gaze" (Sobchack, 2004, pp. 189–191). Instead of peeking quickly from the door, the camera stays with the dying person, allowing the viewer to see the dying process in detail. While these moments highlight the responsibility of watching and permission to see, it also relates back to the questions of modernization and technology, where film technology is used to visualize, or even standardize, different situations in the medical field. The humane gaze creates expectations of what dying looks like, even if these often represent calm and peaceful deaths, and thus marginalize other experiences.

In addition to questions of spatial framing, time adds another level to the filming of deathbed scenes. *ISLAND*, a British documentary about Mountbatten Hospice on the Isle of Wight, includes an immobile seven-minute-long take of Alan's death. Grønstad (2016, pp. 119–135) argues that similarly to intimate images, a long take also emphasizes films' ethical potential because it minimizes dramatization, emphasizes hyperrealism, prioritizes atmosphere over action or speech, and spatializes duration by visualizing the passing of time. Indeed, because slow, or sometimes still, images contradict the cinematic preference for movement, they are powerful moments (Remes, 2012, pp. 259–261). When deathbed scenes slow the tempo and rhythm of a film, they highlight the importance of the moment and ethical connection with the dying person.

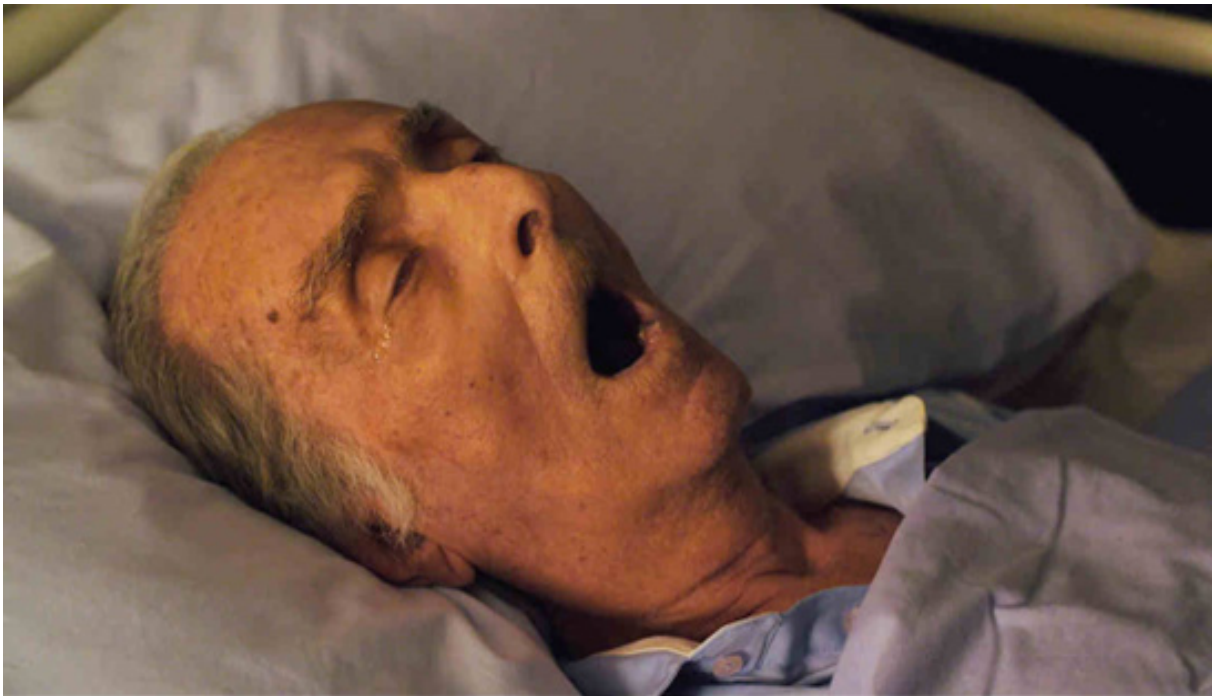

Figure 1 *Death scene of Alan in ISLAND* (Steven Eastwood, Hakawati, 2018).

Similarly to Eda, small movements record Alan's breathing and gasps in breathing. Many times, he appears to have taken his last breath, just before he gasps for more oxygen. Alan's last breath finishes his participation in the world, even though it is difficult to pinpoint the definite moment of death. The viewer keeps waiting for the next breath, and the moment of death can only be recognized after it has already happened. This makes both embodied time and life fluid, as presence mixes with having-been and coming-forth.

After Alan's last breath, when his gasps stop, only non-movement and silence remain. The image and the body stay still until the nurse comes into the room and notices that he has died. This combination, silence and non-movement, pinpoints not only the death of a person but also a transformation in embodied time. When both movement and sound stop in the image, the film does not end. The frames continue to roll even if nothing changes. In these moments, the film makes a spectacle out of stasis, non-movement where only time continues. This use of stasis emphasizes time as an essential element of embodied film, and as Remes argues, perhaps even more so than movement, because even if nothing apparently happens in the image, the viewer witnesses as time goes by and this witnessing creates a constantly evolving experience (Remes, 2012, pp. 263–267). In Alan's case, the long take by his deathbed invites embodied connection, and after his death, the continued use of stasis helps the viewer to recognize the loss. This recognition redirects the awareness of Alan's embodied time to the viewer's embodied time. During the moments when the viewer realizes that Alan has died, the viewer also recognizes the continuation of life around him. Universal time moves on, and when the nurse enters the room, and action re-starts, the focus readjusts to those who remain, to the world and to the viewer that reacts to the death of Alan. This highlights how film moves on and time continues for others.

The moment of death can be challenging for an embodied connection to film. Sobchack argues that cinema has difficulties to reach the transgressive moment of death because embodiment takes place between lived-body subjects. The corpse, which is an inanimate non-

being, cannot invite this kind of active embodied connection, and as such, the humane gaze for so-called natural death "does not so much represent death as it represents the living of the process of dying" (Sobchack, 2004, p. 189). Thus, according to her, death as an event remains unreachable for cinematic technology. However, I argue that because of the ambiguity of the moment of death and the difficulty to pinpoint the exact end of (Alan's) embodied time, there is also fluidity in the viewer's embodied connection to the dying person. Thus, the subtle use of breathing can potentially transcend the limits between being and non-being in film narration. The viewer is allowed to co-experience the situation, if not death itself, and as such, breathing provides unique potential for cinematic technology to connect the viewer not only to what death is as a (medical) process but to what it might be as an embodied experience.

Conclusion

While the totality of the multisensory dying experience remains out of reach of the cinematic apparatus, breathing is one way of narrating mortality. In the end-of-life documentaries, breathing addresses a sense of mortality not only through space, where the breathing bodies are given attention and various images and sounds of breathing repetitiously fill the screen, but also through time. "Being-toward-death" and the temporal fluidity of images of breathing (and non-breathing) characters highlight the sense of mortality and the embodiment of mortality. Consequently, this embodiment becomes connected not only to a breathing body as a spatial or material element but also a body as a temporal element in the narration. In the ICU films, medical technology and its criticism come to the fore. The spatial marginalization of the patients and borrowing time through medical devices override or reduce the agency of the patients and dehumanize their dying. In the hospice and palliative care films, being-toward-death is embraced, and the embodied time of the dying people provides potential for an intimate connection with the dying person, which in turn serves to humanize the dying process.

In these documentaries, breathing exceeds the sensory limitations of the cinematic narration and creates a powerful death-related experience. Thus, breathing becomes more than a physical or medical means to observe dying as a process; it can have a significant cinematic function to create embodied narratives about mortality. The represented images and sounds can affect viewers, and consequently, our bodies and understandings of bodies become altered by cinematic reproduction. The viewer can use the representations of dying bodies to gather knowledge and experiences of dying and death, including questions of the medicalization of death. Through criticism of overusing medical technology and by providing intimate connections with natural deaths, the 21st-century documentary films have challenged cinema's tradition of supporting modern medicalization processes and goals.

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Care practice as aesthetic co-creation: A somaesthetic perspective on care work

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Abstract: *Drawing on Dewey's theory of aesthetics, Shusterman's notion of somaesthetics, and an elaboration of the notion of co-creation, this study analyzes care practices as aesthetic co-creations, that is, inquiries of impressions and expressions through which actors and practices are co-created. A care situation from elderly care serves to analyze the body as a locus of sensory aesthetic appreciation and the potential process of somaesthetic experience and learning. How to learn to appreciate the somaesthetic dimensions and the importance of somaesthetic attention for subtle forms of power in care situations are discussed.*

Introduction

Care work is described as bodywork through which care workers handle the bodies of others (Twigg, 2000). Care work is often defined as "dirty work" (Dahle, 2005; Twigg, 2000) because of its intimate contact with human bodies and their fluids and waste; with dirt, disgust, nakedness, touch, and intimacy; and with bodies' sicknesses, decay, and death. Care workers have to go beyond bodily boundaries that are considered strictly private (Dahle, 2005) and perform intimate bodywork tucked away in bedrooms and lavatories and behind the scenes in nursing homes. To avoid confrontation with human decay and impermanence, care work is performed in the shadows of society:

> *Fundamentally, care work is hidden work, 'dirty work', because it deals with aspects of life that society, especially modern secular society with its ethic of material success and its emphasis on youth and glamour, does not want to think about: decay, dirt, death, decline, failure.* (Twigg, 2000, p. 406)

In the literature, attention to the older body is scarce. The body is mostly studied as a locus of pleasure and consumption (Twigg, 2000) and as an instrument of self-presentation (Dahle, 2005). The body, then, is omitted in humanistic studies (Shusterman, 2006), and the aging body in particular is socially marginalized (Hansen & Grosen, 2019). Care work is mostly performed by low-educated groups and (female) care workers. Moreover, care work studies often sideline bodywork: "Though bathing, washing and other forms of personal care are central to the day-to-day realities of care work, they have received little attention." (Twigg, 2000, p.

