Defining the Role of “Relational Producer” in Arts-and-Health Collaborations in Hospitals

A Reflection on Catalysts and Partnerships

ANNA LEDGARD, SUSANNAH HALL, SOFIE LAYTON, MARK STOROR, NICKY PETTO, JO WRAY AND GIOVANNI BIGLINO

As the profile of the arts-and-health sector grows and interdisciplinary projects with public outcomes become more common, it is useful to explore roles and ways of working at the interface between different disciplines. The authors analyze the complex role of producer, likely to become increasingly relevant in this landscape. While incorporating aspects of existing roles (e.g. hospital arts manager, cultural venue participatory producer, independent creative producer, public engagement manager), the producer has a very specific raison d’être and could be defined as “relational producer.” This role is not well understood and yet central to this field of practice.

TO TAKE CARE OF RELATIONSHIPS

The current political climate in the U.K. is encouraging with respect to the arts-and-health field, including recent recommendations from the All-Party Parliamentary Group on Arts, Health and Wellbeing [1] and the Secretary of State for Health and Social Care acknowledging the value of the arts in improving health outcomes [2]. As recently outlined in the World Health Organization’s review on arts-and-health, the evidence base for the impact of the arts on health and well-being is substantial and growing [3]. Interdisciplinary collaborations are flourishing, exploring creative opportunities at the intersection of the arts and medicine to promote health and well-being, prevent a wide range of health conditions and inform treatment and management of both acute and chronic diseases [4]. These collaborations often involve partners from different professional backgrounds exploring different media (from visual arts to music, from dance to theater to animation) and can lead to hospital interventions for the purpose of quality improvement and/or to public outcomes (in the form of performances, exhibitions, screenings and even entire festivals). When considering the makeup and the dynamics of such partnerships, one must pay special attention to a specific role that is less immediately definable than others (such as that of a nurse, hospital arts manager, artist or scientist). That role is the “producer” of the project, which we propose to define as “relational producer” and whose characteristics are discussed here.

The term curator, generally espoused by the world to relate to the visual arts and museums, comes from the Latin cura, meaning “to take care” or to be a guardian, and is a central defining principle for a producer in an arts-and-health collaboration. We propose that rather than caring for objects and curating them with meaning and context for a public, in the arts-and-health setting, a “relational producer” aims to guard purposeful and effective collaborative relationships between artists, patients, clinicians and cultural partners. While the artist holds the artistic vision, the relational producer supports the artist and holds a solid framework of relationships, enabling the artistic practice and participatory work to develop. A relational producer in an arts-and-health context is not an artist, medic, nurse, psychologist or patient, but the role is underpinned by knowledge and understanding of the language and practices of interdisciplinary creative processes, patient engagement, reflective practice and the workings of clinical contexts. The term relational producer is aligned to theories of relational art practice, a practice grounded in human relations and their social context, and to the central role of collaboration [5]. In this model, a Cultural Leadership Programme initiative of 2010, “Taking Up Space,” involved eight experienced practitioners in defining such a role [6]:

This work demands broad skills: we know how to work across social, cultural and intergenerational differences to bring people together and build community, how to engage...
with people in power; negotiate with institutions; build networks in local places; organise volunteers; fund-raise; open roads and make celebratory spaces.

This model can also be applied broadly to arts-and-health projects, particularly those rooted in participatory practices, i.e. directly engaging patients in exploring their conditions through creative media [7]. Alongside participatory practices, the commissioning of visual artworks within hospital buildings in several clinical centers sits within the arts-and-health model but is not necessarily participatory in nature. The roles discussed in this reflection refer to a participatory approach; the article does not concern itself with commissioned artworks, such as a sculpture in a hospital atrium or paintings hung along corridors.

Caring for an entire project and looking after relationships imply a duty of care for all involved and a strong responsibility to ensure that roles and responsibilities are understood and clear communication is facilitated across the group. For arts-and-health collaborations with patient experience as their principal focus, medical partners, specialist nurses and psychologists (where there are vulnerable patients) need to be deeply involved in the conversation from the beginning.

The other key element coordinated through this role is the overall producing frame, dealing with production and administration of the participatory phase and—when present—of the public outcomes. This also includes taking care of the relationship with a public audience, to whom the public artistic outcome is addressed. Indeed, as recognized by the American Society for the Arts in Healthcare, the arts not only have the potential for encouraging prevention and stimulating health promotion but also can attract attention to a health issue [8], thus creating knowledge at a societal level.

