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# Experience of portraiture in a clinical setting: An artist's story

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## ABSTRACT

In this article the author reflects upon the challenges, rewards and learning he experienced as a portrait painter working on two arts-based research projects in hospitals. He describes how the relationships with the patients and caregivers who sat for their portraits generated new realizations for artist and model. Although initially resistant to the notion of art as research, his profound experiences co-creating with people portrayed, convinced him of the healing values and therapeutic benefits that artistic practices have in abundance. Portraiture, here, served as a bridge that brought the two worlds of art and medicine together.

## KEYWORDS

arts-based research, portraiture, challenges, art as healing, relationship, illness, care

Since I can remember, I have drawn and painted pictures. I am the youngest in a family of artists. For the last 60 years, my father, Norman Gilbert, has worked on paintings in his studio, in Glasgow, Scotland. His pictures, more often than not, included me. In his paintings, I am never depicted alone; my father always pictures me in relationship, with my mother, my brothers and my friends. Reflecting on these images now, I can see that, as an aesthetic whole, they are a record of my father's response to the world. My father's paintings substantiate the relationship of one image to another and of single images to a lifetime's work.

It is hardly surprising that having been brought up in this environment, I too, became a student of fine art at Glasgow School of Art (GSA). In my final year at GSA, I began to turn my attention to working in the field of portraiture, eventually asking my father to sit for me. My paintings from this time record an on-going dialogue and mutuality between what was happening with the paint and my relationship with those who sat for me. The blobs, strokes and smudges in these early paintings, were guided by not only observations but also the encounter with the subject and my own slightly jaundiced sense of what was true. Deeply influenced by the work of Lucian Freud, the models are depicted in the squalid, studio interior. They lie on bare mattresses and moth eaten rugs and sit on sofas bursting at the seams. Many paintings render the

model in the corner of the room, seemingly trapped or incarcerated. There is a forced vulnerability and helplessness that is imposed on the sitter in these portraits. A portrait of my parents entitled Ennui is representative of the cynicism and resignation permeating in much of my early work.

**Figure1: People and black and white patterns. ©Norman Gilbert**

**Figure 2: Ennui. © Mark Gilbert**

After ten years painting in the same studio, with the same working methods and models, I, like the paintings themselves, became tired and indifferent. My practice became predictable and unexceptional. Such stagnation, however, had the potential to compel a shift that could bring relief, new insights and fresh perspectives to my work, which was ripe for transformation.

## Saving Faces (SF) 1997–2000

In 1997, oral and maxillofacial surgeon, Professor Iain Hutchison of the Royal London Hospital asked me to create a series of portraits of his patients. He suggested I attend to, witness and paint his patients before, during and after their surgery. With great trepidation, I accepted the commission, requiring me to work with patients experiencing disease, trauma and facial disfigurement. The project was funded by a legacy that Prof. Hutchison's mother, Dr Martha Redlich Hutchison, a physician with a passion for the arts, bequeathed to her son when she died. The project was called SF.

Hutchison proposed that a portrait painter working with his patients could have a positive, 'therapeutic' influence and hence established the following seven aims of the project:

- to enable a portrait artist access to people with 'extraordinary faces';
- to witness and capture the emotional experience of patients in a way that 'clinical photography cannot';
- to be able to show, in an accessible way, the possibilities and limitations with modern facial surgery;
- to demonstrate that people who have undergone head and neck surgery are able to lead fulfilled and happy lives despite their disfigurement and experience as a patient;
- to illustrate the nature of the surgical process required to treat patients
- to inform those whose interest lay in the physical, anatomical aspect;
- to investigate his own 'nebulous hunch' that the act of being painted and the resultant images could be therapeutic for the participating patients. (Hutchison 2007)

The proposal of SF was staggering to me. I had never worked on anything where the emotional challenges and risks seemed so distinct. The subject matter was so explicit that it immediately made me anxious about not only acquainting myself with patients but also their potential reactions towards their portraits. Despite this, I was intrigued by the challenge of making such images in a form that would be appropriate and resonate with the experience of both the portrayed patient and myself.

