Editorial

Aesthetics and Body Experiences in Health Care

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

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

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

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

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

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

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

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

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

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

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

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