How Portraiture Can Help Build Therapeutic Capacity In Patient-Clinician Relationships

This course will use work from portrait artist Mark Gilbert to demonstrate how artists' relationships with people sitting for a portrait can inform how clinicians relate to patients.

Portraits are now commonly integrated into health humanities courses. They are often used to help health professions students’ cultivate their observation skills. The focus of this exploration, however, is how portraiture applies to health care ethics and professionalism, specifically to nourishing therapeutic capacity in patient-clinician relationships.

**Instructions:** Click the Start course above, or navigate to a section below to begin.
Questions or comments on this module? Contact us here.

LEARN

- Introduction
- What are important concepts of portraiture in clinical settings?
- What are processes and outcomes of portraiture and viewers' roles?
- What's involved in portraiture collaboration?
- How does moral perception inform clinical practice?

Challenge

CME Credit

DIG DEEPER

- Additional Resources
- Appendix: Gallery of images used in course
Mark Gilbert, PhD, Portrait Artist

Since the 1990s, Scottish-born artist and researcher Mark Gilbert has innovated portraiture.
Depicting caregivers’ and patients’ stories and experiences of illness and recovery within clinical, studio, and domestic settings, each portrait expresses intimate collaborations between artist and sitter.
Gilbert’s methods prioritize values of mutuality, reciprocity, trust, and vulnerability.

His artistic processes express the importance of compassionate engagement, a key feature of his arts-based research into portraiture’s clinical, ethical, and aesthetic applications.

Gilbert’s 5 major bodies of work emerge from over 2 decades of practice in major health professions programs in the United Kingdom, the United States, and Canada. Gilbert’s work has enriched and expanded traditional conceptions of portraiture, expressing everyday children’s, adults’, and elders’ experiences of giving and receiving a wide range of care. His portraits poignantly illuminate vulnerabilities we all have in common and our shared individual and community interests in caring and being cared for well.

Gilbert’s collaborations in portraiture prompt ethical and aesthetic inquiry into the most interesting, important, and neglected questions about the goals of health care.
Clinical portraiture is an emerging field at the intersection of art and ethics in health care.
Portraiture in clinical settings illuminates key ethics concepts in health professionalism — specifically, those key to motivating understanding and connection in patient-clinician relationships:

- *mutuality*
- *reciprocity*
- *trust*
- *vulnerability*

## Learning Objectives

At the end of this course, you will be able to:

1. Define key ethics terms and concepts related to portraiture in clinical settings.
2 Identify features of portraiture in clinical settings that can build therapeutic capacity in patient-clinician relationships.

3 Interpret how moral perception informs clinical practice.

Mark Gilbert: Portraits of Care (installation view), 2008. Courtesy of Bemis Center for Contemporary Arts. (click image to magnify)
Lesson 2 of 9

What are important concepts of portraiture in clinical settings?

Portraiture in clinical settings

Mark Gilbert working in his studio in The Memory Clinic, Veterans Memorial Hospital, Halifax, NS, 2019. (click image to magnify)
**What is portraiture in clinical settings?**

Portraiture happens in clinical settings when a subject (a patient or caregiver, for...

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**Professional values**

*Instructions: Click the plus signs to learn more.*

**Mutuality**

Portrait artist and subject mutually share the risks and benefits of portraiture intentions, processes, and outcomes; this expresses the ethical and aesthetic value *mutuality*.

**Reciprocity**
Portrait artist and subject reciprocally share time and space together, navigate communication and silence together, and deepen their relationship’s capacity to serve as a medium for their exchanges, experiences, and stories; this expresses the ethical and aesthetic value *reciprocity*.

**Trust**

When the subject-artist relationship is established over time during these exchanges, *trust* tends to be strengthened, enabling deeper exchanges from which insights can emerge. Such insights are one product of a relationship’s therapeutic capacity and are, thus, clinically relevant when a clinician uses them to help a patient.