From the beginning, I felt that the nature of the interactions between artist and patient would be fundamental to not only the production process but also the resultant images. Nevertheless, I considered Hutchison's notions of potential 'therapeutic benefits' as somewhat naïve and beyond the capacity of portraiture (McDonald 2000). I

was all too aware that it took a great deal of courage to have one's portrait painted at the best of times, and that a sitters response can be ambivalent, at best (Lyall 2002). I carried such doubts into the unfamiliar art-making environments of the hospital clinic and operating theatre. A tiny office situated in an administration corridor within the hospital served as my studio. This little, nondescript space became the setting for countless hours of open dialogue, storytelling, communication and intimate silences that framed the making of the portraits.

Ensconced in my office/studio, painting and drawing in the middle of one of the country's busiest hospitals, I welcomed colleagues, unfamiliar collaborators and patients making unexpected visits. I had no idea who would enter my studio next. Hutchison took sole responsibility of selecting the patients for me to paint, many of who were going through the most traumatic moments of their lives (Thomas 2002). I fretted that as patients adjusted to their new health status, surgical procedures and altered appearances, they could be burdened and fatigued with an abundance of anxiety, stress and even sadness.

Finding relief in the relative familiarity of my artistic practice, materials and methodology, I tentatively acclimatized to the novelty of the hospital environment and gradually drew comfort from my growing relationships with staff and the patients. I absorbed the new and surprising and began relating this unfamiliar context to prior experiences, working practices and initial conceptions of the challenges ahead.

Before the project could begin, permission and approval had to be sought from the Trusts Chief Executive, the research ethical committee, the clinical ethical committee and other members of Prof. Hutchison's department who could potentially invite patients to participate in the study (Magennis 2003). Even so, the ethical implications of using patients as subject matter for artistic purposes made me uneasy. I wondered if I would be focusing on events and aspects of patients' lives that were sensitive and upsetting. I feared that the images would be seen as voyeuristic, exploiting already vulnerable participants. I deliberated over just how possible, justifiable, constructive or proper it was to make such images. Moreover, I questioned how seriously and thoughtfully the portraits would be received and whether or not they would be considered an authentic response to the relationships generated from the portraiture process. I pondered how I would be able to avoid the then prevailing media narrative that seemed to ignore art as inconsequential, except when it set out to shock (Lyall 1997).

How I chose to formally and aesthetically portray the subjects in SF was, as with any portrait, influenced and redeemed by the conditions of production and the issues that arose from the aesthetic practice (Chambers 2010). Prior to SF, the thoughts and feelings of my sitters towards their portraits were of little consequence to my own feelings about the picture. In the hospital, I felt compelled to move beyond this autonomous mode of disengagement to interactions that were more participatory, compassionate and engaged. I considered it a requirement that I work expressively,

conquer my profound anxieties and at the same time, attend to the sitters with respect and sensitivity.