394). Status in this field is emphasized by distancing the bodily aspects and attending to the body as a territory of bio-medicine (Twigg, 2000). Moreover, welfare technologies have enabled bodily distance and "hands-off" care (Hansen & Grosen, 2019). The distanced position to the elderly body recognizes a privileged, professional approach that ignores the embodied sensible knowing in care work, which is collectively deployed through aesthetic interactions (Gherardi & Rodeschini, 2016). The bio-medical approach and political administration enhance efficiency, standards of competence, and an evidence-based rationality that assimilates healthcare with any other "industry," and as a result, there is a risk of rationalizing care and losing sight of the ethics of care (Gherardi & Rodeschini, 2016). Consequently, the central characteristics of care work are overlooked. However, one cannot fully understand care if its embodied dimensions are unattended (Hamington, 2004). As care work requires the endurance of physical nearness to other people, taking care of their bodies requires the enactment of aesthetic sensibility in an embodied presence and the adjustment to care relations and situations. Drawing on John Dewey's theory of aesthetics (1934), Shusterman's further elaboration of somaesthetics (1994, 1999, 2006), and the notion of co-creation as my add-on, this study explores bodywork in care work, which is defined as aesthetic inquiries of impressions and expressions through which the involved actors and care practices are co-created. Inspired by Dewey's view on aesthetics, the actors' expressions are analyzed as artifacts that make impressions and give shape to care practice. Acknowledging the body as a locus of sensory aesthetic appreciation (Shusterman, 2006) draws attention to care workers' capacity to tune in and act intuitively to the emerging and spontaneous character of care situations. Based on these considerations, this study raises the question of how care practices can be seen as aesthetic co-creations and thus as processes of somaesthetic experience and learning.

In the following section, the study and analytical methods are introduced. The theoretical perspectives of aesthetics, somaesthetics, and aesthetic co-creation are then outlined. A micro-communicative analysis is conducted on a singular care situation from elderly care that examines the body in care work as a locus of sensory aesthetic appreciation and, thus, care practice as a potential process of somaesthetic experience and learning. This study also discusses how care workers can come to learn and appreciate the somaesthetic dimension of care work and how this pragmatic understanding of aesthetics differs from existential wonder-driven understandings as an "embodied art of living" (Shusterman, 2006). How somaesthetic attention is crucial for the awareness of subtle forms of power in care communication is also discussed.

Setting and method for studying the body in care work

This study draws on an empirical doctoral study of learning in elderly care performed in Denmark from 2018 to 2021. The study involved various participants from elderly care (i.e., care workers, trainees, supervisors, elderly people, managers, and different organizational consultants). Fieldwork was conducted using the shadowing method (Czarniawska, 2007; McDonald & Simpson, 2014) to study care work at nursing homes. The focus was to recognize the potentials for learning within the work itself and in the interactions between the care workers, the elderly, and the work tasks. Shadowing as a method gives researchers the possibility to study the work of people who move from place to place as they work, rather than staying in one place (Czarniawska, 2007). Therefore, shadowing offers the possibility of gaining rich insights into everyday practices and processes as they unfold in various places and paces at microlevels throughout an observed timespan (McDonald & Simpson, 2014).

While shadowing can be a method of following individual actors (Czarniawska, 2007), the object of shadowing can also be a phenomenon in the unfolding of situations (Buchan & Simpson, 2020). In this case, the studied object is the phenomenon of learning as it unfolds in the organizational practices of elderly care. Drawing on Dewey's philosophy of learning (Dewey, 1916), the study shows the embodied practice of care work as a situated site for learning, defined as both the process of experiencing and the result of richer experiences. The analysis of care relations reveals how learning potentials unfold in close relation to the emerging bodily, discursive, and non-discursive interactions between care workers and the elderly. However, bodily aspects are not the initial focus, and empirical experiences foster insights into the aesthetic and sensory aspects of care work and communication. To further elaborate on the empirical experience, I found inspiration in Dewey's pragmatism and Shusterman's notion of somaesthetics, which developed and critically added to Dewey's philosophy of experience and aesthetics.

By focusing on the phenomenon of learning from an embodied perspective, the data took the form of experienced, responsive data (St. Pierre, 1997) and were stumbled upon instead of collected (Brinkmann, 2014). This study contributes to pragmatism-informed research that emphasizes making available future experiences of high quality (Rosiek, 2013). The ameliorative ideal is the transformation of insight that creates the possibility of new experiences of bodywork in care work as processes of co-creation and learning. This is aligned with Shusterman's (2006) intention to enrich both discursive knowledge and lived somatic experience about the body and mind. The goal is not knowledge per se but improved experience and, in relation, concepts that serve us better (Shusterman, 2006). For this reason, this study presents an analysis that intends to make impressions and produce new insights into learning (as a process and a result) in care work.

To conduct a fine-grained micro-analysis, this study presents a single empirical care situation, a 'small story' (Bamberg & Georgakopoulou, 2008) constructed from extended fieldwork in everyday care work. Inspired by the pragmatist theory of knowledge, the intention is to give an illustrative example that helps to analyze the "breath" of experience and the potentials for learning that unfold within experiences. The criteria for the selection are two-fold. First, the situation should have a certain quality of experience that made an impression on the researcher. Inspired by Dewey (1934), I describe this as an aesthetic quality that has a certain expressiveness. Second, the expressiveness of the situation should have the quality to trigger the reflexivity of the researcher. Accordingly, the selected situation was *an* experience, as Dewey (1934) calls it, of a situation that steps out of the stream of the experiences made, in this case, of care situations in nursing homes. The reliance on *an* experience is trust in the aesthetic quality, the expressiveness (Dewey, 1934) of a situation that makes impressions noticeable, open, and undetermined, and in the fostering of a situation that ignites reflexivity and critical analysis. Therefore, the situation triggers the construction of a mystery (Alvesson & Kärreman, 2007), of something experienced but not yet understandable with the theory at hand. To this expense, the construction of a mystery from the base of a situation makes it possible to know more (Alvesson & Kärreman, 2007) of the qualities needed in attending the body in care work as a locus for aesthetic appreciation and to open the potentials for learning in and of care work by acknowledging and fostering this attention.

However, drawing on a single situation for analysis requires some considerations of why and how the situation is chosen, as it deviates from the ideals of the representations of objective entities given in reality that we might have learned as "golden standards" in qualitative research (Revsbæk & Simpson, 2022). The study is driven by an effort to grasp the fluid and ever-changing

dynamics of living experience (in this case, in care relations) and the subtleties (of communication and learning) that are fragile, vulnerable, and unnoticed (Revsbæk & Simpson, 2022). Certainly, it centers the researcher as an observer, and the narrative "I", from a privileged position, can point to and select *an* experience. This position generates the need for reflexivity and transparency in the researcher's way of knowing. However, as a productive alternative, Jackson and Mazzei (2008) suggest a re-imagination of the subjective "I" as a performative becoming. This means that not only is the narrative constructed, but the researcher is also changed by what is happening in the situation through aesthetic appreciation. Through the act of narration, experience also produces the researcher's "I." For the researcher, it calls for ethical attention to think of events from different perspectives and to give a voice to aspects that are silenced or less noticed (Jackson & Mazzei, 2008). Moreover, it requires attention to how one story is presented as if it is a defined entity, even though, when experienced, it does not have a clear beginning and ending. The idea is not to represent a reality of care work but to bypass the ideal of an objective description and enable the possibilities of enriching future experiences about the body as a locus of aesthetic appreciation in care work (Rosiek, 2013; Shusterman, 2006). Aligned with Shusterman (1999), the current study shows the potential utility of the concept of somaesthetics, not the radical novelty of the idea of care work as bodywork. In the following, I outline how Shusterman understands the somaesthetic perspective and how he, with this term, is inspired by and differs from Dewey's view of experience and aesthetics. Moreover, I contribute with the notion of co-creation, inspired by Dewey, to emphasize the radical social foundation of experiences.