**Vulnerability**

Emergence of some insights is also ethically relevant, specifically when they illuminate our common *vulnerabilities* to illness and injury and our shared individual and community interests in caring and being cared for well.
Evolution of portraiture in clinical settings

Back in the day

Artists have represented illness and injury for centuries. Anatomical drawings, for example, have been used to teach clinicians and document key details since the Renaissance and possibly prior. (click image to magnify)
Representing human form

Artists, notably da Vinci and Michelangelo, though there are others, also studied anatomy as a means of accurately representing human forms in their work, including portraits.

Representing pathology

Portraiture, in various forms—painting, drawing, and photography, for example—has been used to depict physical manifestations of pathology, illustrate and critique clinicians or their practices, and deliver public health announcements and education materials. As biomedical science
Art in medical education

Art, including portraits, is now commonly integrated into health humanities courses to help health professions students hone their observation skills. So, using portraiture in health care practice and in health professions education is not new. But use of portraits in health professions education has, to this point, tended to value portraits as
professions education has, to this point, tended to value portraits as finished products. (click image to magnify)

Portraiture as process

Focus on the processes of creating portraiture and how those processes are experienced by artist and subject has been neglected. Portraiture is a shared, collaborative creative process requiring mutual and reciprocal participation by both artist and subject. From a healing relationship perspective, the journey that clinicians take with their patients can be just as important from a therapeutic standpoint as the destination. Image:

Mark Gilbert, *Willy*, oil on aluminum, 12 x 9 inches, 2008. (click image
Mark Gilbert, *Willy*, oil on aluminum, 12 x 9 inches, 2008. (Click image to magnify)
Which ethical values can portraiture in clinical settings illuminate about patient-clinician relationships?

*Instructions: Select ALL that apply and click Submit.*

- [ ] Mutuality
- [ ] Confirming one's position in a social elite
Reciprocity

Showing how cancer changes people

Looking one's best in fine clothes

Trust

Vulnerability
Lesson 3 of 9

What are processes and outcomes of portraiture and viewers' roles?

Process is more important than outcomes
For Mark Gilbert, the process of creating portraits is, and must be, collaborative. Working in operating rooms, in clinic- and studio-based settings, and in patients’ and caregivers’ homes, Gilbert uses multiple media (drawing, painting, printmaking, and photography) to explore a subject’s experience. Each portrait session gives artist and subject time to build a relationship. From Gilbert’s point of view, developing relationships is essential in artistic process, informing and enhancing the images as they’re created.

Relationship development also gives subjects opportunities to discuss projects with Gilbert, reflect on their situations, and inquire about other subjects’ portraits in the studio. The artist’s relationships with subjects mirror relationships that develop between patients and caregivers. Data collected in Gilbert’s studies include transcripts of all subject-artist conversations and interviews. Gilbert also keeps a researcher journal, in which he reflects on the images, interactions, and ethical questions that arise during the projects and process of creating art.
**Observation in relationships.**

Gilbert often talks about a portrait as a response to a subject being observed. This idea is ethically and aesthetically critical and means that the subject-artist relationship is what makes a portrait possible. This idea is also clinically relevant: the patient-clinician relationship is what makes any health outcome possible.
Mark Gilbert, *Mazeeda B.*, oil on canvas, 60 x 60 inches, 1999. (click image to magnify)
What is a portrait?

There is no single type of portrait that tends to emerge from Mark Gilbert’s work with patients and caregivers.
Some works might not look like portraits equally to everyone, and these prompt some viewers to wonder, “What is a portrait? In order to be a portrait, must a work include a subject’s whole body? Just their face? Part of their face? Part of their face during surgery?”

Emergence of questions like these about artists’, subjects’, and viewers’ expectations of what portraiture offers is another ethically and aesthetically important outcome of portraiture. Such questions can inform patient-clinician relationship formation and maintenance, as patients’ and clinicians’ hopes for what their collaboration can or should accomplish during a period of time can differ. Finding common ground is key for establishing mutual goals and for nourishing trust and therapeutic capacity in a patient-clinician relationship.