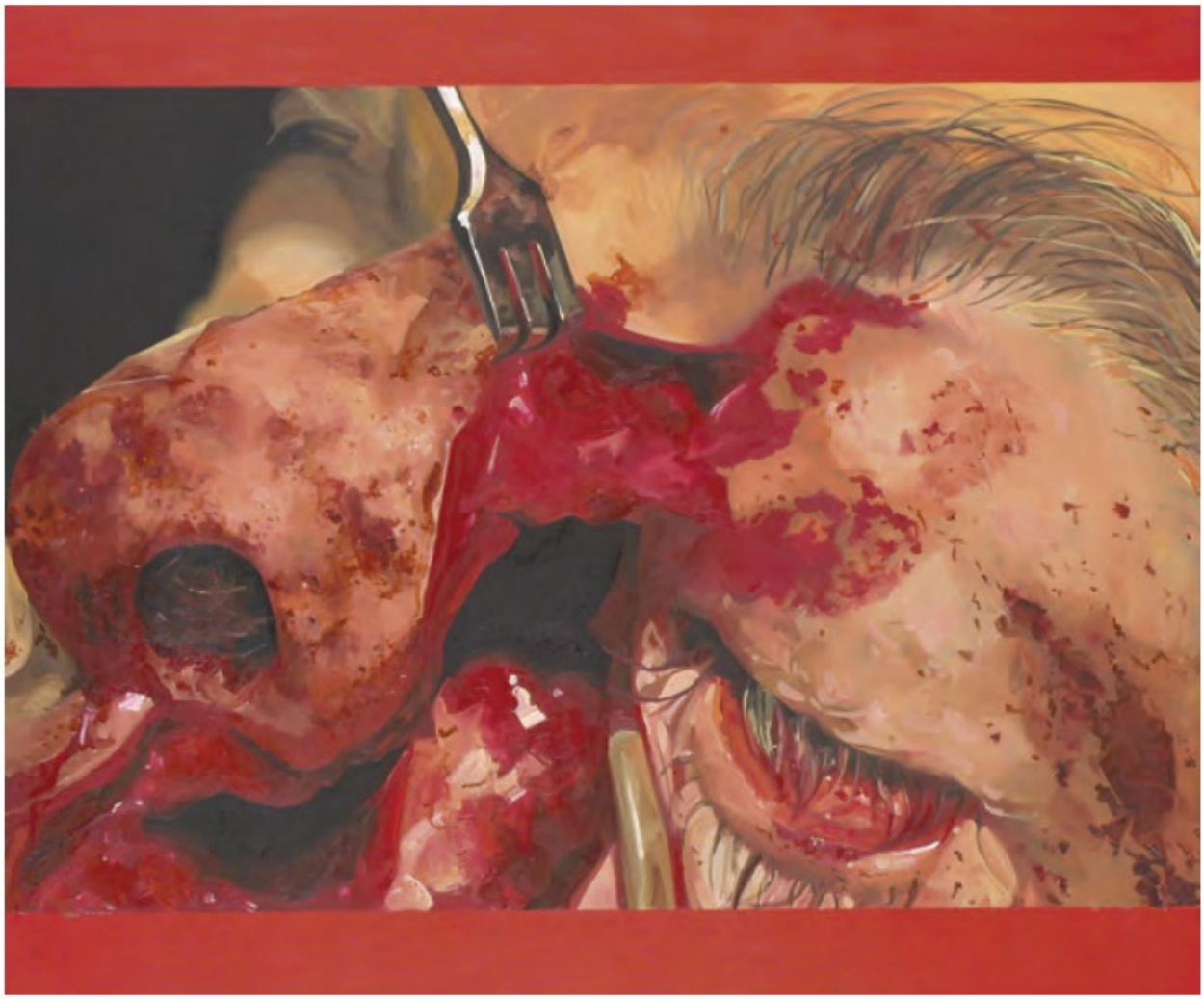
My focus in SF relied, fundamentally, on interpersonal relationships that depended on trust and required honouring the experience of the other. The mutuality I sought was a product of what I perceived as our common vulnerabilities. Through our interactions, I hoped to eradicate the potential for an imbalance of power that can manifest itself in clinical, research and artistic interfaces (Goodyear-Smith and Buetow 2001; Schwartz 2003). I committed to working methods that did not exaggerate or denigrate, sanitize or try to flatter the subject. I sought a portrayal that was genuinely derived and rooted in the other and our relationship, yet still imaginative, expressive and creative. I hoped the portraits would exemplify participants holistically, demonstrating not just their physical journey, but their emotional journey too.

By nurturing relationships with the patients and myself, we planted seeds for the increasingly constructive and collaborative interactions that informed the picture-making process. Rapport was gently constructed through mutual vulnerabilities harboured by both artist and sitter. As my relationship with patients strengthened, my anxieties diminished and I was free to focus on amplifying positive strengths that the patients demonstrated in abundance. They too became more comfortable with the process, and their enthusiastic participation became indispensable.

As the relationships evolved, I began to refer to them as ‘collaborations’. The act of knowing, learning and changing together blurred the traditional artist/sitter boundaries. Although I was applying the marks on the canvas, I hoped participants would feel able to take the lead as models, conversationalists and authors of their own stories. I, the artist/researcher, became a respectful co-learner. This process of drawing out the stories enabled nuances of experience to develop a narrative that also informed the paintings.

