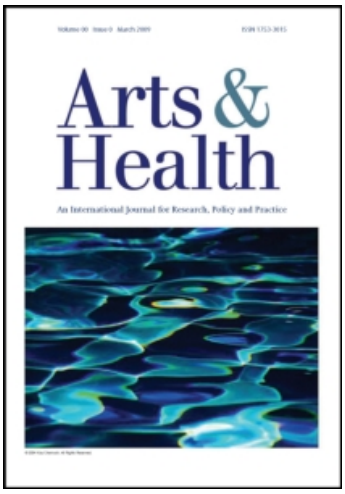

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The state of the arts in healthcare in the United States

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The arts in healthcare in the United States is a field emerged from grassroots beginnings in the mid-twentieth century. Through an overview of the field's development as well as consideration of practice, research, and educational structures, this paper summarizes the current state of the field in the United States. Practice is explored in the context of types of programs, recent field assessments, geographic prevalence of programs, funding mechanisms, and organization of the field. Research is considered in the context of evaluation, traditional research, economic studies, theoretical frameworks, and academic centers, as well as non-academic centers that support field research. The final section explores education and training standards and programs conducted by universities and non-academic organizations, and the roles of the arts and humanities in the education of health professionals.

Keywords: arts in healthcare; practice; research; education; United States

Introduction

This article is intended to provide an overview of the current state of the arts in healthcare as a field in the United States, and is the second in a series of articles focusing on different countries (Clift, et al., 2009). To contextualize current arts in healthcare practice, a brief summary of the field's development, including cultural and social circumstances that paved the way, will be provided at the onset. The article will often reference frameworks for the field that have been developed and defined by the Society for the Arts in Healthcare (SAH). SAH, founded in 1991 and based in Washington, DC, is the largest multidisciplinary advocacy and non-profit membership organization dedicated to advancing the arts as integral to healthcare in the United States. SAH serves as an "umbrella" for the field at the national level (and has members from another 14 nations), and provides resources for and links arts in healthcare organizations and professionals around the globe.

The primary purpose of arts in healthcare is to use creative activities to lessen human suffering and to promote health, in the broadest sense of the word. Art and art-making have been shown to promote competence and self-efficacy; reduce boredom, anxiety and depression, improve immune functioning; and promote coherence between the individual and the world (Evans, 2008, 87). All healthcare practice is founded in observations – or clinical signs – that are as much art as science, and that have been established and systematized over many hundreds of years. This offering of skilled care is itself an art form, just as much as the creation of works of beauty and form.

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The twentieth-century era of scientific medicine in the US witnessed immeasurable and welcome advances. It is easy to forget that before the century that ushered in the Flexner Report in 1910 (Beck, 2004), which created a system of formal medical education to eliminate the prevalence of medical unorthodoxy that was still widespread in the nineteenth century, blood-letting and purging were still common practices. However, these huge advances in biomedical science also led to cure becoming the dominant goal, relegating the giving of comfort and relief of suffering to strictly secondary roles. This system of healthcare has been called a "broken model" (Gazella, 2004, p. 86), and is well illustrated in the depersonalizing terminology of "healthcare providers and consumers" that serves to highlight the business model of modern medical practice, perhaps especially in the United States.

In response, over the past 50 years there has been a growing movement in the US and elsewhere toward a more integrative healthcare model, one that addresses the emerging dissatisfactions of both givers and receivers of care. This holistic paradigm of healthcare recognizes the essential connection of body, mind, and spirit; it embraces both individuals and communities; it is non-mechanistic and non-dualistic; and above all it offers a sustainable worldview (Sperry, 1995, p. 7). There is a growing academic base in the biological and behavioral sciences to uphold these concepts. For example, changes in personal behavior and lifestyle have been shown in carefully designed studies to be both highly effective and cost-effective in reducing heart disease and cancer (Ornish, 2008, p. viii).

It is in this setting that creative activities and the arts therapies are finding their long overdue place in modern Western healthcare. Arts-based researcher Elliot Eisner (1991) sees the artistic use of language, or metaphor, as a precise and "central vehicle for revealing the qualitative aspects of life" (p. 227). Anthropologist Ellen Dissanayake (2000) recognizes art and ritual as universal human activities that are health-promoting for both individual and community (p. 138). And art therapist Shaun McNiff (2008) sees the researching of human experience through the arts as a way to integrate art and science in service to others.

Development of a Field

The expressive arts therapies were first used for therapeutic intent in the US after World War I (Serlin, 2008), and became formalized after World War II with the establishment of the American Music Therapy Association in 1950. This was followed by the creation of similar organizations focused on drama, dance, poetry, and the visual arts. Each of these disciplines has defined training standards, including credentialing and monitoring, and each shares the goals of integrating psychological, physical, and social functioning and well-being.

In the past 35 years, a more broadly based movement has emerged to introduce arts for health within hospitals, hospices, and communities (Brandman, 2008; Deschner, 2005). There is some overlap between these two disciplines, and expressive arts therapists and artists in residence often work together and complement each other. The latter are careful, however, to avoid any claim to formal diagnostic or therapeutic credentialing, but rather seek to offer individual and communal healing in a broadly holistic sense and to create more aesthetic environments for givers and receivers of care.

In the 1960s and 1970s, the US socio-political and cultural climate was favorable for change. There was great dissatisfaction with a long and unpopular war in Viet Nam, and pressure to broaden the concept of democracy to previously un-enfranchised groups

as manifest in the civil rights and women's movements. This spirit of increased inclusiveness was instrumental in the 1965 founding of the National Endowment for the Arts with its mission of increased accessibility to the arts (Ivey, 2000). This in turn created an environment that favored the development of programs such as Hospital Audiences (HAI) and Very Special Arts.

The former, founded in 1969, responded to this spirit by bringing arts experiences to populations in New York City that otherwise would not have had access to them, thus mainstreaming these individuals (Hospital Audiences, 2008). The latter is now known as VSA arts, with the VSA representing its mission: "Vision of an inclusive community; Strength through shared resources; and Artistic expression that unites us all" (VSA Arts, 2006). VSA became affiliated with the John F. Kennedy Center for the Performing Arts in 1974. This organization is dedicated to providing and coordinating arts programs for people with disabilities (VSA Arts, 2006). Although these organizations were not concerned with using the arts as healing modalities per se, their existence was nevertheless quite influential to the early development of the arts in healthcare field in general and to the founding of the seminal hospital arts programs.

Following the creation of the above organizations, numerous arts in healthcare programs emerged. The ensuing discussion will focus on programs that have been particularly influential to the development of the field in some way, and a summary table of programs relative to time of development is included. It should be noted that there are many outstanding programs in addition to those that will be discussed.

Hospital Audiences was particularly influential to the development of what may be the first hospital-based arts in healthcare program in the country. Two physicians at Duke University Medical Center had experienced the impact of the arts in their own lives and imagined that the same "healthy distractions" could be beneficial to the patients they treated (Palmer, 2001). Following a visit with HAI in 1975, the pair implemented a monthly performance series at Duke. By 1978, support from the National Endowment for the Arts facilitated the establishment of the Cultural Services Program. This program was re-named as the Health Arts Network at Duke (HAND) in 2003, and during the intervening years the program grew to encompass regular activities in all performing, visual, and literary arts as well as video, medical education, arts medicine and science, employee programs, and networking (Palmer, 1991).

In 1976, several physicians and the hospital architect at the University of Iowa Hospitals and Clinics were highly interested in developing a more humanized and therefore healing environment. This interest led to the development of Project Art. Initially, the program held monthly exhibits of carefully selected prints in public areas. Other components were added later, such as a performing arts series, a traveling art cart with framed prints and posters for customizing art in patient rooms, and art studio workshops. Project Art also developed an impressive permanent art collection as will be discussed (University of Iowa Healthcare, 2009a).

Another program aimed at providing an environment humanized by the presence of art was spurred by interest from the Facilities and Interior Design departments of the University of Michigan Health Systems. The founding of the Gifts of Art program was established within a new hospital system in 1986 with consultation from Iowa's program leaders (Deschner, 2005). Like the program at Iowa, it also emphasized exhibits and other art in the environment, continuing to focus on rotating rather than permanent exhibits (Deschner, 2005). The program now features an outstanding art cart program, performances, music at the bedside, and healing gardens (University of Michigan Health System Gifts of Art Program, 2008).

These three early programs were highly influential to the further development of the field in the US through providing manuals, consultations, and contributing to the eventual founding of the Society for the Arts in Healthcare by hosting national convocations and symposia. These gatherings were instrumental in raising awareness of the emerging field, of best practices, and in providing networking opportunities. In 1991, the earlier convocations hosted by Duke, Iowa, and Michigan resulted in the establishment of the Society for the Arts in Healthcare.