In light of the increasing recognition of the value of these practices, it is essential to identify where the relational producer sits and how the role is shaped. The relationship with the lead artist, holding the artistic vision for the project, is key. In work that explores people’s experience, the artist can hold the creative center, enabling participants to collaborate and get immersed in the artistic process, building a dialogic relationship, as opposed to going out to the patients and bringing experiences back into their own practice without further direct reference to them. In other words, this is the difference between art made “with” the patients (as active participants) and art made “about” the patients (as subject matter). In participatory practice this is a two-way conversation, and the relational producer must remain close to both artist and participants at this interface. Such a delicate interface will also involve a medical partner (e.g. a nurse specialist) who has critical knowledge of the participants and their condition.

Figure 1 summarizes key dimensions of arts-and-health collaborations based on a participatory creative approach.

In the planning phase of a nascent collaboration, the relational producer needs to research what the priorities of the ward/team/institution are in the broader context of current healthcare priorities and, presently, of key concepts such as “patient engagement” and “social prescribing” [9]. Institutional support is paramount and the relational producer strives to facilitate access to and maintain engagement with senior management teams, reporting back and building a conversation with key partners that have the authority to (a) provide additional access to other partners if necessary and (b) embed the work (or consider the possibility of embedding it) into practice. Therefore the relational producer, in the early phase of the project, focuses on setting clear parameters, securing meetings to build mutual trust across partnerships, facilitating the initial conversations and gathering resources. Once these are in place the focus shifts toward maintaining a reflective engagement process, facilitating the
artistic vision, project oversight and a duty of care for all involved. Figure 2 summarizes key dimensions of the role.

Although the role may appear vague and less defined than other roles that have a very clear remit (e.g. scientist, artist, psychologist, professionals responsible for press and communication), key to this role is the overview across all areas of the collaboration (i.e. navigating different environments such as clinical meetings, creative workshops, school activities, patient groups). The role thus involves an element of translation, which is critical behind the nomenclature of relational producer. Indeed, precisely the role’s encompassing different dimensions is one reason nomenclature is tricky. The different roles and responsibilities discussed here may vary depending on project budget and size; some instances may involve collaboration with a project manager, an administrator or a curator, while in other settings the role may be more all-encompassing.

RELATIONSHIPS, PARTNERSHIPS OR MATCHMAKING?

With regard to the collaboration between the artist and the scientific/medical partner(s), in some instances a good collaboration (or the potential for it) is already in place for different possible reasons (e.g. affinity of interests, a shared experience, an existing embedded arts program). The relational producer may come in at a point where the scientist and the artist are already in a fruitful conversation and will need to consider whether the institutions are in this conversation with them. Despite the scientist being embedded in an academic/medical institution, the institution itself is unlikely to be able to manage something as complex as forging reciprocal partnerships with cultural organizations and managing practical elements of a project with public outcomes, which range from scheduling all aspects of production and contracting freelance staff to handling PR and communications. Even where there is an embedded arts program in a hospital, managing major public engagement outcomes (e.g. touring exhibition) may be beyond the arts program’s remit and capacity, especially where they are funded specifically to deliver services within the hospital itself. A relational producer existing outside of the institution and with experience of the wider art world may be better placed to forge relationships between these disciplines.

There may be other instances where a shared interest is identified and the relationship itself may need to be facilitated, i.e. linking the scientific and artistic partner(s), in other words “matchmaking.” Key to catalyzing these relationships are identifying individual and shared objectives and ambitions (e.g. increasing well-being, helping patients’ understanding of their conditions, supporting medical staff in demanding settings) and outlining the role that an artist could play in that context.

When working in a setting where there are different institutional interests, the artist may risk a struggle to remain true to their creative vision. Here the relational producer can provide support for the artist to experiment or, to some extent, take a risk, by holding such conversations. By working in a sensitive environment where various interests and needs are represented (first and foremost the patients’, but also institutional interests) the artist could experience restraint, frustration, withdrawal or burnout. The relational producer can mediate this by holding the institutional conversation and aligning different views.

Building the institutional relationship is a significant investment. Support from a well-respected individual “on the inside” can substantially facilitate the process, particularly in instances where the imperative to initiate the interdisciplinary collaboration is primarily artistic rather than scientific. Senior managers can drive organizational support for this kind of work, so their vocal support to staff and others adjacent to but not necessarily involved in the project can crucially contribute to build support across the institution, particularly when this kind of project is unfamiliar or regarded as a questionable use of resources. Conversely, lack of support or a dismissive approach from a senior member of an organization can undermine a project very quickly.