The first patient I met was Henry, a barrister by profession. He had cancer of the head and neck. I was uncomfortable with the fact he had cancer and unsure how I would react to his appearance. The surgeon, in post-operative slides and photographs, recorded Henry’s appearance over fourteen operations in as many years; these images took on the demeanour of mug shots but served to be a step-by-step record of the changing shape of Henry’s head as he continued treatment. The photographic images taken of Henry’s operations were unimaginably explicit in their depiction of his opened head and all that was inside. The horror of these images, I felt was tempered slightly when I began to develop a more aesthetic response to the pictures. Under the glare of the surgery lights, Henry’s head took on an almost bejewelled quality. What I saw was an explosion of aesthetic values of the unveiled interior that stood in stark contrast to the more mundane exterior. I saw that amongst the dancing sparkle of exposed tissue, veins, arteries and muscle there nestled puddles of blood of the deepest cadmium. Some of these macro compositions were so extraordinary that they took on an abstract quality seemingly beyond our own world and sense of reality.

**Figure 3: Craniofacial resection. © Mark Gilbert**



My life, prior to this, had been devoid of any experience of cancer or terminal disease. Attempting to decipher and absorb these images, I would be struck by the reality of this life before my eyes when, like a jolt, I noticed an eyebrow, a nostril, some teeth or an ear that allowed me to get my bearings and understand what parts of his head's anatomy I was seeing. Often, there would be an innocuous mass or lump that seemed to distort or obscure what one would expect see; this, I was informed, was the cancer that was being removed. The cancer sparkled and reflected with an intensity that seemed un-paintable, and looked to have little of the menace it physiologically carried in abundance.

By the time I met Henry, the operations had left him appallingly disfigured; he had lost half of his forehead and most of the left side of his face, including his left eye. My earliest impression of Henry was seeing him strolling down the corridor to my studio with a swagger and insouciance. He was a tall and graceful man in a pinstriped suit with an umbrella in his hand. He greeted me warmly. His speech was slurred but

understandable. We immediately had a rapport and his apparent delight and curiosity at being asked by his surgeon to sit for his portrait was of immense comfort to me.

For six months, Henry visited my hospital studio, two or three mornings a week, before attending his chambers. During our time together we worked on a series of drawings and small oil paintings. Our conversations covered all manner of subjects from cricket to politics. Henry took great pleasure in hearing about my experience of acclimatizing to working in the hospital. He would tell me about his thoughts and feelings towards his ongoing treatment and life with cancer. He spoke lovingly of his wife, Anita, and their twins, Andrew and Kate. He reminisced about when he was a student and when he first met Anita. Henry often described how the love and support of his family was fundamental to how he had coped with his illness and its affects. He explained he had little to worry about because he had a loving family and an established career. Henry sympathized with younger patients who may not have had such support and still had to deal with the insecurities of early professional and social life.

Once we completed the initial drawings, I asked if he would be willing to sit for a larger, full-length portrait. He happily agreed, and jokingly suggested that I paint him in the wig and gown traditionally worn by barristers. I was immediately gripped by this suggestion. I was excited that the garments would echo the formal portraits of artists like Frans Hals and Rembrandt. I had not considered the added narrative that his garb would potentially engender in the portrait.

In this portrait, he is pictured surrounded by flat peppermint green background and seated in his old study chair with turned wooden legs. His gown hangs loosely over his shoulders and drapes over the chair. His hands are joined on his lap, and his feet protrude out of the foreground. The shoes he is wearing, to his wife's chagrin, are unpolished. In this single image, we see a man who is severely disfigured as a result of monumental surgery to rid him of his cancer, and through his attire and disposition, we also see a man with confidence and the spirit to still 'perform' in court. I found the juxtaposition of Henry the patient and Henry the barrister powerful. The story this engenders assuages the shock of his appearance. As a portrait, I hoped the image conveyed the charisma and relaxation of the spirit of the man, along with his joi-de-vivre and devil-may-care attitude.