In the late 1980s, Shands Arts in Medicine (AIM) at the University of Florida began to take shape. Like the other university hospital programs, it was spurred by individuals within the system. Unlike the previous hospital programs discussed, this one began with the presence of artists working directly with patients, family, and staff. A physician interested in increasing the presence of arts and humanities in the education of future physicians and a nurse who had experienced the healing power of participating in art making and envisioned artists engaging patients in creative activity joined forces and, studying earlier programs such as Iowa's, devised the concept of the hospital artists in residence program. AIM now operates according to a dual model that includes creating an aesthetic environment as well as participatory art making guided by professional artists in the visual, performing, and literary arts (Shands Arts in Medicine, 2008).

A different sort of organization influential to the development of the field was founded in New York City in 1994. The Creative Center is an independent organization that serves as a central hub supplying trained artists to 22 healthcare facilities in the city. One of the program's founders had been a social worker in a hospital bone marrow transplant unit and therefore had witnessed the high degree of engagement exhibited by her patients with art activities she introduced (Deschner, 2005). These experiences inspired the establishment of the Creative Center as a community of artists, cancer patients, and survivors. (Deschner, 2005).

Having established itself as an identifiable field in the United States, the arts in healthcare movement has taken a greater interest in networking, education, and research and indeed the growth of the field has accelerated in both depth and breadth through initiatives in these arenas. The number of arts programs for hospitalized patients has increased greatly, and there has been a concurrent growth and development of arts for recovery, rehabilitation, health maintenance, disaster relief, prevention of disease, crime or substance abuse, for chronic conditions both physical and emotional, and for healthy aging, to name a few related applications. Box 1 outlines the development of arts in healthcare programs in the US from 1965 through 2009.

Practice

In 2008, the Society for the Arts in Healthcare undertook the task of creating a formalized definition of the arts in healthcare that could provide both understanding and consistency within and outside of the field. The task proved to be somewhat challenging due to the highly multidisciplinary nature of the field and due to the breadth of practice in the US. As this article was being written, the following definition was being prepared for publication by SAH:

> Arts in Healthcare is a diverse, multidisciplinary field dedicated to humanizing the healthcare experience by connecting people with the power of the arts at key moments in their lives. This rapidly growing field integrates the arts, including literary, performing, and visual arts and design, into a wide variety of healthcare settings for therapeutic, educational, and recreational purposes.

Box 1. Arts in healthcare developmental timeline.

1965–1975

- NEA guidelines call for inclusiveness in accessibility to the arts (1965)
- Hospital Audiences, New York, NY (1969)
- Creative Alternatives of New York (1969)
- American Art Therapy Association (1969)
- VSA Arts (1974)

1976–1985

- Commonwealth, Bolinas, CA (1976)
- Duke University Hospital Health Arts Network (originally Cultural Services Program), Durham, NC (1976)
- University of Iowa Hospitals and Clinics Project Art, Iowa City, Iowa (1976–78)
- New Horizons, Children's National Medical Center, Washington, D.C. (1978)
- Aesthetics, Inc., San Diego, CA (1980)
- Arts for People, Dallas, TX (1885)

1986–1995

- University of Michigan Health Systems, Gifts of Art, Ann Arbor, MI (1986)
- Big Apple Circus Clown Care, New York, NY (1986)
- Arts for the Aging, Washington, DC (1988)
- Caring at Columbia, New York, NY (1988)
- Art for Recovery, University of California San Francisco, CA (1988)
- Shands Arts in Medicine, Gainesville, FL (1990)
- Society for the Arts in Healthcare, Washington (1991)
- Art as a Healing Force, Bolinas, CA (1991)
- Rhode Island Hospital and Hasbro Children's Hospital Healing Arts Program, Providence, RI (1991)
- Music for All Seasons, Scotch Plains, NJ (1991)
- San Diego Children's Hospital begins art programs, San Diego, CA (1993)
- Smith Farm Center for Healing and the Arts, Washington, DC (1993)
- New York University establishes online Literature, Arts, and Medicine Database (1993)
- The Creative Center, New York City, NY (1994)
- C. Everett Koop Institute at Dartmouth, Healing and the Arts, Hanover, NH (1995)

1996–2000

- North Carolina Arts for Health, Durham, NC (1996)
- Burlington City Arts partners with Fletcher Allen Hospital, Burlington, VT (1997)
- Moffitt Cancer Center Arts in Medicine, Tampa, FL (1997-8)
- The Art of Elysium, Universal City, CA (1997)
- Snow City Arts, Chicago, IL (1998)
- University of New Mexico Hospital Arts in Medicine, Albuquerque, NM (1999)
- Center for the Arts in Healthcare Research and Education at the University of Florida, Gainesville, FL (1999)
- WellArts Institute, Portland, OR (2000)

Box 1. Continued

- Wake Forest University School of Medicine, Visual and Performing Arts, Winston-Salem, NC (2000)

2001–2005

- National Center for Creative Aging, Washington, DC (2001)
- Arts Council of Central Louisiana Arts and Healthcare Initiative, Alexandria, LA (2003)
- Central Louisiana Arts Council teams with CAHRE, Shands AIM and the Red Cross to offer disaster relief arts programs following Hurricane Katrina, Alexandria, LA (2005)
- Paramount Arts Center, HEARTS (Health Enriched by Arts) Program, Ashland, KY (2005)

2006–2009

- Upper Midwest Arts in Healthcare Network, Minneapolis, MN (2006)
- University at Buffalo Center for the Arts, Arts in Healthcare Program, Buffalo, NY (2008)

The definition reflects the Society's and the field's basic tenet that the arts contribute positively to the well-being of individuals and communities. The field also operates from a basic understanding that incorporation of the arts into healthcare can positively impact patient health outcomes and can improve the ability of caregivers and organizations to provide quality care. Within the field, professional artists and licensed arts therapists use the arts as tools for addressing the psychosocial needs of patients, their family members, and professional caregivers. Service populations are inclusive of these groups as well as hospital visitors and whole communities. The field is oriented to addressing illness as well as health through the arts, and engages individuals and communities both actively and passively through arts activities, exhibits, and performances.

Types of Programming

As has been illustrated in our brief discussion of some early programs, the arts in healthcare in America encompasses a broad array of unique programs and practices. Although a comprehensive categorical list of arts in healthcare programs would exceed that which this article can address, programming is generally grouped under the following categories: (1) arts and aesthetics in the built environment; (2) bedside arts (including individual, group, and public space activities); (3) performing arts in healthcare; (4) caring for caregivers; (5) community arts for wellness; (6) arts therapies; and (7) the arts and humanities in medical and other health provider education. Although there are seven general areas of work in the field, facility-based arts in healthcare programs tend to have one of two primary areas of focus from which they build: arts and aesthetics in the built environment or artist-based programming. The former includes permanent collections, rotating exhibits, interior design, healing gardens, and creative way finding. The latter includes resident artists, volunteer artists, and visiting artists that provide bedside and group services, as well as performing arts, in healthcare settings.

As previously noted, many arts in healthcare programs in the US began with a concern for enhancing the physical environment of care. The modern architecture movement that

began in Germany between the World Wars had a significant impact on healthcare design in the US in the twentieth century. Hospitals built between the 1940s and 1980s reflected the clean, sterile lines and limited ornamentation of modern architecture, which also reflected an emphasis on medical machinery and technology (Kellman, 1988). In the 1980s, the healthcare design field and the new arts in healthcare movement began to engage art and aesthetics as a means for transforming environments of care from sterile spaces meant to facilitate the science of medicine to more comforting environments designed for the comfort and well-being of people. Today, many arts in healthcare programs continue to grow from and maintain a primary focus on the build environment of care.

Texas Children's Hospital (TCH) in Houston, Texas, is one of the largest pediatric healthcare systems in the US and is a flagship for creative healthcare design and for the integration of children's art into the experience and environment of care. The hospital's creative designs have won numerous awards and accolades. The hospital is committed to using art to create a functional and aesthetically pleasing environment that supports the care, experience, and outcomes for staff, patients, and their families (Healthcare Design, 2003). In addition to its installations, TCH hosts an Arts in Medicine program that supports an array of artists and arts activities. The arts at TCH provide an effective link between numerous services, including among others, nursing, Child Life, Pastoral Care, and the Arts in Medicine.

The University of Iowa Hospitals and Clinics (UIHC) is committed to creating an environment that promotes healing, and comforts and delights patients, visitors, and staff through art (University of Iowa, 2009a). Since 1978, UIHC has been building its permanent art collection as a part of its Project Art program. Project Art oversees the care of more than 5,800 objects of art, including over 3,900 works of original art in a variety of media, including drawing, printmaking, painting, sculpture, ceramic art, fiber art, photography, and mixed media. The collection includes works by Iowa artists, Modern American Masters, and Turkish Artisans, and features glass art and a World Cultures collection. The collection is supported by gifts from patrons and artists, and purchases supported by commissions from exhibition sales and hospital funds. UIHC also participates in the State of Iowa's Art in State Buildings program, which mandates that half of 1% of the cost of major state construction projects is devoted to the acquisition and exhibition of fine art (University of Iowa, 2009b).