VALUES AND RESPONSIBILITIES

In enabling a team of artist(s) and scientist(s) to work with potentially vulnerable participants (e.g. patients), the producer and the institution have to be totally confident about the partnership, ensuring the artistic quality and relevance of the activity and avoiding any potentially unsafe situation for the audience that is being engaged. Indeed, patients engaged through a participatory process in creatively exploring their narratives of illness may experience a resurfacing of delicate or even painful memories and—depending on the setting—complex and sensitive issues about the individual may more or less overtly be approached (e.g. a physical disability, sexual potency, anxieties, mortality). Confidence in the partnership can be informed by past practice and instinct but also can be practically facilitated, e.g. devising a workshop to explore the artistic process with the team and clinical staff before involving patients. This can build understanding of the artistic possibilities and highlight potential pitfalls in the process or in the relationships, while establishing a sensitivity to the material and potential boundaries where appropriate. Because uncertainty is intrinsic to the artistic process, with the possibility of generating unexpected outcomes (e.g. emotional reactions in patients), it is especially critical that each team member has a clear sense of their role in ensuring a safe environment. Clear organization and communication within a team are essential to ensure the safety of participants.

One impediment to the relationship-building and thus the process can be the ego of different players. Egos are left outside the room, fostering inclusivity, and values ideally should be shared or at least acknowledged. Questions to be explored at the very beginning should include: Why is this collaboration being established and this creative endeavor undertaken? Is it to improve patient well-being? Is it for my research paper? Is it for my reputation as a visual artist? Is it for parents to acknowledge their needs as primary caregivers for a sick child? Is it for the nurses to acknowledge the losses and grief that they deal with every day? Who is it for? Does it include elements of all of these? Identifying both individual
contributions and potential individual gains [10] at the outset at a team level can set up a positive dynamic, acknowledging different perspectives and recognizing the value of each contribution.

Alongside individual motivations, it is also useful to contextualize the work from an institutional standpoint and within institutional priorities, with often one of the major imperatives to this work being to communicate with or engage the public.

PUBLIC ENGAGEMENT

The relationship with the public (i.e., patients engaged in the process and wider audiences if there is a public outcome) is vital, with the aim of engaging at a deep and authentic level with human experiences through rich creative encounters and compelling, emotionally meaningful interaction. For genuine public engagement, people need to learn or to be moved, or engage empathetically in some way and feel a connection to the work they are engaging with. Herbert Read saw art as “a way of paying attention” [11]. The work has to have some memorable impact for the audience, and that is where art that has its origins in relational processes can be so powerful, because art can engage the imagination through metaphor and poetry, creating meaning and connection with someone else’s experience. Public responses collected at the time of presenting a public outcome can testify to the richness of the engagement process (an example is provided in the online supplemental material), and evidence is increasingly presented in relation to clinical benefits [12], yet systematic research is required to fully understand the impact of experiencing artistic outputs stemming from such arts-and-health collaborations on different communities.

Relationships with cultural partners and venues can be a significant factor affecting the quality of such public engagement. Ideally a relationship will be established with the most appropriate community/organization in relation to the project (geographically and with respect to its context and form, e.g., theater, visual art, music, etc.). In order to give wide public access to the work, a public organization with strong links to its local community represents an ideal scenario. Again, aligning priorities is essential to ensure reciprocity, as is, at a team level, recognizing the priorities and strategies of the venue in relation to the work that is being explored (e.g., seeking to improve its relationship with local universities or hospitals, engaging school audiences, etc.). This stresses the importance of the relational producer being deeply familiar with the artistic process and with the opportunities such processes can offer for local engagement in line with the cultural venue’s priorities.

Just as navigating a relationship with a clinical partner can be delicate and complex, having a conversation with arts institutions and cultural partners requires an equally sensitive and experienced approach in order to be successful. Taking into account different institutional priorities as well as individual priorities and views within the cultural partner organization is thus also of the utmost importance. A short case study based on the authors’ own experience (see online supplemental material) provides an example of successful collaboration between a multidisciplinary team and a museum partner mediated by a relational producer.