My relationship and working experience with Henry introduced me to the patient's capacity to shape their own visual narrative. I made the marks on the canvas and had my own aesthetic aspirations for the pictures, but, the form and appearance of the final portrait is a testimony of a process of engagement, trust and collaboration that the sitter on multiple levels, purposefully guided as the portrait was created. Each relationship I formed during SF was unique; the depth and value of each encounter with each participant cannot be assessed in terms of the number, length or level of productivity. Profound insights could happen in one or two sessions, one or two moments. I had to trust the process and therefore sustain openness to all that I witnessed.

During the portrait sessions, sitters had the opportunity to reflect on other paintings hanging on the walls. Many enquired about those portrayed and then interpreted what they saw. Exposure to the other portraits increased awareness among participants of those in a similar situation to themselves. It enabled them to positively compare and re-evaluate their own experiences, often feeling that their own situation, and health status was not as serious as that of the subject in another painting (Farrand 2002).

**Figure 4: Heary D L. © Mark Gilbert**

**Figure 5: Roland S. with Radiography mask. © Mark Gilbert**

Like Henry, Roland came into my studio with his own unique experiences, background and relationship to his illness. His flat cap, jeans and steel toe capped boots, were the outfit of a self-employed truck driver, born and bred in North London. I met him the night before he was to have had surgery to remove his cancerous tumour along with most of his upper jaw and the left-hand side of his face. I vividly remember my anxiety when describing the project to Roland as he sat on his hospital bed, the evening before his surgery. The fact that he not only took that time to discuss and consider participation but also confirmed that he would take part, I still find remarkable. I attended and witnessed the whole of his surgery. I made pencil sketches and took photographs of Roland's dissected head. Roland and I worked together on umpteen drawings and paintings, including an oil painting of his surgery. During the portrait sessions, Roland discussed frankly how difficult his diagnosis was and his fearful anticipation of treatment, which was temporarily relieved by his sense of achievement after surgery.

What Roland had not anticipated was the sheer horror he was to experience during his radiotherapy treatment after surgery. Our drawing sessions together were dominated by his descriptions of the claustrophobia he experienced when a moulded impression of his head was taken to make a mask that would be used to secure his head and enable accurate delivery of radiation treatment. His feelings of claustrophobia only exacerbated during the treatment itself. The anxiety that this engendered in Roland led this most placid man to become aggressive with the nurses and physicians and left him feeling scared and isolated. Wanting his story to be told in full, Roland explained:

> I wanted Mark to paint me in the mask because I felt the mask was an important part of the process. When he did the painting I was standing up with the mask on and I could feel the tension rising again. When I look at that picture I say to myself, yeah, that's how I used to feel, and it does not bother me at all to look at it. I have got the mask at home. I couldn't leave it at the hospital. My grandson plays with it. He thinks it's lovely.

In 2001, the National Portrait Gallery in London exhibited the collection as a whole. By keeping the work together, we were able to sustain indefinitely the dialogue generated between the images, mirroring the community that had been created among project participants. The sitters had gained greater understanding of themselves from viewing their own and other's portraits and surgical images. These paintings offered patients a vivid insight into the extent and nature of their surgery, influencing their narratives of illness and recovery. On their own, such images could have been seen as gratuitous, manipulatively shocking or objectifying of the patients. Bracketing the surgery images within the before and after visual narrative of the other patients portraits, created a powerful narrative that augmented the portraits and enabled the audience to see what I witnessed, and be informed about what the patients experienced as physically an emotionally. The pictures exemplified how art can constructively embrace and engage with hardships, use them as 'fuel' and turn them into something extraordinary, even beautiful or sublime (McNiff 2004).

## Portraits of Care (POC) 2006–2008

In a subsequent project commissioned by the University of Nebraska Medical Center, POC, I was employed to draw and paint not only patients but also their caregivers. Unlike SF, POC attempted to use visual art as a way of gaining deeper understanding of wide-ranging aspects of science and medicine (Aita et al. 2010) The study consisted of two phases, the art-making and the exhibition phase. Investigators recruited patient and caregiver subjects and invited them to participate. Subjects included both healthy and ill patients across the entire lifespan and both familial and professional caregivers (Aita et al. 2010).