The artist-based model of programming includes arts programs and services positioned and managed within healthcare institutions as well as partnerships between healthcare institutions and cultural organizations. Such partnerships include those with museums, performing arts presenters, community arts agencies, arts schools and universities, and arts in healthcare organizations such as The Creative Center in New York City. Hospital-based Artists in Residence programs, such as those at Duke University, the UCSF Cancer Center, Shands Hospital, and the University at Buffalo Center for the Arts, employ or contract paid professional and volunteer artists to provide supportive creative services directly to patients, their family members, and to professional caregivers in the healthcare setting. These programs, and others like them, support resident artists that facilitate daily programs and patient care, supervise volunteer artists, and work with clinical staff to address patient needs and care plans.

The Snow City Arts Foundation in Chicago (described more fully in another article in this issue) is an example of a unique program that maintains a focus on arts education in healthcare. The organization was founded in 1998 and is committed to improving comprehensive healthcare for hospitalized children by providing them with educational outlets they lack due to their need for treatment. Serving numerous Chicago hospitals, Snow City's Artists in Residence provide workshops and individual sessions for hospitalized

children in creative writing, music, painting, photography, and filmmaking (Snow City Arts, 2008). Snow City has developed unique relationships with Chicago area school boards to ensure that children earn school credit for the art education they engage in while hospitalized, and works to connect children with community arts programs after their treatment is completed.

There are approximately 30,000 trained expressive arts therapists in the United States (Malchiodi, 2005), and there is a considerable body of research speaking to the value of the arts therapies in diagnostic assessment and in therapeutic rehabilitation (Feder & Feder, 1998; Malchiodi, 2005). Art therapy has evolved several theoretical approaches, including psychoanalytical, cognitive-behavioral, and humanistic, and is used with children, adults, families, and groups. Its parent organization is the American Art Therapy Association. Music therapy uses psychodynamic, behavioral, biomedical, and humanistic approaches to help in developmental issues, emotional and behavioral problems, palliative care, and self-actualization. The American Dance Therapy Association is the parent organization of dance/movement therapy, which is a well-established form of psychotherapy used in developmental, physical, and palliative settings. It uses dance and movement to try to integrate body, mind, and spirit through action-based and spontaneous activities. Drama therapy and psychodrama use narrative and role-play to address various psychological issues, particularly in relation to past trauma and abuse. The National Association for Poetry Therapy was founded in 1981, and uses poetry and other literary forms to promote self-expression, interpersonal and coping skills, and palliative therapy. In summary, the expressive arts therapies are finding an increasing place in all healthcare environments in the US, and have been shown to offer psychological and physical benefits to individuals and communities from newborns to elders with a wide spectrum of health issues.

Recent Field Assessment

In 2004 and again in 2007, SAH partnered with the Joint Commission (the national accreditation agency for healthcare) and Americans for the Arts (a national arts advocacy agency) to conduct surveys that examined the presence and characteristics of the arts programs in US healthcare facilities. The surveys were developed collaboratively by the partnering organizations and administered by the Joint Commission to accredited healthcare institutions throughout the US. The 2004 survey, with 2,333 respondents from unique healthcare institutions, showed that nearly half of the responding institutions hosted arts programs, and that the greatest prevalence of art activities in these programs was in the permanent display of art such as paintings, murals, and sculpture (73%), followed by performances in public spaces (49%) and healing gardens (32%).

In 2007, 1,807 institutions responded to a similar survey. Although the respondent base was slightly smaller, results suggest growth in the field with an increase from 43 to 49% of healthcare institutions reporting arts programs (see Figure 1). As in the 2004 survey, the vast majority of 2007 respondents represented hospitals (61%), with long-term care facilities at 5%, and hospice and palliative care organizations following at 4%. Music, visual arts, and crafts were shown to be the most prevalent art forms represented (see Figure 2); and once again, the permanent display of art was the most prevalent type of programming represented, with performances in public areas following (see Figure 3). An analysis of the types of professionals providing services in hospitals showed that hospitals support nearly equal numbers of artists, arts therapists, and child life specialists.

A 2008 survey of SAH members (conducted by Americans for the Arts in partnership with the Society) yielded a different prevalence in types of programs, suggesting that

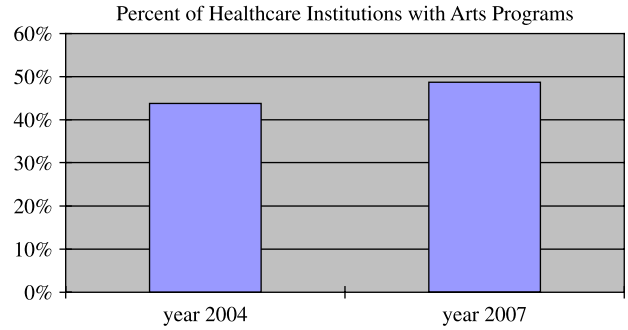

Figure 1. Percent of Healthcare Institutions with Arts Programs.

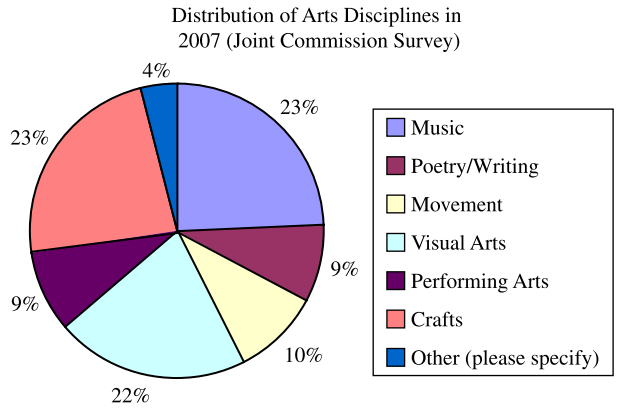

Figure 2. Distribution of Arts Disciplines in 2007.

many institutions that provide artist-based programming consider themselves to be a part of the arts in healthcare field and affiliate themselves with the Society through membership, while many other institutions that primarily undertake environmental arts programming do not affiliate themselves with the field (see Figure 4).

As shown in Figure 5, the 2007 survey also explored the demographics of arts in healthcare service populations. The data demonstrated that these programs serve extremely diverse populations. Hispanic/Latino, Black/African American, and White populations were the largest groups served and were represented in nearly equal proportions ranging from 18 to 19%. Sixty of the survey's respondents reported the number of individuals served by their arts programs annually. Collectively, those 60 programs serve 2,213,690 individuals per year, suggesting an average annual service population of 36,895 for arts in healthcare programs.

Both surveys were interested in identifying reasons why healthcare institutions invest in the arts. In both 2004 and 2007, benefits to patients and contributions to a healing environment were the top reasons cited across all types of institutions (see Figure 6).

Geographic Prevalence of Programs

Although there are certainly individuals in the US who may be practicing or planning arts in healthcare programs without any knowledge of the existence of the field, sooner

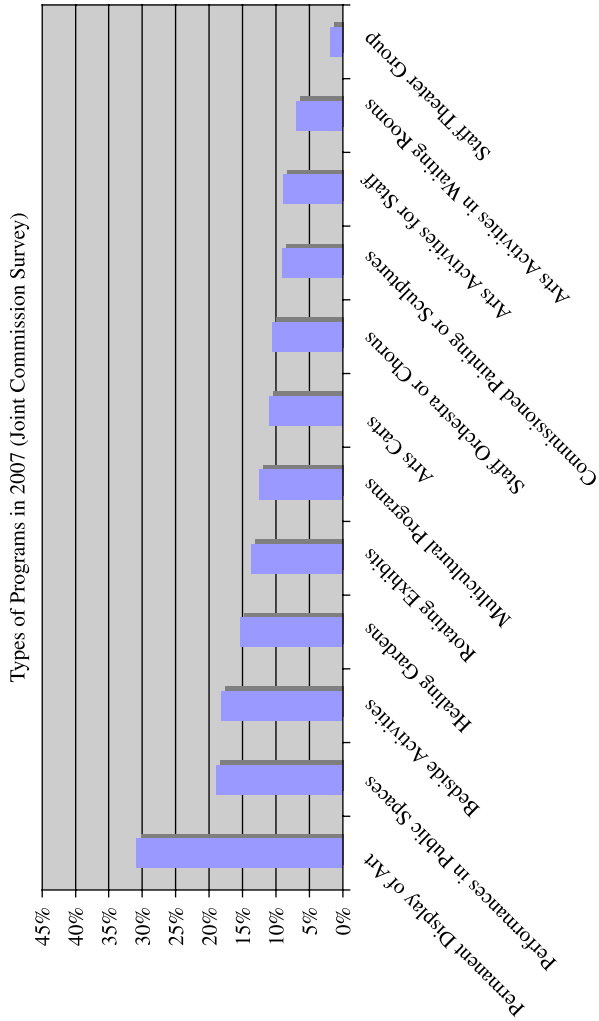

Figure 3. Types of Programs in 2007.