THE ORGANIZATIONAL AND ADMINISTRATIVE DIMENSION

An arts-and-health collaboration requires operational producing, financial and production management, especially if working toward a public event or outcome. The relational producer will be responsible for budget oversight with collaborating partners, requiring expertise on managing finances and accountability procedures. This can be complex, with different accounting systems between hospitals and cultural organizations, and clear articulation of financial responsibilities across institutional partnerships is critical. Identification of resources and fundraising are a collaborative responsibility with institutional partners and are often led by a relational producer and/or an academic partner. Depending on the size and budget of the project, a production management role could be included in the collaboration, providing the necessary support to present the practical product of the participatory process in a public place. The relational producer oversees this role alongside the artist liaising with the production manager and technical team, ensuring clear timelines and roles and including practical elements such as issuing contracts and drawing up technical production requirements, health and safety measures and insurance. The relational producer will also oversee press and communications, advocating for the acknowledgment, and appropriate crediting, of participants’ creative input throughout the project. High-quality and effectively managed production of public outcomes is not only desirable but ethically necessary in valuing the creative contributions of all those participating in the project (including patients).

PROBLEMATIZING THE ROLE

While the relational producer is a crucial element for a successful arts-and-health collaboration in a medical context, the role also presents potential risks. As with any work carried out with a vulnerable audience (e.g., patients in a hospital setting), the relational producer must be aware of ethical constraints and pertinent good clinical practice frameworks. Also, with insufficient time allowed for relationship building, the success of the collaboration can be compromised from the start, while, conversely, diluting the necessary struggles within the communication process can prevent the team from arriving at a shared understanding in the early phase of the collaboration. With regard to the relationship with the artist(s), the latter could be inadequately supported, where under-resourcing includes not only underestimating financial resources but also underestimating time for reflection and debriefing. Unconscious or (less likely) conscious appropriation is also a potential risk, particularly in relation to a creative public outcome. Finally, failing to bring the right people onboard at different stages in the collaboration can result in a loss of credibility for the project.
CONCLUSION

In an attempt to define the role of relational producer (as broadly as possible, acknowledging the variety of projects and collaborations that can influence/limit features of the role), we suggest that the participants are at the center, and the relational producer, the artist and the key partners are situated closely alongside them, maintaining values, ensuring a duty of care for all, enabling high-quality artistic practice and ethical participation and communicating clearly across different domains and disciplines. This is the scaffold on which multipartner arts-and-health collaborations and public engagement depend.

Acknowledgments

The authors acknowledge the generous support of the Wellcome Trust, Arts Council England, Guy’s and St Thomas’ Charity, GOSH Arts, Blavatnik Family Foundation, Above & Beyond Foundation, Bristol National Institute for Health Research (NIHR) Biomedical Research Centre (BRC) and the British Heart Foundation.

References and Notes


4 Fancourt and Finn [3].

5 Nicolas Bourriaud defined relational aesthetics as “a set of artistic practices which take as their theoretical and practical point of departure the whole of human relations and their social context, rather than an independent and private space”: N. Bourriaud, Relational Aesthetics (France: Les Presses Du Réel, 1998) p. 113.


10 Bourriaud [5].

11 Khan et al. [6].

12 Fancourt and Finn [3].

Manuscript received 15 June 2019.

ANNA LEDGARD, a producer, project manager, researcher, lecturer and professional development leader, has 30 years’ experience shaping collaborative arts practice with hospitals, communities, schools and cultural organizations.

SUSANNAH HALL, as Head of Arts, leads on the arts and humanities at Great Ormond Street Hospital, commissioning, programming and managing diverse and innovative arts and creative experiences for young people, families and staff.

SOFIG LAYTON’s art includes installation, site-sensitive performance and theater; her most recent work explored the creative interface between patients and the scientific/clinical landscape, based on a participative narrative process.

MARK STOROR is an award-winning artist with an international reputation and extensive experience working collaboratively with a wide range of organizations and communities, including work in hospitals, prisons, schools and housing estates.

NICKY PETTO is a producer and arts manager with knowledge of visual art, cultural placemaking, festivals, performance and participatory practice.

JO WRAY is a health psychologist and Senior Research Fellow in the Centre for Outcomes and Experience Research in Children’s Health, Illness and Disability (ORCHID) at Great Ormond Street Hospital. A mixed-methods researcher with a particular interest in the development and testing of measures of outcomes and experience, she currently pursues projects including an interdisciplinary program of research bringing together art, technology and the voice of patients.

GIOVANNI BIGLINO is a biomedical engineer; his current research is very collaborative, involving cardiologists, surgeons, imagers, psychologists and artists, aiming to explore combining technologies and creative practices to represent health and disease in new ways and spark new conversations in society.