An old science laboratory still replete with test tubes and vacuum flasks served as my studio. The laboratory for the traditional positivist researcher is a space where context is often regarded as something to be suppressed; this space, where

experimental conditions and control were normally a priority became the setting for an activity where those working within it were unable to predict what would happen or what they might gain. Quite possibly, it was the first time that this room was home to research without a hypothesis. The space was transformed from one of structured order and cleanliness to a chaotic store of paints, canvases, paper and charcoal, most of which eventually ended up ground into the once immaculate floor tiles. As the sittings progressed and portraits developed, the lab became a home for aesthetic interactions that transformed the space. The laboratory housed human-subject experiments with mediums and surfaces, with colour and tone, lines and smudges.

I created over 100 artworks in various media for this arts-based research study. POC included oil paintings on canvas and aluminum, charcoal drawings on paper and directly onto canvas, Indian ink on paper and on canvas, mono-types, a woodcut and photogravure. This experimentation in form and material resulted from the struggle to find an expressive voice for each picture that best represented the sitter and the subject; as the research aspect gained importance, I took increasingly more interest in what the pictures were saying and how they said it. I had to realize that the subjective nature of my role as a researcher was congruent to my role as an artist.

**Figure 6: Portraits of care, Bemis Center of Contemporary Art, Omaha, Nebraska**

The postmodernist notion of the artist as someone whose practice actively addresses social issues and aspires to be socially responsible is applicable to both artist and researcher. I struggled to position myself in a space that embraced and

sustained the aesthetic, collaborative and participatory aspects central to the project. POC enabled patients, caregivers, viewers and myself to not merely be observers of our fate but participants and co-creators of it. The exhibit included a series of portrait heads in a collective portrayal. The collective whole of portraiture demonstrated in POC confronted the individualist notion of art and research.

A multi-disciplinary team of investigators and professionals in the fields of medicine, fine art, nursing ethics and qualitative research analysed what the portraits 'revealed' about the nature of care and care giving in the context of health and illness (Aita et al. 2010). My position in POC required taking on new roles as an artist/researcher. I strived to combine the creative and imaginative strands of art with a science that sought to explore experience. I pursued methods that would honour the nature of aesthetic creativity and its potential for discovery and healing. I recognized the visual arts as a potential form of data collection and research methodology. These representations of health and illness, and care and care giving shaped and formed my experience of participation in the study. I discovered how artworks of this nature tell stories and are brought into existence through their performance.

My awareness of the properties and viscosity of paint and different pigments, the absorbency of canvas, and the strength or fragility of charcoal all factored into the works created. My increased awareness of what it meant to live with illness, my growing familiarity with the patients and caregivers, my observations of each person's physical characteristics, their mental states, their spiritual practices and beliefs, their intellectual side, and their social-emotional state and traits all contributed to the process of art-making in POC. From the very start, I was in a constant process of making sense of what I was witnessing, with whom I was interacting, and where these events took place.

I looked for and observed refrains and patterns that the participants were not always conscious of. I demonstrated my personal vision while attempting to avoid lapsing into self-indulgence. I remained open and receptive to stimuli to achieve a resonance in the portrait to the patients and caregivers, as witnessed and painted. Sustaining a vigilant focus on the subject, I tried to keep a balance between my own context and the subject's context. I also tried to sustain the space to create context for the viewer. I attempted to create relatable art and paintings that could be a source of empowerment for sitters, viewers, and artist alike. I became increasingly interested in the potential of art-making having an emancipatory function, giving a voice to those who may be or feel marginalized, isolated, lonely or restricted in their capacity to express themselves or share their experiences.

The discussions and conversations that permeated the sitting sessions were abundant in openness and poignancy, illuminating the sitter's story. Trust was essential in enabling the more silent and intimate process of the portraitmaking to flow with purpose. The questions I asked the sitters were partly an attempt to gain insight into the whole being of each sitter and avoid rhetoric. I would ask about their lives, their families, work and interests. They too would ask me questions about my work and background.