**Whom to paint and why?**

Exploring and interrogating artists’, subjects’, and viewers’ expectations about how subjects are represented—as doing or not doing, having or not having, prioritizing or not prioritizing something—is another ethically and aesthetically important outcome of portraiture.
Viewers might wonder, for example, “Why would you do a portrait of someone who’s sick? Why would you have someone do your portrait when you’re sick? Should a subject look and feel beautiful, or at least look their best and feel their best? Shouldn’t the subject be a wealthy person wearing beautiful clothes? What makes a subject distinguished, important, worthy of being painted?”
Mark Gilbert, *Roland with Radiotherapy Mask*, oil on canvas, 34 x 34 inches, 1999. (click image to magnify)
Viewers might also reflect on their own biases about portraits and the subjects of portraits. In a clinical context, critically looking at portraits can help us interrogate our preconceptions and assumptions, foster open-minded and nonjudgmental reflection, and practice tolerance of ambiguity and uncertainty, especially in cases in which technical knowledge alone is not enough to help us navigate and improvise together.

Such questions can inform patient-clinician relationship formation and maintenance, as patients’ and clinicians’ views of what the other deserves from them and what the other owes them can differ. Exploring these features of reciprocity is one way to learn whether and how much trust has been assumed and how much has actually been earned and accrued in a patient-clinician relationship.

Portraits and roles of a viewer in portraiture
What would a viewer look at in this portrait, other than the subject? Devoid of narrative with only a flat, monochromatic background, this presentation
prompts a viewer to confront Henry’s visible disease and, specifically, how his tumors have disfigured his face. Perhaps Gilbert leaves a viewer with more questions than answers about Henry.

Which questions does this portrait raise for you as a viewer?

Henry de L.’s tumor resection is represented in this portrait by Gilbert. This style of representing a person’s face in a portrait challenges what might be construed as our traditional conceptions of portraiture. A viewer must orient themselves to identifying Henry’s tooth, eyebrow, or nostril in this intraoperative portrait, which explicitly draws a viewer’s attention to Henry’s body and his experience of being embodied in this surgical moment.
Patients and clinicians learn about each other both visually and narratively.

In your role as viewer of a portrait...

- *Where is your eye drawn?*
• **What about the portrait’s construction, about how the image is assembled, informs how you “read” the portrait?**

• **What do you learn about the subject just by looking and what else do you need to learn narratively and from whom to get a fuller understanding of the subject’s experience?**

Stories are a typical means by which patients convey information to clinicians, and they help develop patient-clinician relationships. In your role as a listener to a patient’s story...

• **What do you hear that accords or does not accord with what you see or what you can measure?**

• **How do you respond if a story you hear does not mutually reinforce what you see?**

These questions can inform our thinking about how patients and clinicians get to know each other when they meet for the first time, share new information with each other, share a new experience together, navigate doubt or confusion, or try to motivate reconciliation.

Match each feature of portraiture in clinical settings to the appropriate element of therapeutic capacity of a patient-clinician relationship.
Instructions: Drag each feature on the left to the appropriate element on the right.

- Portraiture values processes over products
- How much trust has been assumed and how much has actually been earned and accrued
- Viewers are part of portraiture
- Roles played by visual and narrative information
What's involved in portraiture collaboration?

Building trust by sharing vulnerability and risk

“A portrait is not just a picture of an individual, but a picture of someone being looked at; fundamentally it's a visual testament to a relationship.”

Mark Gilbert

**Being observed and judged.**

Sitting for one’s portrait means becoming comfortable with being observed. Both sitting and painting a subject’s portrait requires artist and subject to share their vulnerabilities. The artist, for example, marks a canvas in ways that build the rest of the creative endeavor the canvas records, and the
portrait, eventually, will be turned to the eye of the subject for her review, assessment, and judgment. In both **seeing** and **being seen**, portraiture is the process in which the subject-artist relationship generates what’s represented on a canvas and gives permanence to a set duration of time.