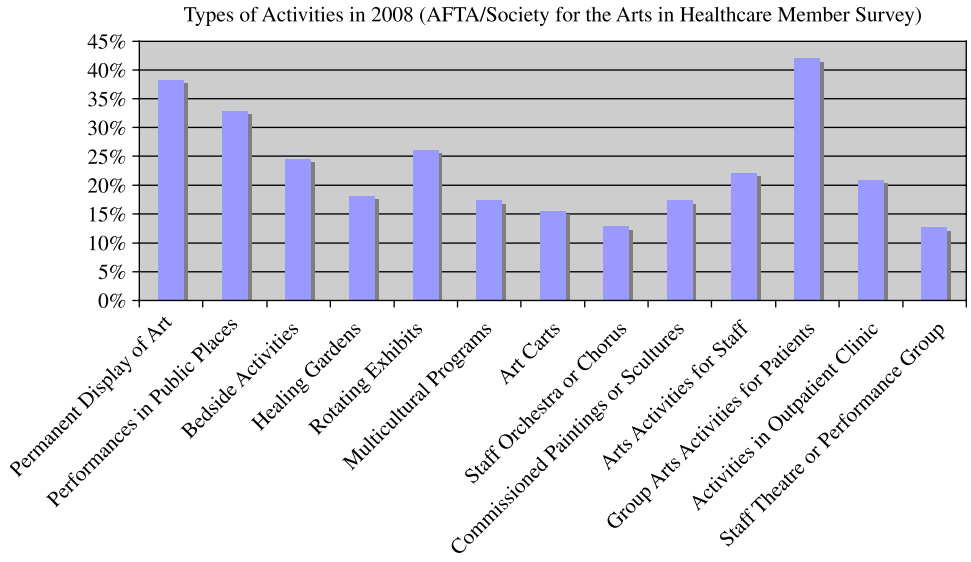

Figure 4. Types of Activities in 2008.

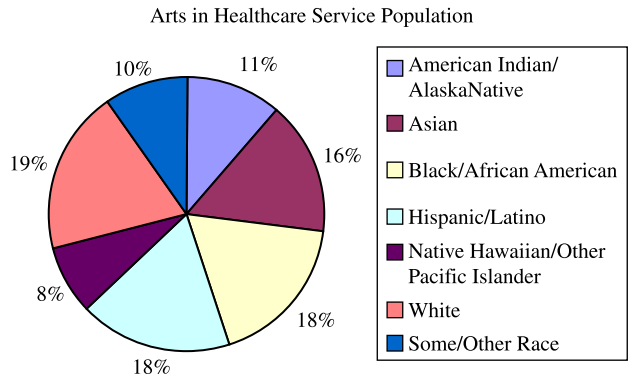

Figure 5. Arts in Healthcare Service Demographics.

or later they will become curious and search for similar programs. A quick search on the Internet will reward them with myriad peers. A search on December 17, 2008, for arts+in+healthcare using the Google search engine yielded 12,500,000 results (Dell Search Results for arts+in+healthcare, 12/17/08). As of the same date, the Society for the Arts in Healthcare had approximately 1,700 members representing at least 582 different organizations (Society for the Arts in Healthcare, 2005–2009). As demonstrated in the 2004 and 2007 surveys, there are far more arts in healthcare programs and practitioners in the US than are represented by SAH members. However, in attempting to make a reasonable geographic quantitative analysis of prevalence of the field, the authors applied information from the Society's membership directory to the US Census Bureau's designation of US regions. In Box 2, the figures in parentheses represent the number of individual members and the number of organizations, respectively (members/organizations), in each state.

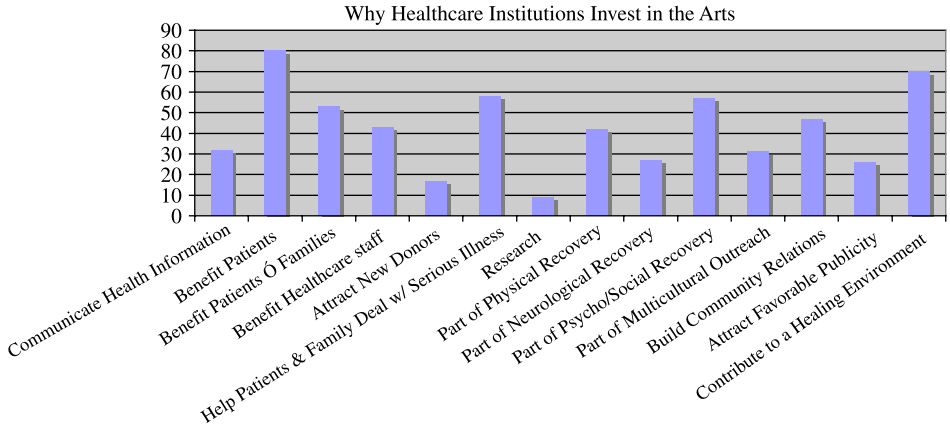

Figure 6. Why Healthcare Institutions Invest in the Arts.

Box 2. US Members/Organizations, Society for the Arts in Healthcare, December 2005–2009.

Northeast	Midwest	South	West
New York (175/67)	Illinois (58/25)	Florida (99/47)	California (137/72)
Pennsylvania (100/43)	Minnesota (47/17)	Maryland (45/22)	Oregon (48/13)
	Ohio (43/16)	Virginia (44/13)	Washington (26/14)
Massachusetts (95/44)	Michigan (30/12)	Texas (33/11)	Colorado (22/13)
	Missouri (26/16)	North Carolina (31/9)	Arizona (19/7)
New Jersey (71/33)	Wisconsin (20/10)	Kentucky (29/13)	Utah (9/6)
Connecticut (15/8)	Indiana (17/8)	Tennessee (25/9)	Montana (9/3)
Maine (14/5)	Nebraska (11/6)	District of Columbia	Nevada (9/3)
Rhode Island (11/4)	South Dakota (8/5)	(23/10)	New Mexico (7/3)
Vermont (9/3)	Iowa (7/4)	Georgia (16/4)	Alaska (7/2)
New Hampshire (8/6)	North Dakota (3/1)	South Carolina (15/8)	Hawaii (2/1)
	Kansas (0/0)	Louisiana (11/5)	Idaho (1/1)
		Alabama (11/5)	Wyoming (0/0)
		Oklahoma (6/2)	
		Mississippi (5/1)	
		Arkansas (4/2)	
		Delaware (1/0)	
		West Virginia (1/0)	

Amongst the broad regions, the Northeast has the highest membership total (498) and the most organizations (213), followed by the South with a membership of 395 individuals representing 117 organizations. The West comes in third in terms of individual members (287), but tops the South in numbers of organizations at 138. The Midwest has the fewest members (270) and organizations (114).

On an individual state basis, the top five in terms of highest numbers of members are New York (175), California (137), Pennsylvania (100), Florida (99), and New Jersey (71), while the same ranking in terms of organizations registered with the Society is California (72), New York (67), Florida (47), Pennsylvania (43), and New Jersey (33). A higher prevalence of programs in the US are based in more urban areas and larger health centers. In the past few years, recognition of the lack of programs in rural areas has become a concern of SAH. As a result, the Society has offered online seminars on the topic of developing programs in rural areas and, in 2008, the State of Florida Division of Cultural

Affairs dedicated funding to the development of a model for the development of arts in healthcare programs in rural hospitals.

Funding Mechanisms

The 2004 and 2007 surveys administered by the Joint Commission in partnership with the SAH and Americans for the Arts explored mechanisms of fiscal support for arts programs in American healthcare institutions (see Figure 7). Surveyed US institutions were asked to report on how their arts programs are funded and managed. In 2004, 40% of organizations cited their organization's operating budget as a source of funding for arts programs, while in 2007 that percentage rose to 56%. This growth in internal funding marks a significant increase in the support of arts programs by healthcare organizations. It also signals increased stability for programming and an increase in the extent to which healthcare institutions value the arts. Additionally, support from foundation and endowments funds rose to match that of volunteer organization support. An increase in the number of paid arts administrators was also indicated, signaling growth in the professionalism of arts in healthcare programs.