The body as a locus of aesthetic appreciation

Care work entails a fine-grained attunement to often vague and unspecific expressions of the elderly and to situations in which the elderly's verbal responses are scarce. To this subtle communication, the notion of somaesthetics can serve as a useful analytic perspective for understanding the fine lines of bodywork. The elderly's responses may be a sigh or a moan uttered to express discomfort, a gaze that is undetermined, or a hint of a movement that indicates an uncertain intention. The folded and unopened newspaper or a coffee cup that is untouched can be signs of the elderly's mental status. A pause in words or a certain intonation of a word can express a feeling that is unspoken. To notice fine lines like these in communication entails bodily attention, in which the body functions as a sensory apparatus that takes in and is moved by the expressiveness of a situation (Dewey, 1934). Shusterman (1999) claims that we can gain a better mastery of the actual workings of our actions and our will's application in behavior if we explore our bodily experiences more deeply through somaesthetic attention. He defines somaesthetics "as the critical, meliorative study of the experience and use of one's body as a locus of sensory-aesthetic appreciation (aisthesis) and creative self-fashioning" (Shusterman, 1999, p. 302). This comprehension has a normative and prescriptive character that is uncommon in a more descriptive and analytic aesthetic (Shusterman, 1999). The pragmatic claim is that our knowledge about the world is improved by enhancing our awareness of our bodily states and feelings and by perfecting our bodily senses, not by denying them (Shusterman, 1999). It is about cultivating our bodily habits:

> *To improve our bodily habits and psycho-somatic integration we need to bring our somatic functioning and its attendant feelings into greater consciousness, so we can learn both to detect subtly different modalities of posture and movement and to assess the quality of their coordination and their attendant affectivity* (Shusterman, 1994, s. 138).

In his masterpiece on aesthetics called "Art as Experience," which inspired Shusterman's development of somaesthetics, Dewey writes poetically that "experiencing like breathing is a rhythm of intakings and outgivings" (1934, p. 58). Experience, then, is the continuous process of taking in the world and giving out responses, and through this process, man and the world are created (Shusterman, 1999). In the context of this paper, these considerations can help us understand how care practices and the actors involved are created and re-created (and co-created, as I will argue) through continuous intakings and outgivings. Therefore, Dewey and Shusterman point to the double status of humans as both objects and subjects—as objects of materiality taking form as something in the world and as subjects of sensibility that experience, feel, and act in the world (Shusterman, 2006). As highlighted by Shusterman (2006), we both *are* bodies and *have* bodies, and this fundamental ambiguity in human lives constructs the body as a source of perception and action *and* as an object of awareness. Therefore, perceiving vague expressions as valuable signs in communication requires care workers to recognize that their experienced impressions of a care situation are not merely private or individual but are resonances of something going on in a shared situation (Dewey, 1934). This means that sensory and emotional experiences should be analyzed in close interactions with the situations in which the impressions are experienced as indicators of something that is possible to experience in the situation. Therefore, the impressions carry valuable information about the situation, the elderly, and the care workers themselves.

An important point raised by Shusterman (2006) is that somaesthetic attention "needs to be primarily directed not to the inner feelings of our embodied self but to the objects of our environment in relation to which we must act and react" (p. 11). This means that feelings are part of somaesthetic attention, but they are not handled as inner representations of internal aspects but as a result of the interaction with the environment—in this case, the care situation. Metaphorically, Shusterman (2006) writes that our eyes are naturally looking out toward the world, not into our innerness. Somaesthetic awareness involves seriously taking the impressions of a (care) situation and perceiving bodily reactions without devaluating these impressions. However, it is challenging, as Shusterman (2006) claims, that we tend to cultivate moral rationality against the "brute flesh of the body." Dewey (1934) points out the following:

> *We undergo sensations as mechanical stimuli or as irritated stimulations, without having a sense of the reality that is in them and behind them…. We see without feeling; we hear, but only a second-hand report, second hand because not reinforced by vision. We touch, but the contact remains tangential because it does not fuse with qualities of senses that go beyond the surface. We use the senses to arouse passion but not to fulfill the interest of insight.* (p. 21)

"The interest of insight" is the potential to go beyond the surface, but this is not understood as a psychodynamic or subconscious surface. Dewey discusses the value of exploring the potentials in aesthetic experiences to give insights into what is going on in a shared situation. This means going beyond the surface of an impression of a situation and taking seriously the impulse that triggers aesthetic appreciation (Shusterman, 1999). It is the inward part of experiencing, the intaking and impression that resonates with our individual (and shared) world of experiences. "Taking in" is having an experience, the passive, surrendering, or undergoing of an experience, while "giving out" is the active process of doing and expressing. Therefore, expressing is a word for the outward consequence: the outgiving (Dewey, 1934). This perception centers the body as the basic, yet necessary, instrument of human performance, perception, action, and thought–a tool of tools (Shusterman, 2006).

Somaesthetic attunement as an offset for reflection and co-creation

However, even though Shusterman builds the notion of somaesthetics on Dewey's theory of experience and aesthetics, he also raises criticisms of parts of Dewey's understanding. One part regards the emphasis Dewey places on the non-discursive and immediate quality of experience as unifying and fundamental in itself for our thinking. Instead, Shusterman (1994) emphasizes the role of the immediate experience, not as the foundation but as a means for the reorganization of experience and for thinking. The controlling criterion is how the quality of the immediate experience functions to bring into consideration what can be thought about and done in a situation to create better coordination and integration (Shusterman, 1994). In other words, Shusterman's critique of Dewey is that the immediate experience is not, by its mere appearance, the foundation of thinking but rather that it works as a trigger for reflection. It is through noticing the experiential quality and consciously reflecting on it that thinking is improved (Shusterman, 1994). Aesthetic quality gives the immediate experiences a degree of expressiveness (as *an* experience) (Dewey, 1934) that can create impressions for the experiencing actor, the receiver. The expression then forms a materiality (an expressive object) (Dewey, 1934) that the receiver aesthetically can appreciate and that, if fostered, can initiate reflexivity. However, it needs to be cultivated, a point that Shusterman (1994) seems to believe is understated by Dewey.

Through my reading of "Art as Experience," I have noticed a part of Dewey's theory of aesthetics that I, by now, still have not found to be well elaborated by Dewey scholars. My concern is to understand the notion of "co-creation" that I find underlying and often implicit in much of Dewey's work. From this point, I will argue for somaesthetic attunement as an offset for co-creation, that is, joint creation, elaboration, and, if taken seriously, inquiry of somaesthetic experiences. I agree with Shusterman's critiques that Dewey elsewhere (e.g., in his works "How We Think" and "Logics") downplays the function of aesthetics in experience as a trigger for reflection. However, inspired by the way Dewey (1934) describes the subtle social and artful process of creation and re-creation entangled in experience, I apply the notion of "co-creation." The idea is to understand more of the transformative entanglement of impressions and expressions in experiences—in this case, in care work experiences. The notion of co-creation underlines that individuals and practices are not final, definite constructions but that they are created in continuous social processes as artifacts by creators and receivers (Dewey, 1934). Care workers must ask themselves what elements experienced in the care situation resonate with their experiences. In undergoing the expressiveness of the situation, in other words, by establishing a reflexive standing to it, the situation and relation are merged into a continuous whole. As Dewey (1934) points out, this is an "intertwined interaction that reorganizes our prior experience while it as well reorganizes the expressiveness of the object" (p. 108). The entangled interaction gives rise to something that is more than the interacting actors in isolation. The fine texture in interactions is the result of the co-creation of creators and receivers of the practices that function as expressive objects (Dewey, 1934). In this creative process, the care worker and elderly take turns acting as the creator of expressions that serve as impressions for the other and as the receiver that carefully appreciates the expressions of the other. It is a joint accomplishment in which they share an interest in securing the flow of communication (Dewey, 1934). The co-creation of care work requires, on the one hand, the capacity to contribute with adequate expressions and, on the other hand, to take in and appreciate the impressions made: "Constant observation is, of course, necessary for the maker while he is producing." (Dewey, 1934, p. 49). In care work, care workers (as the makers/creators) embody the attitudes of the elderly (the receiver) while they work (produce care responses), and vice versa. As I will now analyze, departing from a small

care work narrative, this entails that care workers pose themselves as recipients and appreciate how their expressions can be experienced.