Time during clinical encounters is often framed around setting a specific goal or purpose for the time patients and clinicians spend together. It can be helpful for both patients and clinicians to try to discern and acknowledge how the other person is vulnerable during a clinical encounter and which risks each takes and accepts in order to try to motivate, if not achieve, their shared goal or fulfill their common purpose.
Seeing and being seen.
Sitting for one’s portrait generates instant intimacy that requires becoming comfortable with being observed. Both sitting and painting a subject’s portrait requires artist and subject to share their vulnerabilities. For an artist, the process of making a portrait is never entirely in one's control and is susceptible to error, accident, and failure. It is an inherently uncertain process, requiring profound observation and improvisation. A subject, perhaps new to sitting for their portrait, enters into this process not knowing the end at the beginning.

The portraiture process allows subject and artist opportunities to know each other as they interact and collaborate and as marks accrue on the canvas. Subjects have space to figuratively stand at their own easel, tell their own story, make their own marks, and then step back to see what surfaces. Portraiture generates relationships that develop among subjects, artist, and portraits themselves.

One patient felt the portrait would have an “aura” that his reflection in a mirror didn’t have. On viewing his portrait at the end of his first sitting, he said forlornly, “I look sad.”
**Sharing vulnerability and risk.**

Discerning how the other person is vulnerable during a clinical encounter and acknowledging which risks each takes and accepts in order to try to motivate their shared goal is key to both patient and clinician fulfilling their common purpose.
Mark Gilbert, *Kathryn*, pastel on paper, 65 x 53 inches, 2019. (click to magnify)
"It was not until my second portrait sitting that I realized what a truly vulnerable position Mark was in, as I watched him in his intimate moment of creating."

- Kathryn

**Navigating expectations and uncertainties together**

**How will I look?**

An artist will likely be aware that many patient-subjects will be sensitive to how they are represented in their portraits. As they adjust to new developments in their health status, surgeries, recovery, and altered appearances, they might feel anxious, stressed, and sad. An artist is keenly aware of risks of focusing on events in patients' lives and aspects of patients’ appearances that could be too upsetting. And an artist might fear that some might regard portraits of patient-subjects at vulnerable times in their lives as voyeuristic or exploitative.
"What does 'John' look like? I'm not expecting flattery."
- John
"This is something that will be around, for hopefully for a very long time, and it is kind of neat like it captures this moment in my life."
- Lisa
"Basically, my reactions to the first charcoals sketches were that I didn't think they looked like me at all, and I didn't like them. But it was a new process, really."
- Jim

**Will they like what I've made?**

An artist might feel the patients will be more sensitive to how they are portrayed. As they adjust to their new health status, recovery, surgical procedures and altered appearances, they may be burdened and fatigued with anxiety, stress, and even sadness. Moreover, the artist might feel they are focusing on events and aspects of patients’ lives and appearance that are too sensitive and upsetting. The artist might fear that the images will be regarded as voyeuristic and exploit already vulnerable subjects.

**Uncomfortable together.**

While both patients and clinicians are likely eager to seek new information to resolve uncertainty, some situations require working together to become more comfortable with uncertainty about what will happen, despite shared clinical goals and hope for good outcomes. **Mutuality** and **reciprocity** in patient-clinician relationships express the importance of sharing experiences (including discomfort) to strengthen the patient-clinician relationship and preserve commitment to the relationship’s therapeutic purpose.
Mark Gilbert, *Jarad*, oil canvas, 66 x 60 inches, 2008. (click to magnify)
Disappointment.

Cultivating awareness of how we respond to dashed expectations (about portraits or about patients’ progress, for example) or how we might benefit from being less attached to expectations or outcomes can also have value in maintaining therapeutic capacity in relationships in which patients have disappointed their clinicians or in which clinicians have disappointed their patients.

Means of engagement

Kinds of reflection.

When sitting for a portrait, some patient-subjects tend to reflect on their experience with health and health care. When this happens, both artist and subject engage in what Mark Gilbert refers to as “experiential reflection,” which happens when they are monitoring a present experience, and “narrative reflection,” which happens when they focus on fitting pieces of a sitter’s story and presence into a cohesive whole that informs how a portrait develops.
When I start looking back over stories of my life, I see patterns I didn’t see before.