In addition to funding mechanisms identified through the surveys, some institutions in the US have developed very innovative methods for supporting arts programming. The Gifts of Arts program at the University of Michigan Health System supports its programs through revenue from numerous sources, including the sale of art in its galleries and from vending machine revenue. Some programs also undertake product sales (such as greeting cards featuring patient artworks) and fundraising events. It should be noted that, in the US, there are no current proposals for direct billing or third-party reimbursements for the services of healthcare-based artists in residence. There is, as is demonstrated in the recent survey data, a clear trend toward arts services being supported by organizational budgets.

Organizing the Field

SAH is the most significant organizing entity for the field in the US (see Box 3). Although the Society is based in the American capital, its vision is to be an international resource uniting the arts and healthcare. As a convening organization, SAH hosts an annual international conference and periodic symposia throughout the US. The Society works to advocate for the arts in healthcare at the national level through active engagement and

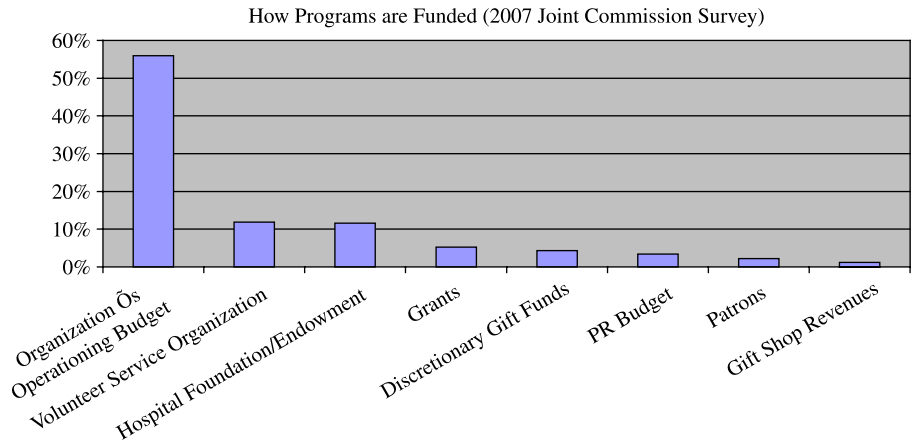

Figure 7. How Programs are Funded.

Box 3. The Society for the Arts in Healthcare.

The Society for the Arts in Healthcare achieves its mission to advance the arts as integral to healthcare by:

- Demonstrating the valuable roles the arts can play in enhancing the healing process.
- Advocating for the integration of the arts into the environment and delivery of care within healthcare facilities.
- Assisting in the professional development and management of arts programming for healthcare populations.
- Providing resources and education to healthcare and arts professionals.
- Encouraging and supporting research and investigation into the beneficial effects of the arts in healthcare.

partnership with the National Endowment for the Arts, Americans for the Arts, the Joint Commission, and numerous other national organizations and agencies as well as the national legislative system. In addition, it provides an extensive array of supportive and professional development services to the field, including a comprehensive website, grant opportunities for members, organization of special interest groups, and its CREATE Services, which encompasses consulting services, grants and awards, educational programs, technical assistance, member networks, and exhibits – all designed to aid in professional and organizational development.

Defining Value: Research

The arts in healthcare movement in the US has grown considerably and rapidly over the past several decades and with it, an increase in the call to measure results. "Measuring" is occurring on two levels: evaluation and what is often referred to as traditional or basic research. Technically, evaluation *is* a form of research, and confusion often arises between the two because processes such as data collection activities (e.g. conducting surveys or interviews) may look the same. However, in the traditional sense, researchers cite some differences based on purpose, particularly the intended use of the findings.

Evaluation

With the exception of creative arts therapies research, program and project evaluation has progressed at a faster pace than basic research activities. In the early years of the arts in healthcare movement, it seemed to be enough for program personnel to justify their existence by simply describing their observations and perhaps offering a quote or two from satisfied and enthusiastic participants. Today, more formal program or project evaluation is becoming the norm (Camic, 2008).

Summative or Outcomes Evaluation

Many of the US programs have supporting documentation, evaluations, surveys, and patient and staff satisfaction data that form a large body of evidence on the practice and success of these programs. For example, some programs use outcome studies measuring patient satisfaction as a means to evaluating the effectiveness of using the arts in healthcare settings; however, a handful of programs have conducted rigorous evaluations that have gleaned much more information (see Box 4).

Box 4. Evaluation of The Creative Center, New York, NY (KCI Research & Evaluation, 2002).

In 2002, KCI Research and Evaluation conducted a year-long quantitative/qualitative study of training and other program processes that took place in 2000/2001 in the Hospital Artist-in-Residence (AIR) Program of The Creative Center in New York City. The intent was to use the evaluation results to guide training of the AIRs as well as the creation of the Training Program.

Sample. A total of 60 patients and 56 staff members from 5 of the 7 hospitals the Creative Center serves.

Instruments. The evaluator, in consultation with the Executive Director and the Coordinator of the AIR Program, with input from the artists, developed the criteria by which patient satisfaction and patient outcomes were to be measured and provided the basis for the development of the questionnaires. Two surveys were developed: a 26-item patient questionnaire and a 16-item staff questionnaire. Although the instruments were designed to be self-administered, in many cases an interviewer would need to assist the patient with completing the form.

Data collection and analysis. Questionnaires were disturbed or administered by four carefully selected and well-trained interviewers. One interviewer was bilingual Spanish–English. The quantitative data were analyzed using the SPSS statistical analysis software package; qualitative data were analyzed by the evaluator manually.

Results. Data from both patients and staff showed that The Creative Center's major objective of relieving patient feelings of boredom, anxiety, loneliness, and sadness was achieved, with only 6–10% of respondents reporting these feelings after the artistic experience, contrasted with 18–33% who reported them previously. Additionally, the number of respondents who reported feeling "cheerful" doubled from 22% to 46%. A secondary, but important, benefit was noted: making the caregiver's job easier. "A significant number of staff interviewed said that the patient was more willing to talk about treatment options and/or responded better to treatment after the artist's visit" (KCI Research & Evaluation, 2002, 16). For the complete report, see www.thecreativecenter.org.

Formative or Process Evaluation

An essential aim of evaluation is to provide information to improve future practice. Although stakeholders may at times seem interested only in outcomes, program leaders have found that learning how these outcomes come about is a critical element in project improvement. A number of United States arts and health researchers (e.g. Graham-Pole & Lander, 2009; Lander & Graham-Pole, 2006; Rollins, 2007) are turning to Appreciative Inquiry (AI), an empowering method for understanding and improving an organization's programs, processes, products, policies, and systems (Preskill & Catsambas, 2006). For an example, see Box 5.

Lander and Graham-Pole (2006) have applied AI and its teaching application, Appreciative Pedagogy (AP) to palliate care research, education, and clinical practice. With the theory that research into the experiences between patients and their caregivers may improve communication, they have begun a systematic multicultural AI study based on professional caregivers' and students' stories of loss.

Box 5. Appreciative Inquiry with Arts for the Aging, Bethesda, MD (Rollins, 2007).

Arts for the Aging (AFTA) provides free artistic outreach services to older adults in more than 50 senior day care centers and nursing homes. Staff were eager to engage in a participatory evaluation process to enable them to learn more about their organization, to develop new evaluation tools to capture relevant data for current and future programming and projects, and to further incorporate evaluation into everyday activities. Incorporating Phase 1: *Inquire* of Appreciative Inquiry into their annual artist/instructors' meeting was a first step in the evaluation plan.

Sample. Twenty artists representing a variety of artistic disciplines – music, creative writing, visual arts, storytelling, dance.

Instrument and process. Each artist was asked to choose a partner and was given an interview guide. The guide included three sets of core questions tailored to the specific inquiry about their peak experiences, values, and wishes. Artists had 15 minutes to interview their partner, and then reversed roles. After the 30-minute interview segment, everyone reported out on his or her partner to the larger group. The evaluator analyzed the data manually.

Results. Regarding characteristics that resulted in their greatest experiences, four themes emerged: (1) *Paying attention* (45%), (2) *Being open and flexible* (50%), (3) *Being creative and innovative* (30%), and (4) *Pulling from all that they are* (95%).

About the senior participants artists revealed two themes: (1) *Being present with many gifts*, and (2) *Being a teacher/role model*. Concerning what they valued most about AFTA and its programs, 55% pointed out that the organization truly honors age in a society that does not, 50% mentioned personally feeling respected and valued, 15% expressed appreciation for AFTA's openness to innovation and new ideas, and 25% were grateful for the practical support AFTA provides.

Three wishes that could make more exceptional experiences possible included more collaboration/cooperation with the centers (45%), more financial resources that would allow for more sessions, additional art supplies and musical instruments, further development of their skills (50%), collaboration with other artist/instructors (25%), and programming requests (40%) such as more intergenerational programming, expanding program services to other geographic areas, or expanding their roles by training senior center staff.