The narrative: A care situation

In the care situation, I followed Anne, a care worker in a nursing home. I had previously met Anne as she took part in a series of workshops with stakeholders of elderly care I had held as part of my doctoral study. This morning, Anne was working with two colleagues on the second floor of the nursing home, which houses eight elderly residents. She was about to begin her third visit this morning at Karen's place. Karen needed help getting through her morning routine before taking her breakfast in the common dining room. There was, in fact, nothing extraordinary about this situation. However, it met the criteria of the study's analytic strategy because it had the ability to foster impressions and reflections about the embodied nature of care work and, specifically, about the body in care work as a locus for aesthetic appreciation, making it possible to analyze care practice as aesthetic co-creation. The narrative is as follows:

> *Anne knocks on the door at Karen's place. "Good morning, Karen," she says as she enters Karen's bedroom. Karen is still in bed. "Have you slept well? You are sleeping in such a fine blouse," Anne continues. Karen points toward the wardrobe. "There are…," she says, without completing the sentence. Anne follows with her eyes the direction of Karen's hand movements, which seem to fulfill her expression. "Yes, I did the laundry yesterday. You have plenty of clean clothes. There are clean panties and all. They probably haven't arrived from the laundry room yet." Karen sighs, "Oh, how lovely." Anne goes to the bathroom next door. The sliding doors are open. As she walks in, she says out loud, "I will get the things ready. Will you be having a bath today?" Karen replies, "Yes, I will." Anne places a transfer tower in front of Karen and says, "Now, you have to move your legs out." Karen sighs heavily and tries to move her body. Anne supports her legs as Karen manages to swing her legs off the edge of the bed. Anne says, "Good. Now, you need to place your left arm on the platform. I will raise the bed a bit." Karen sighs and pulls herself up slowly in a standing position, leaning on the transfer tower for a while. Anne helps Karen undress. She pushes a bathing chair in position behind Karen and asks her to sit. Karen sinks heavily into the chair, and Anne moves the chair to the shower. She turns on the shower and wets Karen's hair and body. "Now, tell me if the water is too cold or hot." Karen sighs. Anne washes her hair. "It foams well. You will only need one lap." Karen sighs, "Oh, how lovely," and closes her eyes. Anne washes her body. Karen helps by raising her arms one by one. Anne says, "This is good teamwork, Karen." Karen sighs. Anne says, "I need to get you a new bag [stoma] and a new bandage for your hip wound."*

This narrative illustrates an everyday care situation in which the care worker and the elderly need to cooperate and communicate with the elderly to get out of bed and be ready for breakfast. The situation shows a care situation in which the professional care worker supports the elderly. For the care worker, it is a work task, and for the elderly, it is a daily life accomplishment that she previously managed on her own. It is an ordinary care situation that positions the elderly as care recipients and the care worker as caregivers. However, a micro-communicative analysis with emphasis on bodily communication illustrates that the actors are not maintained in positions

exclusively as caregivers and care receivers because they fluently shift positions as creators and receivers several times during the course of action in a co-creative and bodily aesthetic process. This perspective makes possible an analysis of the interaction between the care worker, the elderly, their bodies, and the morning routine as an aesthetic co-creative inquiry and helps to understand more the dimensions of sensuousness, imagination, and reflection, which are at stake in the care situation.

The morning task—getting up, having a bath, and getting dressed—is a concrete task to deal with in collaboration with Anne, the care worker, and Karen, the elderly. Handling this task is not merely a cognitive and intellectual affair but is also a sensuous, emotionally, creative, and imaginative affair (Dewey, 1934). Therefore, the situation requires more than practical and technical skills. Anne needs more than knowledge of how to transfer a body to different positions; she also needs to know how to communicate bodily and emotionally with Karen in order for her to participate in the processes of the body's transfer. Anne takes the position of Karen to help her move her leg out of bed and get up standing. How would Karen experience it? How can Anne support Karen's response? The impressions that the situation creates are decisive for the outcome of the situation and for the quality of the task solution. Taking in the appropriate impressions requires Anne to be profoundly present in the situation. However, there is a lot for Anne to be attentive to if she is to succeed with the bath. What is the current state of the elderly mentally and in terms of their health status? How was her sleep? Is she awake and ready for the day? Will she collaborate mentally and physically in getting out of bed? Will she understand her guidance? Will she agree on the terms of the tasks?

This situation shows that Karen's verbal abilities are limited. She answers with one-syllable words, sounds, simple and short sentences, and gestures. As most of the communication is based on sounds, glances, and touching, Anne is left with very little verbal response to guide her (re) actions. Shusterman (2006) gives the following example of how the body's position and status are at work and, thus, how delicate communication is:

> *I need to be aware of my own body positioning and breathing, the tension in my hands and other body parts, and the quality of contact my feet have with the floor in order to be in the best condition to assess the client's body tension, muscle tonus, and ease of movement and to move him in the most effective way. Otherwise, when I touch him, I will be passing on to him my feelings of somatic tension and unease* (p. 15).

The care worker's assessment of the status of both the elderly and herself provides her with data to analyze how to react adequately. Anne must practice this subtle and highly bodily-based means of communication for her to attend to Karen's needs and communicative intentions and to her own bodily resonance. Therefore, if Karen is to experience herself as a part of the communication, Anne must communicate in a language other than strictly verbal. The art for Anne is to expand her bodily responsiveness and ability to listen to the body in a sensitive and slower bodily presence, which is called forth by the specific situation. Anne has to listen well to act adequately. Aesthetic appreciation is a here-and-now matter. Anne cannot prepare for what will happen as the somaesthetic meeting emerges in an instant in care work. To meet Karen, Anne has to seize the present moment, which emerges as an opportunity. She needs to experiment with how she can somaesthetically support Karen's participation and the fulfillment of the work task by means of the body as a locus of aesthetic appreciation (Shusterman, 2006) of Karen's expressions and her own impressions.

The co-creative practice is also about the production of expressions, as it is about impressions: "To define an impression signifies a good deal more than just to utter it. Impressions, total qualitative unanalyzed effects that things and events make upon us, are the antecedents and beginning of all judgments" (Dewey, 1934, p. 317). Dewey's point is that available data are signs to appreciate, analyze, and value to form adequate responses to a situation—in this case, the performance of "caring care." Appreciation entails the capacity to take in the immediate experience and reflect the impression to give out in adequate ways that ensure the enrichment of experiences (Dewey, 1934; Shusterman, 2006). Through their communication, the situation takes the form of a joint social matter—they need to work together to get out of bed and complete the bath. Communication is a bodily and sensuous—somaesthetic—matter (Shusterman, 2006), in which they need to adjust themselves to each other's bodily reactions. Karen utters a short, interrupted sentence, "There are...," which does not say much. However, aligned with Karen's bodily gesture as she points toward the closet, Anne seems to fulfill the sentence in her head and to understand the intention: "There are no more clean clothes in the closet." Taking Karen's perspective, the care worker learns how to interpret Karen's verbal and bodily expressions into impressions and how to transform and give back these impressions in adequate outgivings (Dewey, 1934) that align or challenge Karen's capacity to participate and communicate. Rather than rejecting the body as unreliable because of its sensory grounding, the somatic awareness of the care worker is cultivated, and the functional performance of the senses is improved (Shusterman, 2006). The situation shows Anne the potential to improve how to register the elderly's communicative intentions and how to communicate in order for Karen to participate. Anne has the choice to highlight and reinforce Karen's bodily expressions or to ignore and prevent herself from being understandable. Therefore, taking care of a care situation sees the need for an appreciative action in which the care worker analyzes the available data, her own impressions, and the situation as a whole and takes actions on behalf of this analysis (Dewey, 1934). The care worker takes the available data seriously as potential resources to learn more about the elderly, herself, the care situation, and her course of actions within it. Conversely, Karen can learn how she—with her available resources—can make her wishes and needs perceptible and how she can take in—*or* reject—the care worker's attempts to assist her. These back and forth switches illustrate the social and experimental processes I describe as co-creation that I see unfolding in everyday care practices, with the actors as creators of expressions and perceivers of impressions. By analyzing Karen's movement with her hand and her half-sentence as an expression of "no more clothes," Anne recreates her impression dramatically to a new representation as an expressive object (Dewey, 1934). Karen's uttering forms an expressive object that Anne recreates into another representation based on Karen's expression and re-created into a new form (an expressive object) to which Karen, again, can react. Through these means, Anne opens up an active and creative interaction with what is and what is about to happen in the situation (Dewey, 1934). Anne's somaesthetic experience of the embodied nuances and qualities of the situation expands her interpretation of the world, which, as Shusterman (2006) points out, is Karen's needs and experiences and how Anne can support and steer the care situation in a fruitful direction. For a moment, Anne acts as a receiver who analyzes the situation (nice blouse, hand, closet) to determine the missing laundry and Karen's need for clean clothes. Aesthetic appreciation creates a potential co-creative space for learning in which both can act as creators and receivers (Dewey, 1934)—in this case, "the good bath." However, Anne has to try out actions to analyze from Karen's reactions what impression her actions make. Karen seems satisfied with Anne's representation, and the morning routine can continue. However, the bodily sensation may have been too vague for Anne to acknowledge or for her to use as a material for interpretation, and Karen could have also rejected Anne's representation.

Discussion

This study analyzes a single care situation as an aesthetic co-creative inquiry that takes the form of the interactions between two involved actors and the task joining them. In the following, I will discuss aesthetic co-creative inquiry as a potential process of learning, how somaesthetic capacity must be developed as part of a caring habit, and how attention to the body as a locus for aesthetic appreciation is crucial for care workers to acknowledge subtle forms of power within care situations. I reflect on how this pragmatic approach differs and brings in other aspects to consider, aside from the phenomenological perspective on the body in care work. Finally, I discuss the strengths and weaknesses of my study.