- William

Scanning and enduring.

Other kinds of reflections upon subjects’ illnesses can happen during portraiture, too. Mark Gilbert painted the portrait of a woman named Lisa, who had no visible signs of her illness. Lisa was indeed a patient, however, and endured numerous postoperative scans.

The background of her portrait appears domestic, and portraits in this casual style invite a viewer to consider the subject’s life more fully. Mark’s and Lisa’s engagement during the portraiture process offered Lisa opportunities to remark on her progress.
“If I can get through this, I can, you know, get through anything … I did overcome that!

- Lisa

**Communicative silence.**

In cases in which subject and artist are unable to verbally communicate, silence can be deeply communicative during portraiture. Mark Gilbert painted Anthony, a patient who had his jaw, tongue, and larynx removed, due to a large head and neck cancer.
It was not until I worked with Anthony that I recognized silence as a deeply communicative act. Anthony lost his tongue and larynx, but he did not lose his voice. The silence that took its place became a profound form of expression.

Mark Gilbert on painting Anthony

Community.

For some subjects, sitting for their portrait is an opportunity to share their stories and experiences of illness or injury with others who might derive benefit from seeing their portrait. Mark Gilbert’s exchanges with Lisa also drew attention to each sitter’s capacity to engage with, via portraiture, a broader community of subjects, including patients. She remarked upon being a member of the community of patients whose portraits Mark Gilbert had painted, saying, “[Everyone participating in the portrait study] all
overcame something…everyone kind of has that look that ‘I did it’.” As Gilbert was a node in a social network of patient-subjects, so clinicians are nodes in networks of patient with some common sources of suffering.

Mark Gilbert, *Jim in the Hyperbaric Oxygen Chamber*, pencil on paper, 9 x 12 inches, 2013. (click image to magnify)

**Instructions:** Click the play button below to hear a short clip from an interview with one of Mark's subjects, Dr Jim Van Arsdall. In this clip, Dr Van Arsdall describes the experience and benefit of being surrounded by the portraits of other people Mark was working with during the creation of his own portrait.
Transcript

Tim Hoff: You mention that just being in that space and seeing the portraits that Mark was working on was helpful or therapeutic to you. Can you expand on why that was? Was it just the fact of seeing other people going through similar things that you were going through or what was important about that?

Dr Jim Van Arsdall: Part of it's the similarity. I think that's true. Part of it is curiosity because I was able to ask about them, and, you know, to a limited degree Mark was able to talk about them. Not their clinical problems, but the experience that he had drawing them, so, you know, you get to know them that way. And, quite frankly, you get to know them through the portraits. Because you see theirs change too. Not only did I see their final product, but I saw the charcoal and all that as it went on through that way. Okay? So I think that's part of it. It was just a relaxed atmosphere. And again, a familiar atmosphere because it was where I had been before. Every one of Mark's subjects that I've talked directly to talk about how helpful it was, in many different ways than what I did. The other thing is, part of this - I say it would be helpful with any artist - Mark Gilbert is a very special artist.
Mark Gilbert, Kjell II, oil on canvas, 66 x 60 inches, 2008. (click to magnify)

Exchange.
Exchanges about each other’s experiences can deepen clinicians’ conceptions of what an individual patient needs from a patient-clinician relationship that could be helpful and valuable to them beyond only clinical purposes and goals. Engaging with patients specifically about their experiences, even by just sitting with them in silence, can inform broader understandings of what patient-clinician relationships, and health care, are for.

**Instructions**: Drag each card to the appropriate side.
NOT an element of collaboration that helps build therapeutic capacity of a patient-clinician relationship

| Dress to impress | Giving directions about posture | CONTINUE |

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CONTINUE
How does moral perception inform clinical practice?