Results of the AI process provided AFTA with data about the characteristics to look for when selecting new artists for their program, information about some issues to address with the centers to which they provide services, and elements to consider for new programming. Artists seemed empowered from engaging in the AI process and actively participated in the development and implementation of the evaluation instruments and data collection activities that followed.

Basic Research

Much basic research in arts and healthcare in the United States has been qualitative. Methods that convey information about patient, staff, and family responses to their experiences and the healthcare environment are especially useful to healthcare institutions because it is difficult to measure quantitatively emotions such as loneliness, fear, joy, and relief (National Endowment for the Arts [NEA], 2003). Qualitative methods

are becoming more accepted in arts in healthcare research, particularly when accompanying quantitative methods. Lander & Graham-Pole (2006) point out that although qualitative research may seem to be an "orphan field" of evidence-based medicine, "the bedside practice of every physician is founded in observation – *clinical signs* – that have been gathered over several hundred years and systematically recorded for every medial student's classroom" (p. 13).

American and European researchers have found that qualitative methods can provide a richness and depth in data that often is not captured using quantitative methods (Camic, Rhodes, & Yardley, 2003). For example, researchers exploring the impact of an art program on an inpatient oncology unit used semi-structured interviews with seven patients and seven nurses who cared for these patients following participation in an established art program (Ferszt, Massotti, Williams, & Miller, 2000). Findings revealed benefits such as improved patient coping with pain, improved nurse-patient communication, and improved attitude toward hospitalization.

However, because efficacy of any treatment or procedure in a healthcare setting is generally proven by scientific methods and quantitative research, a limited amount of this type of research, e.g. controlled investigation with a strict protocol and clearly defined measures, is taking place in arts and healthcare research in the US. Findings from quantitative research would likely capture more attention from hospital and other healthcare institutions' decision-makers and thus help practitioners garner more credibility and support (NEA, 2003). The NEA (2003) offers three reasons for the lack of controlled arts and healthcare research: (1) it is expensive and requires expertise in research techniques and methodologies; (2) research studies are highly competitive for support in institutions that are already experiencing budget cuts and tight resources; and (3) medical and administrative staff members disagree as to the value of conducting arts and healthcare research with the same models used in traditional healthcare research (p. 11).

Nevertheless, controlled arts and healthcare research is being carried out in the United States. One of the first studies with a control group was Gene Cohen's two-year multisite national study on the impact of professionally conducted community-based cultural programs on the general health, mental health, and social activities of persons age 65 years and older (Cohen, 2006). See Box 6 for an example of a short-term intervention study by Noice and Noice (2004).

Box 6. Experimental Design with Control Groups.

A Short-Term Intervention to Enhance Cognitive and Affective Functioning in Older Adults (Noice & Noice, 2004)

This study investigated the benefits of a short-term intervention for older adults that targeted cognitive functioning and quality of life issues important for independent living.

Method. Participants (124 community-dwelling persons aged 60–86 years) took part in one of three study conditions: theater arts (primary intervention), visual arts (non-content-specific comparison group), and no-treatment controls.

Results. After 4 weeks of instruction, those given theater training made significantly greater gains than did no-treatment controls on both cognitive and psychological well-being measures. A comparison of theater and visual arts training showed fewer benefits in fewer areas for visual arts.

Economic Studies

In our current economic crisis, the healthcare dollar is increasingly dear. Although initially arts in healthcare research focused only on outcomes for patients, families, and staff, today savvy researchers are translating their findings into economic terms. For example, Cohen (2009) compared medication use and doctor visits between individuals who participated in a chorale group and the control group in his Creativity & Aging Study. He calculated an annual savings of $172.91 per year per participant. Although this may not seem like a large sum, if one considers the current and projected numbers of people in the aging population, participation in creative activities can add up to big savings for Medicare, other insurers, and individuals.

Other researchers are exploring the economic benefits of their findings on healthcare staff. For example, Parrish Medical Center in Titusville, Florida, opened a new hospital in 2002. Two years later, a survey of 734 staff members found that the majority believe the design features – access to natural light, improved airflow, separation of public/patient transport areas, and "homelike" patient room design – positively affect the quality of their worklife and help them provide care more effectively. As a result, staff turnover is now at 13% per year, compared to 20% annually in the old facility (Center for Health Design, n.d.).

Staff turnover, particularly nurse turnover, is a huge issue for hospitals. One study found that the cost of registered nurse turnover ranges between $62,100 and $67,100 per nurse (Jones, 2005). Alongside nurse retention is the issue of the nursing shortage, which is slated to persist through the next two decades, with demand growing at 2–3% per year (Buerhaus, Staiger, & Auerbach, 2009). Increasingly, hospitals and other health care organizations are developing and implementing strategies to retain the valuable nurses they hire (Christmas, 2008). Thus, arts in healthcare research that highlights economic benefits will likely play a larger role in the growth of the field in years to come. Conserving nursing resources is another economic issue. Walworth (2005) conducted a comparative analysis that examined the cost-effectiveness of music therapy as a procedural support in the pediatric healthcare setting that resulted in findings with implications that addressed this issue. See Box 7 for details.

Theoretical Frameworks

In a recent article in this journal, Cohen argued that sometimes the evidence or outcomes demonstrating success is not enough for results to be taken seriously: "If there is not an understanding of the underlying mechanism to explain why the results happened, then no matter how robust the findings of the research, they could be dismissed" (Cohen, 2009, p. 48). As arts in healthcare research activities become more sophisticated, investigators are paying more attention to theory. For example, Cohen's Creativity & Aging Study (2006) builds upon two major bodies of gerontological research theory: (1) Sense of Control, and (2) Social Engagement.

Other studies are applying theories of psychoneuroimmunology (PNI), a transdisciplinary scientific field concerned with interactions among behavior, the immune system, and the nervous system (Solomon, 1996). For example, Walsh, Radcliffe, Castillo, Kumar, and Broschard (2007) tested the effects of an artmaking session on reducing anxiety and stress among family caregivers of patients with cancer using a saliva sample from each participant to measure salivary cortisol, which indicates stress levels, and asked them to complete the Beck Anxiety Inventory (BAI). A two-hour artmaking session followed pre-testing. Post-tests included a repeat BAI and a second saliva sample. Anxiety was significantly reduced after the artmaking session.

Box 7. Procedural-Support Music Therapy in the Healthcare Setting: A Cost-Effectiveness Analysis.

This study examined the effectiveness of music therapy in eliminating the need for sedation and reducing distress in pediatric patients receiving inpatient and outpatient non-invasive procedures and determined the cost-effectiveness of music therapy as procedural support.

Sample and procedure. Over a one-year period, all music therapy-assisted pediatric echocardiograms (ECG) ($n = 92$, ages 6 months to 7 years), computerized tomography (CT) ($n = 57$, ages 1 month to 9 years), and other procedures, such as IV insertions ($n = 17$, ages 18 months to 11 years) at a general medical hospital were evaluated to determine the success rate of completing each procedure without the need for sedation. Live music therapy techniques that provided distraction were used for the children undergoing echocardiograms and other procedures, while techniques that induced sleep were used for the children undergoing CT scans.

Data analysis. Interventions were considered successful if the behaviors elicited by a patient did not interfere with the procedure and if the procedure was completed without sedation.

Results. There was a 100% success rate of eliminating the need for sedation for pediatric patients receiving ECGs, an 80.7% success rate for pediatric CT scan completion without sedation, and a 94.1% success rate for all other procedures.

Economic benefits. When interventions were successful, no registered nurses were required to be present to assist. Cost analysis on the ECG patients alone for the 92 patients was $76.15 per patient, totaling $7,005.80. This cost is based on the following reasons:

- The RN was not required to assist, eliminating $55 per procedure.
- The sedation cost of $9.45 per dose was eliminated.
- The sonographer time was reduced from 1 hour to 20 minutes, decreasing the cost of the sonographer from $23.00 to $5.75 per procedure.
- The cost of the music therapist averaged $5.55 per procedure.

The year-long project resulted in 184 RN-hours saved for other duties, and with an average of 20 minutes per procedure, the equipment and staff could be scheduled for three times as many procedures as previously, and space in recovery rooms was increased.

Perhaps one of the most highly developed theoretical bases in the US is that employed by designers of healthcare environments. The field of environmental psychology, the study of transactions between individuals and their physical settings (Gifford, 1987), involves issues such as control, privacy and social interaction, personal space, territoriality, and comfort and safety (Shepley, 2005). Although most design professionals are not trained as environmental psychologists, increasingly more are applying theories from the field to their healthcare work. For example, the Press-Competence model (Lawton & Nahemow, 1973) is frequently considered when developing healthcare environments. This theory suggests that the more compromised patients are with regard to their physical or emotional health, the more susceptible they may be to negative aspects of the physical environment.