Learning how to care

As stated in the introduction that care cannot be fully understood if the embodied dimensions are unattended (Hamington, 2004) and that learning how to care is a highly somatic affair (Twigg, 2000), this study stresses that somaesthetic attention can function as a means for reflection, a trigger for learning. This attention can enhance the embodied sensible knowing in care work that is collectively deployed (Gherardi & Rodeschini, 2016). Like any knowledge, caring can be developed into an embodied capacity to practice the body's caring knowledge into caring habits (Hamington, 2004). It is imperative for the quality of care work that care workers learn to undergo the sense of uncertainty they experience in emerging care situations about how to interpret (take in impressions) and react (give out expressions) appropriately. Noddings (2012) defines the ethics of care as the mutual recognition and appreciation of responses that serve to further construct a caring relation in receptive attention and empathy. Emphasizing responsiveness and receptiveness in caring helps to acknowledge the kinds of bodywork that draw attention to central aspects, often overlooked and understudied, in care relations and communication.

The sense of uncertainty turns the perspective of learning from one focusing on solving problems (e.g., learning how to help the elderly with their morning bath) to another focusing on how the care worker is experientially (bodily, emotionally, and intellectually) entangled with the life of the elderly and the care work. Focusing on the uncertainty—or the "mystery" of the entanglement (Gherardi, 1999)—helps to acknowledge care workers as integrally connected with others as co-constructors (and co-appreciators) of the narratives of life (and care work). This perspective of learning (in entangled somaesthetic experiences) helps to question the contributions of the care worker to the development of shared activities in a material world of increasing interdependence (Gherardi, 1999). This means that acknowledging the dimensions of the body as the locus of aesthetic appreciation is a matter of attending to how the (re)actions of the care worker are part of a greater whole (Gherardi, 1999), involving the quality of life of the elderly and of the work of the care worker.

These considerations are derived from socio-material and pragmatic stances that differ from an existential–phenomenological stance to the body in care work (e.g., van Manen, 1998; Herholdt-Lomholdt, 2019). These approaches distinguish themselves from pragmatism by arguing an understanding of aesthetics not as a way of knowing but as a way of being and seeing what is beyond everyday experiences and within it as a surplus of meaning (Herholdt-Lomholdt, 2019). The set-offs are similar: care workers and the elderly are under a shared impression of an unfolding phenomenon and together share an experience. However, how the care workers' reflection of the situation is triggered (i.e., how they learn from it) differs depending on whether the stand is pragmatic or existential. From a pragmatic standpoint, I

argue for an offset in the uncertainty caused by the enactment in a care situation, whereas the existential–phenomenological viewpoint argues for a wonder-driven approach to ethical and existential dimensions (Herholdt-Lomholdt & Hansen, 2016). Emphasizing ontological-based meaningfulness, existential philosophy criticizes the pragmatic epistemology of practice for being driven by problem solving. However, somaesthetics requires aesthetic reflexivity (Shusterman, 1999), not just cognitive problem-solving skills (Gherardi, 1999). The way Shusterman and Dewey see aesthetic philosophical practice can be used as a way of qualifying care practice as aesthetic co-creation. Dealing with the uncertainty that is emerging in the interactions in care situations, in which doubt, hope, power, and vulnerability are at stake, is to train people to become more caring and aesthetically attentive to the embodied situations in care work and in life in general. Based on this pragmatic perspective, somaesthetics is about experiencing, reflecting, expressing, and enacting what is known and experienced.

Symbolic power and caring culture

If the somaesthetic dimensions of care work are left unattended, there is a risk of not taking into consideration the expressions of power in care work. The power that is entangled in care work is embedded symbolically and is invisible in the caregivers' helping actions toward the elderly (Järvinen & Mortensen, 2002). As a consequence, symbolic power is seldom acknowledged as power. For most, help is given with goodwill. However, for this reason, it can be difficult for the receiver to reject help. The receiver has to show gratitude lest she be considered rude and ungrateful, even though the help may not be what she wished for (Järvinen & Mortensen, 2002). The power is in a twilight zone, where it is challenging to get a hold of because it is interwoven in help and goodwill (Järvinen & Mortensen, 2002). The power is to define, declare, and decide on behalf of the elderly and to act and react to impressions. The care worker may think that she knows what the elderly feel and how to react to the needs of the elderly, but if the person's experience of what happens differs from the care worker's intention, then the intention is to be suspended in favor of the experience of the elderly (Van Manen, 1998). To acknowledge the symbolic power in care work is to attend to the fine-lined somaesthetic appreciation, in which the wishes and needs of the elderly are interpreted (*or* not), and the (re)actions of help are shaped.

Moreover, attention must be paid to structural power in the ways care services are organized and the degree to which care workers are offered spaces and tools to learn how to appreciate the bodily aspects of care work. (Organizational) learning is inherent in the process of creating and using knowledge while organizing (Gherardi, 1999). Therefore, if care practice is organized in ways that restrict the co-creative inquiry, the somaesthetic aspects will remain silent, the symbolic power will be invisible, and the care workers' ability to support the participation and wellbeing of the elderly will be limited. Attention must then be paid to organizational structures and caring cultures that enable language, values, social institutions, and artistic media for the actors to think, act, and express themselves aesthetically (Shusterman, 2006). A care culture requires somaesthetic awareness and reflexivity, spaces, and tools to consider the body as a central locus for aesthetic appreciation.

Strengths and weaknesses of the study

Shadowing the phenomenon of learning in this study did not initially entail a specific focus on bodywork in care work. This dimension became apparent through the analysis of the shadowing activities. Consequently, and in accordance with mystery-driven research (Alvesson

& Kärreman, 2007), the empirical data qualified the theoretical development, as the analysis stressed the importance of somaesthetics in care work and learning. However, as this analysis was conducted after I left the field, the study did not realize the full potential of shadowing as an in situ analytic method in which care workers take part in in-the-moment interpretations (Buchan & Simpson, 2020). This can be considered an inconsistency of the study, as the findings of the analysis are not validated or qualified in practice.

This study's micro-narrative focus on a singular care situation has strengths and weaknesses. One strength is the possibility of conducting an in-depth analysis of a "small story" (Bamberg & Georgakopoulou, 2008), which helps to understand more of the subtle somaesthetic dimensions in care work. One weakness is that a singular situation as a small sample can never represent care work in all its variations as an organizational practice consisting of myriads of care situations related to organizational structures. Another consideration is how the situation is selected and constructed as a narrative (Czarniawska, 2004). The situation is not a story told by a care worker or collected by a researcher. Instead, it is expressed by a researcher as it made an impression while experienced *and* in order to show a certain theoretical thesis—care work is bodywork in more subtle forms than just being "dirty" bodywork with fluids and decay. This study shows that bodywork is about the art of communication. One can question whether the narrative is a correct presentation of reality. However, from a pragmatic standpoint, there is no correct version of reality to present. From the theoretical stand of this paper, there is a somaesthetic appreciation of *any* perceiver, but if handled reflexively, these impressions can be shaped into figurations that say something about what is going on in the world and the nature of experience (Dewey, 1934).

Conclusion

This study approaches the study of care work as bodywork using an analytical lens with emphasis on the somaesthetic dimension of the body as a locus for aesthetic appreciation and thus for communication and learning between care workers and the elderly. Drawing on Dewey's theory of aesthetics, Shusterman's notion of somaesthetics, and the added notion of co-creation in a micro-analysis of an everyday care situation from elderly care, this study shows how care workers and the elderly act as creators and receivers in an aesthetic co-creative process. To secure the future quality of care situations with hopefully richer experiences, the care worker must step in a position as a receiver who sensibly and aesthetically appreciates what is at stake and what happens as a result of actions. Therefore, this study stresses the importance of establishing a caring culture that emphasizes somaesthetic awareness and reflexivity and enables spaces and tools to deal with uncertainty in care work. This entails analyzing the subtle forms of power that are at stake in care relations and organizational structures.

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Somaesthetics in early Korean history: The educational scope of the *hwarang*

Jiyun Bae

Abstract: *This paper is concerned with first, reviewing hwarang in early Korean history through the eyes of somaesthetics and second examining the educational implications of hwarang. Hwarang's features (aesthetic ideology called pungryudo, their core activities, including songs and journeys) are highlighted from the perspective of somaesthetics. At the core of the hwarang's activities are such elements as entertainment, pleasure, and joy. In the context of today's education, the hwarang and somaesthetics promote the insight that one's intellectual and practical life is integrated into one's lifestyle based on these bodily experiences.*

1. Introduction

Somaesthetics and education are in a pull-and-push relationship. For example, when systemized and programmed in a curriculum, somaesthetics may present a normalized and standardized means of achieving self-awareness and self-cultivation. However, both have the same structure in that they are only possible in relationships with others or with the environment, even though bodily self-awareness is central to somaesthetics. What would happen if somaesthetics were constructed as an educational, political, or social system? History may give us a glimpse.