Moral perception

Mark drawing a participant, as part of a study exploring the experience of people living with dementia and their partners in care. Halifax, Nova Scotia, 2019. (click image to magnify)
Moral perception is one’s capacity to discern others’ vulnerabilities and needs, so it critically informs a clinician’s conceptions of what a patient deserves from them and shapes how to respond to that patient.

Moral perception also situates whether and when a clinician’s speech and actions are responsive to that patient’s vulnerabilities and needs.

A clinician’s moral perception conditions how they wield the therapeutic capacity generated via their relationships with patients.

Investigating habits of perception is key to how well clinicians draw upon the therapeutic capacity of the relationships they cultivate with patients in order to respond to a patient’s needs and vulnerabilities.

Portraiture can help clinicians investigate their habits of perception and how moral perception informs clinical decision-making, interactions, and practice.

Look again at Mark Gilbert’s portrait of Henry de L.
Recall your initial impressions of this portrait from what you’ve learned visually and narratively so far about his story.
Now also consider this triptych of images from Henry’s surgery

To investigate your habits of perception using portraiture, consider the following questions:

- To which visual properties—colors, shapes, textures, movements, lines, curves—is your perception drawn and why?
• Which kinds of visual information would you find most challenging to represent orally or narratively?

• What narrative information external to these images do you think you need to better inform your view of what’s happening to Henry and how you might respond to him?

• What do your interactions with these portraits suggest to you about your patterns of perception? For example, is there anything about your perception patterns you’d like to change and why, or is there anything about your perception patterns you’d like to celebrate and reinforce and why?

• What do your patterns of perception suggest to you about how you relate to patients and their needs and vulnerabilities and how you construe what you owe them?

Exchanges that are part of portraiture collaboration enable artist and subject to get to know each other. The process of contextualizing each other’s experiences informs both artist’s and subject’s understandings of strengths each person brings to a relationship as well as each other’s vulnerabilities.
Consider this portrait of Henry

In this portrait, we learn new things visually about Henry.

Henry was a barrister in the United Kingdom specializing in personal injury law. He lived in London with his wife, Anita, and their two children, Andrew and Kate. According to Mark Gilbert, Henry demonstrated a *joi de vivre*, confidence, and charisma that starkly contrasted with expectations an observer might have formed solely on his appearance.

Now that you have both new visual and narrative context about Henry’s life and experience, which features of what you just learned do you think might change how you relate to a patient like Henry and why?
The following describe the concept of moral perception and its roles in clinical practice.

Instructions: Select ALL that apply and click Submit.

- Moral perception is defined in terms of one’s capacity to discern others’ vulnerabilities.
- Moral perception critically informs a clinician’s conceptions of what a patient deserves from them.
- Moral perception is a technical term referring to facial representation in portrait painting.
- Moral perception situates whether and when a clinician’s speech and actions are responsive to that patient’s needs.
- Moral perception informs their clinical decision-making, interactions, and practice.
This activity introduced you to key ethics and aesthetic values in clinical portraiture that can inform patient-clinician relationships and prompted you to consider how the collaborative creative process of portraiture can be applied to building therapeutic capacity in clinicians’ relationships with patients.

This activity has also invited you to consider how your habits of perception inform what you construe as visually and narratively important about others. We’ve considered how those construals inform our conceptions of what others deserve from us and, specifically, how clinicians draw on the therapeutic capacity of their relationships with patients in order to respond with care to patients’ needs and vulnerabilities.
Lesson 7 of 9

CME Credit

Want to earn CME credit for this activity?

Return to the AMA Ed Hub activity and click the Take Quiz tab to proceed.
Lesson 8 of 9

Additional Resources

Websites

Mark Gilbert's Website

GO TO WEBSITE

Continuing Education from the *AMA Journal of Ethics*®

Earn Continuing Education (CME/CEU Credit) with podcasts, ethics cases, and more activities from the *AMA Journal of Ethics*.