Today, many hospitals throughout America feature both abstract and realistic artwork. The use of abstract art is frequently substantiated by various color theories

(Tofle, Schwartz, Yoon, & Max-Royale, 2004). Appleton's prospect/refuge theory (1975), although not entirely substantiated, is often used to explain certain individuals' preference for nature scenes in artwork and gardens in healthcare settings. The theory states that taste in art is an acquired preference for particular methods of satisfying two inborn desires – opportunity (prospect) and safety (refuge), circumstances believed to be optimal for

Box 8. The United States Academic Centers for Arts and Healthcare Research.

Center for the Arts in Healthcare Research and Education (CAHRE)
The University of Florida's CAHRE, Gainesville, FL, is committed to advancing research, education, and practice in the arts in healthcare, locally and globally. Regarding research, Co-Directors and committee members conduct research projects that study the effects of the arts in healthcare on individual, collective, and institutional levels. CAHRE encourages research and scholarship in the field by providing a framework and other support for studies by individual researchers as well as effecting its own projects. Research goals include expansion of the current body of research in the field, development of appropriate measurement tools, and the facilitation of related research throughout the nation.
http://www.arts.ufl.edu/cahre/default.asp

The Arts and Quality of Life Research Center
The Arts and Quality of Life Research Center, Boyer College of Music and Dance, Temple University, Philadelphia, PA, promotes research, training, and innovative programs that demonstrate the unique role of the arts in making a difference in people's lives. To this end, the Center focuses on exploring uses of various creative arts to enhance human functioning, developmentally, intellectually, psychologically, socially, physically, aesthetically, and spiritually.
http://www.temple.edu/boyer/researchcenter/

The Art/Global Health Center at UCLA
Located at the University of California Los Angeles, The Art/Global Health Center is committed to supporting and developing scholarship focused at the nexus of art and health; to fostering interdisciplinary interaction among artists, public health workers, and medical professionals, at UCLA and beyond; to creating new opportunities for engaged scholarship; and to reuniting the consideration of art and health around the globe. These objectives are currently pursued through the Center's major initiative MAKE ART/STOP AIDS.
http://artglobalhealth.arts.ucla.edu/about.html

The Center on Aging, Health & Humanities

The Center on Aging, Health & Humanities at the George Washington University in Washington, DC, establishes programs focused on understanding, studying, and promoting creativity that accompanies aging. The Center coordinates a major research program focused on creativity and aging and houses the Creativity Discovery Corps, a new program targeting the creative efforts of three groups: creative older persons themselves; programs that creatively foster the release of human potential in older individuals; and volunteers who are creative in their efforts to promote both the visibility of talented older persons and the best practices of programs that help older persons to be creative.
http://www.gwumc.edu/cahh/

human survival and reproduction in the savannah. The theory proposes that humans respond to such things as art subconsciously and that individuals attracted to such circumstances would have stood a better chance of survival by choosing to spend time in such places. Thus, the theory implies, art that puts the viewer in between prospect-dominant and refuge-dominant areas will be most appealing.

Academic Centers

As research in the field of arts in healthcare has progressed, some universities have made a commitment to research in this field by developing centers devoted to this research topic. A sampling of such academic programs in the US is offered in Box 8.

Non-Academic Organizations That Promote Arts in Healthcare Research

A growing number of non-academic organizations promote arts in healthcare research. In addition to the Society for the Arts in Healthcare described earlier, other active organizations are described in Box 9.

Education and Training

In the climate of the twenty-first century, continued growth and development in the arts in healthcare has spurred the development of education and training programs. While degree programs have not yet developed, numerous institutions in the US, including academic institutions and non-academic organizations, are addressing education and training for field practitioners and for organizers.

Professional Standards and Credentials

As has been noted, the arts in healthcare encompasses a wide array of practices. These practices are facilitated by an equal array of professionals, including:

- professional artists,
- community artists,
- arts educators,
- arts administrators,
- healthcare administrators,
- physicians, nurses, and other health professionals,
- medical and other researchers,
- arts therapists, expressive arts therapists, and occupational therapists,
- child life specialists,
- artists, architects, and designers,
- psychiatrists, psychologists, mental health counselors, and social workers.

Arts in healthcare services are also commonly delivered by volunteers, including artists, community crafts people and performers, medical students, and students of the arts. While formalized credentials or licensing have not yet been established for practitioners in the field, general standards for practitioners do exist. In 2005, the Arts in Healthcare Advocates, a group made up of the directors of long-standing US programs, gathered to develop a white paper entitled *Arts in Healthcare Programs and Practitioners: Sampling the Spectrum in the US and Canada* that describes a sampling of programs, including structures and staffing (Deschner, 2005). The work of the Advocates led to some common consideration of hiring standards for artists, which are reflected in the guidelines set in

Box 9. A Sampling of Non-Academic Organizations Promoting Arts and Healthcare Research.

Center for Health Design
The Center for Health Design (CHD), Pleasant Hill, CA, is a non-profit organization that supports, develops, and disseminates information and research that demonstrate how supportive environmental design enhances health and well-being. Since 1988, CHD's focus has been on healthcare facilities. CHD offers technical support, a healthcare design action kit, research reports (including Ulrich and colleagues' (2004) report of the role of the physical environment in the hospital of the twenty-first century), a journal of healthcare design, a booklist, a directory of products, and a list of exemplary facilities in the United States. Of special interest is the Pebble Project research project that provides examples of healthcare organizations whose facility design has made a difference in the quality of care and financial performance.
http://www.healthdesign.org/

National Endowment for the Arts
The National Endowment for the Arts (NEA), Washington, DC, is a public agency dedicated to supporting excellence in the arts, both new and established; bringing the arts to all Americans; and providing leadership in arts education. Established by Congress in 1965 as an independent agency of the federal government, the Endowment is the nation's largest annual funder of the arts, bringing great art to all 50 states, including rural areas, inner cities, and military bases. NEA has arts in healthcare as one of their leadership initiatives. In addition to resources on their website, the organization has held symposiums on the topic and recently hosted an arts in healthcare research roundtable, the second in a series of meetings the Office of Research & Analysis is convening to bring together arts and culture researchers to discuss trends and issues facing the field.
http://www.nea.gov/resources/accessibility/artsnHealth_top.html

National Association of Children's Hospitals and Related Institutions
The National Association of Children's Hospitals and Related Institutions (NACHRI), Alexandria, VA, is an organization of children's hospitals with 218 members in the US, Canada, Australia, UK, Italy, China, Mexico, and Puerto Rico. Children's hospitals work to ensure the health of all children through clinical care, research, training, and advocacy. The organization recently released a new publication, *Evidence for Innovation: Transforming Children's Health Through the Physical Environment (2008)*. This report, developed in partnership with the Center for Health Design, presents a scientific review of 320 articles in the literature and the business case for evidence-based design.
http://www.childrenshospitals.net

Society for the Arts in Healthcare
In addition to offering research resources on the website that include a link to the CAHRE research database, the Society, based in Washington, DC, has an active Research Committee, a Research Special Interest Group, a consulting service (SAHCS), webinars, the American Art Resources and Society for the Arts in Healthcare Research Grant, and a research award for completed published research. Research and evaluation also are promoted through the rigorous requirements of the Blair Sadler Award, which is presented annually at the Society's spring conference.
http://www.thesah.org

place by Shands Arts in Medicine, a program that employs 14 professional artists in residence. Through anecdotal experience, the authors believe that these guidelines may be generally representative of the field at large. Shands requires artists in residence have a minimum of a bachelor's degree in a related field or demonstrated equivalent professional artistic experience outside the educational setting. Artists must complete a related training program and demonstrate an understanding of the complexities of the clinical setting, or have at least one year of previous professional experience working in a healthcare setting. New artists are also required to complete the Shands Arts in Medicine mentoring program.

Program-based Training Models

There are myriad trainings and certifications in specific practices closely related to arts in healthcare practice, such as the Clown Care training of the Big Apple Circus (Children's Hospital Boston, 2009), the International Harp Therapy Training Program (IHTTP) (n.d.), and Anna Halprin's long-standing training programs at the Tamalpa Institute (Halprin, 2000, 15). The Creative Center in New York has developed a long-standing National Training Program (The Creative Center, n.d.) for hospital artists in residence. The program provides professional training to artists focused on work with cancer patients in medical centers, clinics, and hospitals. The one-week program includes seminars, workshops, and open studios led by artists, physicians, nurses, and psychologists from New York educational and medical centers; and features internships at major medical centers.