This paper aims to examine the educational significance of *hwarang*, a system involving groups of young men in early Korean history, from the perspective of somaesthetics, so that we can envision the relationship between somaesthetics and education.

Somaesthetics is an attempt to expand the academic base of aesthetics to interdisciplinary studies and practices. Shusterman adopted some pre-modern undifferentiated Asian cultural ideas and practices as embodiments of somaesthetics, including Confucianism from China (2004), sitting meditation (*zazen*) from Japan (2012, Chapter 13), and sexual aesthetics from India (2012, Chapter 12). For example, unlike with hedonism, Shusterman discovered intrinsic value, totality, and divinity in sexual experiences based on Indian classical theory. Hence, I recognize the art, comprehensiveness, and sacredness of *hwarang*, and in this research, I explore its significance to contemporary education.

Some features of somaesthetics are found in *hwarang* practice. Bodily activities (e.g., dance, singing, performance, martial arts, travel, and pilgrimage) are the disciplines that are the most significant to the *hwarang*. Enjoying engaging in, playing during, and deriving entertainment

from those activities are essential missions and synonyms or beyond for studying, working, or disciplining in modern connotations. The ideology underlying the *hwarang* ideology is *pungryudo*, the way of the stream of wind, which means to play or live in the present moment. The *hwarang* selection criterion of a "beautiful person" and their *pungryudo* spirit reveal an aesthetic ideology from early Korea.

Lastly, I aim to reconsider the educational significance of the *hwarang*. In the context of education in Korea, the *hwarang* have been repeatedly highlighted throughout the years and included in textbooks on history, ethics, the Korean language, and social studies as a symbol of the Korean ethnic identity, as well as of Korean patriotism, bravery, and sacrifice. In the field of education, the *hwarang* have long been referenced as a model of how to educate people to be harmonious and whole. From the viewpoint of contemporary education, many studies have considered the *hwarang* to be an ideal from which current educators should learn and integrate their knowledge, virtues, and physicality into the current educational system. However, instead of advocating adoption of the *hwarang* as an excellent educational model, I explore the educational aspects and the implications of their somaesthetics of beauty, pleasure, enjoyment, and play.

2. The *Hwarang* and Their Core Activities

The term *hwarang* refers to groups of young men and group leaders during the Kingdom of Silla (57 B.C.–935 A.D.) on the Korean peninsula. The leaders, known as *hwarang*, were usually aristocrats, and the members, known as *nangdo*, were from various social classes. Most were teenagers who banded together for religious, military, political, and/or educational purposes. The *hwarang* became part of the state system during King Chinhung's reign (540–577); the groups' features, appearance, and origins before that time are uncertain. The scope of arguments regarding the identity of the *hwarang* varies: a youth corps for wars, religious groups for conducting rituals, young talent for selection by the state, ethical role models of the age, or an educational organization. As Silla underwent dynamic transformations, the *hwarang* likewise experienced changes in their functions and characteristics. The *hwarang* originated in relationships in the context of tribal states' ritual activities before the rise of the Kingdom of Silla. Subsequently, Silla exploited the *hwarang* to support centralized governmental authority to compete with two other kingdoms during the Three Kingdoms period (in the sixth and seventh centuries).

Two vital historical records, *Samguk Sagi* and *Samguk Yusa*,[1] elucidate the origins of and outline the *hwarang*. Neither document is a contemporary source, as both were written during the Goryeo Dynasty, which appeared after the fall of unified Silla.

> *[T]hey then selected a handsome boy and adorned him, calling him* Hwarang*, to uphold him [as a leader]. Followers gathered like clouds, sometimes to refine each other's sense of morality and honesty (相磨道義), sometimes to enjoy collectively music and song (相悅歌樂), and to train in and appreciate mountains and streams (遊娛山水), going far and wide. Because of this, they knew if a man was corrupt or honest and selected those who were good and recommended them to the court. Thus[,] Kim Taemun, in the* Hwarang Segi*, wrote, "Wise advisers and loyal*

1 *Samguk Sagi* (*History of the Three Kingdoms*) was written by Kim Pusik (1075–1151), the official scholar of the Goryeo Dynasty, and is an orthodox history of the Confucian position. *Samguk Yusa* (*Memorabilia of the Three Kingdoms*), written by the Buddhist monk Ilyon (1206–1289), contains more descriptions of Buddhist concepts, myths, and daily life. In this paper, I refer to Ilyon (2013) and Kim (2012a) as translations of these texts into modern Korean. For the English translation, I refer to Ilyon (2006) and Kim (2012b). I modified some English translations as needed.

> *subjects excelled from this. Outstanding generals and brave soldiers were produced from this.*" (Kim, 2012b, pp. 130–131)

The above passage notes the three core missions of the *hwarang*: to refine members' morality, enjoy singing and music, and engage in sightseeing in nature. Ahn (2004), a Korean pedagogist, has labelled these the curriculum of *hwarang* education. Each is understood as comprising an ethical and moral education, as well as an emotional education through the arts, and the cultivation of the body and mind. This understanding shows respect for the *hwarang* as a symbolic and traditional Korean model of harmonious education that integrates letters with arms and emotion with reason.

2.1. The Songs and Music of the *Hwarang*

Songs and music have rhythm, melody, and lyrics rooted in the bodily dimension. The songs of the *hwarang*, as the primary musical form, have complex related dimensions of ritual, *hyangga* (rural or Silla songs), and knowledge.

The songs and music of the time imply primitive ritual aspects, as they were performed during feasts and rituals. A foreign historian has found them worthy of special mention. Moreover, the Chinese historical document *Hou Han Shu* (*Book of the Later Han*), features drinking, singing, dancing, and entertainment during rituals in The Three Han, formerly the kingdoms of Silla.

> *In the area of Mahan state, every year after the farming work of May, they celebrate with spirits, singing, dancing, and drinking all through the day and night. Dozens of people in the village come together and stamp their feet to beat a rhythm for the dance. The festival is held in October as well when farming is complete. The people of Jinhan state preferred to sing, dance, and drink.* (Min, 1997, p. 33)

In Silla, a successor to the Three Han States, *palgwanhoe*[2] (the Buddhist Festival of Eight Vows) was the most important ritual, and the *hwarang* played a significant role in it, performing, it is assumed, a combination of music, singing, dance, plays, games, and martial arts (Choi, 2016). It has also been assumed that the Silla people gathered to enjoy the performances the *hwarang* created, organized, and presented. The primitive ritual aspect of *hwarang* music encompassed singing, dancing, eating, drinking, shouting, chanting, and group movements (e.g., people stamping their feet). Through enjoyment of these ritualized bodily movements, the *hwarang* provided the Silla people with an aesthetic experience, brought them joy, and brought them closer to the spirit of god.

Secondly, *hwarang* song, *hyangga*, a genre of poetry in Korean literature from the Silla era, illuminates the capability of the *hwarang* as creators or songwriters. A Silla monk with membership to the *hwarang*, Wolmyeong, said, "I only know *hyangga* because I belong to the group of *guksun* [another name for the *hwarang*] and am unfamiliar with Buddhist songs." Only fourteen *hyangga* are extant, and the themes vary from religious and shamanistic to emotional and practical. Since songs are seamlessly embedded into people's lives through their grounding in the bodily dimension, *hyangga* was a powerful tool for consolidating the ideas, ethics, and emotions of the time. Even the king encouraged the *hwarang* to compose *hyangga* and made it one of their significant roles. As *hyangga* were widely sung and shared among the people of the

2 *Palgwanhoe* is a religious ritual that combines indigenous religions' harvest ceremony and the Buddhist Eight Vows ceremony, which was held for the first time during King Chinhung's reign, during which the *hwarang* were officially sanctioned. The ritual was held once per year for seven days, and the tradition passed into the following dynasty, the Goryeo, even after the fall of Silla.

kingdom, the artistic talent of the *hwarang* and their status as artistic creators must have been exalted.

Lastly, the emphasis on songs and music implies that the *hwarang* possessed literary knowledge. The *hyangga* of the *hwarang* are ten-line poems, a highly-developed structure, written using Chinese characters, while other forms, namely four- and eight-line *hyangga*, were transmitted orally. When Silla initiated diplomatic relations with China in the sixth century, which was less advanced than Baekje and Goguryeo (the two other kingdoms on the Korean peninsula), there was strong demand for but short supply of intellectuals proficient in Chinese and Confucian classics. Although Silla had its own writing system called *hyangchal*, an adaptation of Chinese characters to transcribe the local Silla language, more advanced knowledge of Chinese was needed. According to Hamada (2002, pp. 98–101), the student monks of Silla who traveled to China became or taught *hwarang* when they returned home, which partly explains why the *hwarang* were able to compose ten-line *hyangga*.