GO TO WEBSITE

The *AMA Journal of Ethics*®

The *AMA Journal of Ethics* exists to help medical students, physicians and all health care professionals navigate ethical decisions in service to patients and society. The journal publishes cases and expert commentary, medical education articles, policy discussions, peer-reviewed articles for journal-
based and audio CE, visuals, and more. All content is free to all (no fees to read, listen, or contribute).

Portraiture in Health Care

The June 2020 issue of the *AMA Journal of Ethics* considers how portraiture introduces innovative strategies for perceiving ethical and aesthetic value and motivates deeper and fuller understanding of patients’, clinicians’, and others’ health care experiences.

Articles

*Portraits of Care: Medical Research Through Portraiture*

The Portraits of Care study used portraiture to investigate ideas about care and care giving at the intersection of art and medicine. Study results showed the introspection of subjects that revealed their sense of identity and psychological status. Patients appear as ‘whole people’, not fragmented by diagnosis. Caregivers' portraits reveal their commitment to care. There is also a sense of mutuality and fluidity in the background stories of subjects. Many patient subjects have been caregivers and, at times, caregivers are also patients. Public data emphasized the identity transformation of
subjects, the centrality of the idea of mortality, the presence of hope despite adversity, and the importance of empathy and compassion in care.

Portray of a Process: Arts-Based Research in a Head and Neck Cancer Clinic

The role of art in medicine is complex, varied and uncertain. To examine one aspect of the relationship between art and medicine, investigators analyzed the interactions between a professional artist and five adult patients with head and neck cancer as they co-created portraits in a clinical setting. Using narrative inquiry and qualitative arts-based research techniques five emergent themes were identified: embracing uncertainties; developing trusting relationships; engaging in reflective practices; creating shared stories; and empowerment. Similar themes are found in successful physician–patient relationships. This paper will discuss these findings and potential implications for healthcare and medical education.

What Do Warhol, Pollock, and Murakami Teach Us About AI in Health Care?

As with medicine, artistic practice has a historical relationship with technologies. As technology advances, artists and medical practitioners will struggle with the complexities of introducing artificial intelligence into
pursuits that have long been defined as fundamentally human. How will intelligent mechanization continue to aid efforts in art and medicine, even as it complicates them?

The Use of Visual Arts as a Window to Diagnosing Medical Pathologies

Observation is a key step preceding diagnosis, prognostication, and treatment. Careful patient observation is a skill that is learned but rarely explicitly taught. Furthermore, proper clinical observation requires more than a glance; it requires attention to detail. In medical school, the art of learning to look can be taught using the medical humanities and especially visual arts such as paintings and film. Research shows that such training improves not only observation skills but also teamwork, listening skills, and reflective and analytical thinking.


This essay describes an example of how we—one professor of the elective course Art, Medicine, and Clinical Moral Perception at Creighton University School of Medicine, one Director of Adult Programs at the
Joslyn Museum of Art in Omaha, Nebraska, and fourth year medical students-practice perception skills using art objects.

**Legalism, Countertransference, and Clinical Moral Perception**

This target article focuses on dynamics that arise in three typical ethically complex cases in which psychiatric consultations are requested by physicians: a dying patient refuses life-prolonging treatment, an uncooperative patient demands to be allowed to go outside and smoke, and an angry patient demands to be admitted to the hospital. The discussion canvasses what is at stake morally and clinically in each of these cases and explores clinician–patient interactions, dynamics in relationships between consulting physicians and consultant psychiatrists, patient transference, and physician countertransference.

**Bemis Center for Contemporary Art:**

*Mark Gilbert: Here I Am and Nowhere Else: Portraits of Care * | *Gallery 1*

*Here I Am and Nowhere Else: Portraits of Care* is an exhibition of portraits of caregivers and patients resulting from a collaborative research effort involving Mark Gilbert and Drs. Virginia Aita and William Lydiatt.
CBC The Current
This Scottish artist is using art to inspire compassion for dementia patients

Videos

Saving Faces: A film by Midge Mackenzie

The Medicine of Art - A Nebraska Story
Directed by Michele Wolford

Let Art Change You: Dr Mark Gilbert

Course Transcript