Most hospital arts programs provide structured individual mentorship to new artists in residence and develop their own training programs and materials. For example, Duke's program created a Hospital Arts Handbook, and The Creative Center published and sells a guide entitled *Artists-in-residence: The Creative Center's approach to arts in healthcare* (Herbert, Waggoner, Deschner, & Glazer, 2006). A number of established programs, including the University of Iowa and Shands Arts in Medicine, offer structured site visits for consultation to guide new programs in establishing training mechanisms.

Professional development in the field is undertaken by the Society for the Arts in Healthcare, the National Center for Creative Aging (NCCA), the North Carolina Arts for Health, and the various arts therapies associations. In addition to the professional development services described earlier, the Society for the Arts in Healthcare has an extensive ToolBox of resources on their website for program development, management, and expansion (Society for the Arts in Healthcare, 2005–2009). The North Carolina Arts for Health network implemented a training institute in 2003 and has revised the format for 2008 that is aimed at renewing creative energy for arts in healthcare practitioners and providing insights into the use of the arts within the healthcare system and the state of the field in North Carolina.

University-based Training and Curricula

As professionalism increases in healthcare-based arts programs, so does the demand for academic training and credentialing. Employers and practitioners alike are looking for more in-depth training and documentation of that training. Although, as noted above, there are no accredited degrees offered currently in the US in the arts in healthcare, several universities have developed curricula and certificate programs. These programs will be described as distinct from arts and humanities curricula in medical schools, which will be discussed in the next section.

University courses in arts in healthcare topics range from special offerings to stable components of ongoing curricula. The earliest coursework was developed at the

Box 10. Arts in Healthcare Courses Offered by the University of Florida.

Introduction to the Arts in Healthcare
Arts in Healthcare Clinical Practice
Dance in Medicine
Dance Clinical Practice
Writing and Healing: Process and Practice
Music and Health
Spirituality and Creativity in Healthcare
Reflective Writing
Culture, Health, and the Arts: Sub-Saharan Africa and the US
The Arts and Healing in Europe and North Africa (Study Abroad)
Arts in Healthcare Service Learning in the Gambia (Study Abroad)

University of Florida in the College of Fine Arts by the Center for the Arts in Healthcare (CAHRE). In 1996, CAHRE developed the Dance in Medicine course, which has since expanded into a 12-credit certificate program (CAHRE, Courses, n.d.). CAHRE currently offers at least 11 arts in healthcare courses per academic year in four colleges at UF (see Box 10), including opportunities for overseas study (CAHRE, Study Abroad, n.d.). CAHRE's new Arts in Healthcare Certificate, a 12-credit program, is designed to be earned by UF and non-UF students as well as professionals.

Since 2001, CAHRE has offered the Arts in Healthcare Summer Intensive, a three-week comprehensive training program for arts in healthcare practitioners, administrators, and healthcare providers. The program covers both theory and practice, including guided clinical experience with Shands Arts in Medicine. Students may elect to an emphasis on clinical practice, administration, or a combination of both (CAHRE, Summer Intensives, n.d.) and can earn academic or continuing education credits. In 2007, CAHRE partnered with the University at Buffalo Center for the Arts to develop a new annual summer intensive training program at UB, which in 2009 will expand to include an advanced clinical practice track for professionals.

Montgomery College in Silver Spring, MD, offers a course entitled "Artists in Hospitals," designed to introduce artists to work in healthcare settings. The course includes supervised hospital visits and is taught by Dr. Judy Rollins who also teaches "Arts for Children in Hospitals" for medical students at Georgetown University (Society for the Arts in Healthcare, 2005–2009). Georgetown University School of Medicine is currently in the process of planning the development of a Center for the Arts and Humanism in Medicine.

Arts in Medicine I at the University of New Mexico is a service learning course dealing with the ways creativity and the arts impact healing and are used in the arts in healthcare field. It includes informational sessions, arts workshops, and clinical projects based in the UNM hospitals, Psychiatric Center, Cancer Research and Treatment Center. Students may receive credit through the appropriate arts discipline and the service learning is individually contracted (University of New Mexico, n.d.).

The Arts in the Education of Health Professionals

Modern evidence-based medicine has evolved an increasingly specialized focus, with the narrowly defined outcomes and interpretations of clinical trials as its gold standard. This has its origin in the United States in the publication of the Flexner Report in 1910 (Beck, 2004), describe earlier. No one today would question the dramatic advances in

medical science and practice that ushered in this era of high-tech medicine. But in seeking to eliminate scientific unorthodoxy and bias, medical science also came to largely discount the vast store of "subjective" psycho-socio-spiritual experience that is the essential story of human suffering and healing. The modern medical student spends several years learning that everyone's physiology and pathology is essentially the same, only to find out very early in practice that we are all in fact quite different (Platt, 1965). It is in failing to account for this individual uniqueness that evidence-based medicine has fallen short. And it is in the incorporation of the arts and humanities into medical and nursing education that the system asserts an intention to return a more holistic view to the practice.

As more subjective, patient-centered approaches have evolved at the bedside and in the clinic, so too has humanism found an important place in medical education. Training programs in the medical humanities and narrative medicine have become ubiquitous in the US, the UK, and elsewhere (Charon et al., 1995; Coles, 1979; Greenhalgh & Hurwitz, 2004; Hunter, 1991; Jones, 1997; Kleinman, 1988). Pioneered in the 1970s and 1980s, these programs have since infiltrated mainstream US medical education, although they remain elective in most curricula, and are also becoming more prevalent in nursing education.

Medical humanities is a broadly inclusive term that incorporates the fields of humanities (literature, ethics, philosophy, and religion), the social sciences (anthropology, psychology, and sociology), and art (music, theater, and the visual arts). Because they reflect every aspect of our world, the medical humanities are ideally suited to help in interpreting our whole subjective experience of illness, suffering, and healing. This is reflected in the extraordinary outpouring of all forms of arts representation concerned with human health and illness, particularly in the fields of literature and the dramatic arts, both for professional and lay audiences/readership. "On Doctoring," an anthology of medical literature first published nearly 20 years ago, included more than 100 contributions from over 70 writers, from the Bible until the modern day (Reynolds & Stone, 1991). This genre of writing by and about doctors and other health professionals continues to burgeon. Many medical professional journals now include sections devoted to poetry, patient stories, and personal vignettes and reflections on the subjective and narrative aspects of illness.

Arts programs have developed within the medical schools of numerous major research universities, including Harvard Medical School's nine-week course in partnership with the Museum of Fine Arts, Boston; Yale School of Medicine's partnership with the Yale Center for British Art; a new "mini-elective" course offered by the University of Pittsburgh School of Medicine with the Carnegie Museum of Art and Andy Warhol Museum; Tufts University School of Medicine's partnership with the School of the Museum of Fine Arts; and the Frick Collection program with the Weill Medical College of Cornell University. Courses are offered at these and other universities, including Tulane University, Stanford University, Emory University, the University of Florida, the University of Connecticut, Columbia University, and the University of California, San Francisco, to name a few.

Medical schools that have incorporated visual art programs into their curriculum have proven the value of such educational approaches through research. A study by Joel Katz and Shahram Khoshbin from the Departments of Medicine and Neurology at Harvard-affiliated Brigham and Women's Hospital is published in the *Journal of General Internal Medicine* (July, 2008), and an earlier study by Yale Medical School's Irwin Braverman, M.D., professor of dermatology, former student Jacqueline Dolev, M.D., and Linda Friedlander, curator of education, Yale Center for British Art is detailed in *Journal of the American Medical Association* (September 5, 2001). Katz and Khoshbin found that students receiving the training were likely to make more observations than those in the

control group, and showed stronger visual acumen through greater accuracy, complexity, and sophistication in what they observed. Braverman, Dolev and Friedlander found that students who received the training improved their detection of details by 10%, while control groups showed no improvement in detection of details.

Final Reflections and Recommendations

The arts in healthcare has emerged as a significant field and as a recognized component of the healthcare systems in the United States over the past half century. Although advancements in professional practice, research, education, and organization of the field at the national and international levels are significant, coordinated efforts are required for continued growth and for stability of the field. To maintain its growth trajectory, particularly in light of the current widespread budget cuts in healthcare, the field must undertake coordinated efforts in developing a body of research that documents and articulates the impact and value of the arts for patients, caregivers, healthcare systems, and communities. This body of research must appeal to the broad spectrum of healthcare professionals, including administrators and policy makers, and address the business case for the arts in healthcare. As our aging populations grow and our economy changes, the costs associated with healthcare become central and critical issues. Arts in Healthcare studies should address cost-effectiveness and return on investment as well as the impact of the arts on the health and well-being of individuals and communities. Only as the body of research grows to include economic evidence of the value of the arts in healthcare will development of the field benefit not only from individual and organization efforts, but from policy-related achievements as well.

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