2.2. Journeys of the *Hwarang*

Referring to Lee (2014), the agenda for and memorable aspects of the journeys of the *hwarang* reported in the records can be summarized as follows: to be initiated into the mysteries of the mountain spirit to overcome crises in the kingdom, train in swordsmanship, spy, have mystical experiences, hold religious ceremonies, hunt, sightsee, perform merciful acts toward poor filial girls, and compose songs and poems to dedicate to the king. On some journeys, they were, by happenstance, captured by barbarians but saved by other *hwarang*, or they experienced a supernatural phenomenon and composed a song about it, or retired from secular society to begin ascetic practice. Generally, journeys connote breaking away from one's daily routine, refreshing oneself, indulging in leisure, attending special events, and undergoing personal growth. Further, the journeys of the *hwarang* included self-cultivation (修行) and practicality.

We must delve into the meaning of "play" or "travel" (遊, *yu*) in order to grasp the self-cultivation aspect of the journeys of the *hwarang*. Lee (2014) asserted that usage of *yu* in Silla entailed more than mere playful amusement and supported this argument by referring to the synonymous usage of *yu* and "self-cultivate" in historical documents.

> • Kim Heumun, when he was young, *played* (遊) in a *hwarang* group.
>
> • Kim Yushin said to Yeolgi, "When I was young, I *played* (遊) with you, so I am very familiar with your constancy and integrity."
>
> • Gumgun says that I belonged to Geunrang's disciples and practiced self-cultivation (修行) in the garden of *pungwol* [another name for the *hwarang*]. (Lee, 2014, pp. 19–21)

"Play" or "travel" and "self-cultivation" are synonymous in the above contexts. We need to understand the notion of "play" or "travel" comprehensively, as encompassing amusement, training, cultivation, prayer, cooperation, and study. In modern Korean, *yuhak* (遊学), meaning to study in a faraway land, contains vestiges of the notion's complexity.

Physical training during journeys was a significant feature of the self-cultivation aspect. Kim Yushin, a *hwarang*-turned-general who led the victory of Silla in the Unification War, was a well-known master of fencing. His journeys in the mountains involved intensive sword training and mystical experiences that helped him acquire power. Contrary to the biased general sense

of *hwarang* as military groups, the military aspects of the journeys of the *hwarang* are neither primarily typical nor conventional (Tikhonov, 1998). Nevertheless, their journeys comprised hunting, martial arts training, and/or reconnoitering.

Some journeys are indicative of the religious or spiritual side of self-cultivation. Two *hwarang*, Bochun and Hyomyung, led thousands of followers on a journey to enjoy the beauty of the mountains. En route, the two disappeared, leaving the secular world to escape to a sacred mountain. Afterward, they began studying Buddhism, made tea to offer to the Buddhas, and prayed and meditated in a temple, a hermitage, and on the mountain peak. This example allows us to envision the spiritual self-cultivation of the *hwarang* during their journeys. They worshiped the natural objects they encountered (e.g., trees, rocks, and the mountain peak as a hierophany of the Buddha), presented offerings in temples or before statues, meditated, and studied nature. Aside from their patriotic and notable religious pursuits, the religious self-cultivation of the *hwarang*, such as purification, praying, chanting, offering tea, and meditation, would have had a practical somaesthetics impact on their bodily senses and consciousness; for instance, their bodily consciousness would have become more refined, their consciousness would have sharpened, and their daily lives would have been enhanced by aesthetical enrichment.

Additionally, the complex meaning of "play" in the mountains and streams included intellectuality and practicality. The existence of monk *hwarang* and their destinations on their journeys support this. Around the sixth century, monks were intelligentsia who actively accepted the influence of Chinese ideas and culture through Buddhism. According to Lee (2014, p. 29), the monks were involved in the education of the *hwarang* in the role of conveying advanced knowledge. On many of their journeys to the temples, monks accompanied the *hwarang*, so it is reasonable to believe that the *hwarang* encountered refined Chinese culture during these journeys.

The *hwarang* were greatly admired during their heyday. Their journeys to the mountains and generally into nature, which had a mystical and sacred meaning, secured their prestige. Journeys were a powerful opportunity to enhance their spiritual presence and political position.

3. *Pungryudo*: The Dao of Elegance

3.1. *Pungryudo*

The symbolic significance of the *hwarang* and their core activities or missions involving songs and journeys should all be seen as reflecting *pungryudo*, the aesthetic ideology. *Pungryudo* (風流道, the way of *pungryu*) refers to the principle held by or thoughts of the *hwarang* in the Silla era. *Pungryu* (風流) remains in modern Korea as well as in China and Japan. In modern Korean, *pungryu* signifies a tasteful and free-spirited lifestyle and appreciation for art and the environment. It also refers to the specific genre or title of Korean traditional music. On the other hand, according to the historical records, *pungryu* in the Silla era was a somewhat mysterious yet normative idea that combines three traditions.

> *Our country has a mysterious principle called* pungryu. *The origin of this teaching can be found in detail in the history of the* hwarang *and, in fact, includes the three teachings that transform people when exposed to them. [The idea of] "at home [be] filial to your family, outside the home [be] loyal to the state" is taught by the Minister of Punishments in Lu [Confucius]. "Following the doctrine of inaction and*

> *the practice of teaching without words" is the principle of the scribe of Zhou Taoism [Lao Tzu]. "Refraining from doing anything evil and to practice reverentially everything good," this is the teaching of the prince of India [Buddha].* (Kim, 2012b, p. 131)

It seems that *pungryudo* was a harmonious mixture of Confucianism, Buddhism, and Taoism that provided practical agendas (e.g., loyalty, filial piety, trust, non-action, and respect for life) for the *hwarang* and society. However, these explanations were scripted during the Goryeo Dynasty when the three teachings were established solidly enough, and Silla *pungryudo* disappeared. In the early Silla period, when organization of the *hwarang* system began, the three teachings were gradually recognized in Silla,[3] and it can be argued that *pungryudo* derived from these three teachings. It is appropriate to view *pungryudo* as a traditional Silla ideology and as a mixture of indigenous beliefs, such as Shamanism and the Maitreya cult, with the three religions. *Pungryudo* represented the idea of an aesthetic and desirable lifestyle.

3.2. The Aesthetics of *Pungryudo*

Pungryudo, as its name indicates, originated in *pungryu*, China's traditional aesthetics, and later spread to Korea and Japan. *Pungryudo* was the core thought and value that the *hwarang* were meant to pursue. The normative aspect of *pungryudo* has been emphasized because of the prevailing understanding of the *hwarang* from the viewpoint of the modern educational context. However, as the selection criterion of the *hwarang*—a beautiful person—shows, *pungryudo* was more aesthetics beyond ethical norms.

Min (1997) has argued that *pungryu* (Ch. Fengliu, Jp. Furyu) is an East Asian primary classical aesthetic concept that still exists today. It originated in China no later than the second century B.C. and applies to a wide range of concepts, including morality, art, nature, and personality. It was subsequently adopted in Korea and Japan, where it developed differently in each context, becoming a fundamental aesthetic. The Korean sense of *pungryu* is:

> *An open-minded spirit, free from worldly values that exhibits vitality while having a relationship with reality. Nature provides an open place where freedom of the spirit is not spatially bound, and poetry, music, liquor, and entertainment are mediums for engaging such a spirit. Korean* pungryu *is a way of behaving and a way of life with an aesthetic and ethical character.* (Min, 1997, p. 9)

Min noted that *pungryu* was a methodological concept, asserting that it had practical applications, such as in politics, social relations, literature, arts, entertainment, sexuality, and daily living, throughout Korean history. According to Min, the "enriched content of *pungryu* is nothing but the aesthetic life" (1997, p. 7).

Pungryudo is one of the significant roots of Korean *pungryu*, as it is the first that appears in historical records in which the beauty of the *hwarang* is noted as a central feature of *pungryudo*. Chosen *hwarang* and their appearance, decorum, grooming, attitude, behavior, performance, and stories set the ideal aesthetics of the time. Their beauty encompassed representational and experiential dimensions, aimed at the "completeness of the existence of a good and beautiful personality" (Min, 1997, p. 50). In somaesthetics, these two dimensions describe a variety of pragmatic disciplines (Shusterman, 2000, pp. 272–275). In representational somaesthetics,

3 In the Kingdom of Silla, Confucianism was officially accepted during King Sinmun's reign (681–692), Taoism was officialized during King Hyoso's reign (692–701), and Buddhism was established as the state religion during King Beopheung's reign (514–540).

the body's external appearance, such as fashion and cosmetic beauty, is emphasized, while in experiential somaesthetics, inner experiences, such as yoga or *zazen*, are emphasized. However, they are not strictly exclusive, and they often overlap.

The *hwarang* were literally a group of beautiful men:[4] "They selected two beautiful girls [for the *wonhwa*, which was a prototype of the *hwarang*]"; "beautiful noble boys were selected and adorned, and their faces were powdered"; and there was "a beautifully shaped person" and a "person of good virtue" (Ilyon, 2013, pp. 340–345; Kim, 2012b, pp. 131–131). Furthermore, Silla was the most fashionable of the Three Kingdoms. Many crowns, caps, earrings, necklaces, rings, and shoes made of fabric and adorned with jewels, stones, gold, and glass have been excavated, and the number and quality of these items have reached a remarkable pitch. It is imaginable that the fashion of the *hwarang* was even more splendid than that of the ordinary aristocrat. As such, the people of Silla lauded their beauty. These descriptions fit the *hwarang* ideal of a beautiful personality and the Kingdom of Silla's intentions to use the *hwarang* as symbolic leverage to strengthen their authority.

The lives of the *hwarang* reflected experiential aesthetic values such as loyalty, friendship, bravery, wisdom, belief in the supernatural, and spiritual power. For example, the *hwarang* Eungnyeom, who met thousands of people in the course of his journeys, shared with the king what he believed to be the three most impressive virtues to embody in life: simplicity, frugality, and humility (Ilyon, 2013, pp. 171–175). This is reminiscent of "non-action," which is the course of nature in Daoism. The *hwarang* Jukjirang even bribed a local official to bail a *nangdo* out of his unfair forced labor (Ilyon, 2013, pp. 146–149). The great General Sadaham released prisoners of war from a battle he won and eventually died from overwhelming sorrow at the death of a fellow *hwarang*. The Confucian values of love and humanity (*ren*) are evident in these episodes involving Jukjirang and Sadaham. Jukjirang's and Sadaham's love for their fellow *hwarang* alludes to homosexuality (Gu, 2011).[5] Two other *hwarang*, Daese and Guchil, disappeared into the mountains to pursue spiritual enlightenment (Kim, 2012b, pp. 135–136), implying Daoism values or Maitreya belief.

Individual *hwarang* had a distinctive way of life. The normative, touching, unconventional, and noble lives of individual *hwarang* might have greatly impressed the Silla people, and their life stories were handed down through the generations. *Pungryudo* aimed at both representational and experiential aesthetic ways of self-cultivation, which influenced broad fields such as politics, society, religion, arts, and daily life.

4. Educational Significance of the *Hwarang*

In the *hwarang* education system, what and how to perform life were given in holistic ways, such as through music including songs, journeys, communion with nature, pleasure, and entertainment. In that sense, meliorism, which indicates the direction of somaesthetics (the belief that humans can change the world for the better), was also shared with the *hwarang* as *pungryudo*, which taught living one's life fully in the present. This ideology guided them to comprehensively realize their

4 The word *hwarang* has two parts: "flower" (花, *hwa*) and "gentlemen" or "court attendants" (郎, *rang*) (Mohan, 2001, pp. 161–162). However, many arguments about the etymology of *hwa* have arisen. First, *hwa* is a phonetic borrowing to spell the native ancient Korean words for "purity" and "beauty" (*kol*); second, it signified a military emblem comprising decorative feathers; and third, it was a symbol of the Maitreya tradition, in which the flower has a symbolic meaning (Lee, 2000, pp. 37–40).

5 Historical records of *hwarang* homosexuality are limited to literary allusions. On the other hand, some contemporary creations in which *hwarang* appear depict their homosexual relationships. The *Hwarang Segi* manuscripts discovered in 1989 are rich in depictions of the sexual lives of the *hwarang*, including homosexuality, but these are considered highly likely to be forgeries.

representational/experiential and aesthetic/normative goals. Considering today's systematic educational goals (especially in schools), experiential and normative goals are advocated as the antipode to the representational and aesthetic dimensions. However, educational goals ought to emerge naturally from one's integrated way of life rather than in a divisive dualism. Education needs to support an integrated educational goal to holistically instruct individuals on life.

Hwarang songs and music were an integrated self-culture tool. They had practical meaning in terms of knowledge acquisition and structuring that met society's demand. It reminds us of the importance of art education as self-culture in Confucianism, in which Shusterman pointed out that music was highly appreciated as an educational method. Confucianism considered music and ritual (*li*) to be key elements for the cultivation of both the self and society. Art is not merely for satisfying personal pleasure but is "a crucial means of ethical education that can refine both the individual and society by cultivating our sense of good order and propriety while instilling an enjoyably shared experience of harmony and meaning" (Shusterman, 2004, p. 20). The role of art in modern education needs to be readdressed, as all art has a unique social background, as well as ethics, common sense, and pleasure.

Moreover, the journeys of the *hwarang* should lead us to rethink the significance of nature in education. Nature as a place for learning and playing, referred to as mountains and bodies of water, implied a wide range of meanings. It was seen as a place that encouraged aesthetic experiences and a distant place away from everyday life, given that a change in the environment to which one's body is accustomed is an efficient strategy for the impetus of enhancement through the provision of new bodily sensations, feelings, and a new consciousness. Nature was also viewed as a place to access the gods. Hence, journeying into nature was a sacred pilgrimage that encouraged the divine aspect of the aesthetic experience. *Hwarang* were aware of the sacredness of their journeys, and their sacred nature was widely elevated through it. At the same time, for the *hwarang*, nature was a site for studying society, history, and culture. They witnessed the lives of local authorities, intellectual monks, and commoners throughout the state, observing Silla's politics, social structure, and culture. The site to which they most often journeyed, the mountains, constituted actual territories, borders, and battlefields. This background brought a sense of realism to their tactics and practices of physical discipline

To determine how *hwarang* approached their lives including their educational methods, we must focus on three words in the descriptions of their core activities: pleasure (悅), play (遊), and entertainment (娛). For the *hwarang*, studying, working, practicing, and training were not separate activities divorced from enjoyment or pleasure. Regarding enjoyment (樂) and pleasure (悅), somaesthetics holds the same view. Shusterman referred to Confucianism's understanding of pleasure and claimed that it is deeply related to improving the state of one's life; that is, "The true aesthetic way of self-cultivation is a path of pleasure, which is why it is better to love and enjoy the way rather than merely to understand it" (2004, p. 31). Pleasure is not hedonistic but closer to a clear sense of self-awareness.

Shusterman asserted that Western academia has isolated pleasure from meaning, truth, and knowledge, again referring to Confucian notions of pleasure to criticize the situation. Unlike Western philosophy, Confucianism emphasizes enjoyment and pleasure as notions deeply related to knowledge (Shusterman, 2004, p. 31). Shusterman (2004) referred to the well-known opening of the *Analects*: "Having studied, to then repeatedly apply what you have learned—is this not a source of pleasure? To have friends come from distant quarters—is this not a source of enjoyment?" (p. 30) He showed appreciation for Confucius' insight regarding the equivalency of pleasure and knowledge.

Shusterman (2003) also criticized the downplay of entertainment in traditional aesthetics and philosophy, in which art represents the sublime and transcendence, while entertainment represents mere pleasure. He emphasizes that pleasure, the essence of entertainment, should be understood in many dimensions. He indicated five layers of pleasure to liberate the meaning of "pleasure" from its confinement to a single dimension, hedonism (Shusterman, 2003, pp. 303–305). The *hwarang* journey reflects all five dimensions of pleasure that Shusterman proposed. The first is the pleasure of the senses, which entails sharpening the senses through experiences in nature, the enjoyment of unfamiliar food, and experiences of changes in nature. The second is the pleasure of understanding the qualities and meanings of objects and events; for instance, the *hwarang* understood the meaning of nature in various ways (e.g., militarily, politically, socially, mythically, and in terms of survival) throughout their journeys. Thirdly, escaping daily life is also an aspect of pleasure that can be derived from a journey. Fourthly, transcendental pleasure is linked to sacredness: The journeys of the *hwarang* reflected divine pleasure through religious rituals and spiritual practices in the sacred mountains. Fifth and finally, the collective pleasure shared among the *hwarang* in the context of group excursions indicates a social dimension of pleasure.

At the core of the *hwarang*'s activities are such elements as entertainment, pleasure, and joy. In the context of today's education, the meaning of these elements is superficially understood as the opposite of work, study, patience, or effort. Instead, the *hwarang* and somaesthetics promote the insight that one's intellectual and practical life is integrated into one's personal lifestyle based on these bodily experiences.

Both the object and method of *hwarang* education were performed in an integrated way. Their music and journeys were a composite of art, knowledge, self-cultivation, spirituality, and practical value. The music of the *hwarang* was a complete ritualistic art form, directly based on bodily experiences (e.g., singing, dancing, eating, drinking, chanting, moving, and playing). Their music and journeys were processes by which knowledge was embodied, produced, and refined. As in the somaesthetics perspective, knowledge is not the essence of foundationalism; instead, it is established on bodily sense and practicality. Moreover, the educational objective of their activities was the ideal of a "beautiful personality." The *hwarang* were admired and regarded as extraordinary beings through their activities. Lastly, the practicality of their activities should also be noted once again. Their activities had practical purposes, such as the social, political, and military ends of the Kingdom of Silla, including the realization of individual aesthetic life. The activities convey the practical meaning of pragmatism as a philosophy for living.

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