The initial questions evolved into rich conversations. I did not seek to analyse or remedy the feelings that arise when one becomes patient or caregiver. I enquired in a manner that was generous, open and receptive to the sitter and infinite possibilities. Our conversations were not just a by-product of the process, preventing the subject from getting bored; they were an outlet, which allowed all of us to engage with our fears and anxieties, passions and hopes and enabled greater mutual understanding.

The paintings recorded our experiences while simultaneously pointing to ‘universal themes’ relevant to the overall human experience (Aita et al. 2010). My personal thoughts and notions filtered my interpretation of who and what was before me. These interpretations in paint, charcoal and print aspired to discover and share something new, a new way of doing something or seeing something. I sought an aesthetic knowing through this process, with the hope to inspire deeper knowledge, wisdom and continued discovery. POC turned out to be a personally fulfilling path of enquiry that explored aesthetic ways of knowing, not only for myself but also for participants and viewers.

One picture in the POC collection depicted a patient and caregiver together, Rob and Mardi, a married couple, were both cancer survivors and consequently both patients and caregivers. They shared the portraiture experience together. Mardi stated:

> The canvas enabled Rob and I to identify the elements that we had simply not been able to see our daily life together. My strong public exterior was overshadowed by a waifish vulnerability and Rob’s face reflected a survivor’s reconciliation of past hardships with the reality of life as it is now. The cancer journey is never over. Rather it is the evolution of a new life with a ‘new normal.’ It embraces past experiences while being open to new possibilities, cherishing the precious present.

The universality of giving and receiving is exemplified in my experience with Daisy, a 7 year old. Having been born with gastroschisis, she was to receive multiple organ transplants due to complications. I witnessed how she was able to effortlessly calm her understandably fraught parents. The child’s compassionate interactions with adults showed a profound level of awareness and wisdom that was extraordinary and moving. Joey, Daisy’s mother, described her daughter as an ‘old soul shining through’, able to teach and exemplify a life of grace with illness. Joey elaborated, that she hope Daisy’s portraits would allow people to ‘pull the camera back and see the larger picture and be educated and enlightened about the humanity in us all’.

Many participants discovered aspects about themselves that they had never encountered before; they found expressions, body language and demeanours that they could only recognize through reflection upon their own experience through the works of art. Glenna, a patient who had undergone umpteen surgeries for cancer of the head and neck, as well as, breast cancer, said, in response to her participation in the portraiture process, ‘I could see myself as others see me. It helped me to accept the way I look’.

The action of sitting for their portraits enabled patients and caregiver's time and space to contemplate (Aita et al. 2010).

Two POC participants, Roger and Anthony, who as a result of their disease and surgery were unable to talk, demonstrated the power of non-verbal communication and interactions formed in aesthetic performance. Roger, treated for amyotrophic lateral sclerosis (ALS), was completely immobile. He communicated through computer technology that was attached to his wheelchair. Anthony, a Native American and an enrolled member of the Winnebago tribe of Eastern Nebraska, had his larynx, along with his tongue and lower jaw, removed due to cancer. Anthony wrote short notes during the portrait sessions. Although one might assume that such compromised interactions would be problematic, the one-sidedness and awkwardness of our verbal language-based communication, however, was immediately equalized and remedied by the silent act of creating the portraits.

For Roger, unforgiving nature of his disease meant that he was not only unable to speak but also lacking in the capacity for self-expression. By drawing Roger, I was allowed to be more sensitive and attuned to his expression. The silence that we worked in was not an empty void, but a vessel for enhanced awareness and acknowledgment of each other's presence. The intimacy and sensitivity that was engendered during these sessions was maybe even more profound without the convenience of easy, verbal interaction. For me, the drawing sessions gave us the opportunity to communicate with a profound purpose. The way we related to one another, either side of the easel, was as immediate, instantaneous and constructive as any verbal interaction. The resultant images continued this dialogue, communicating with the same silent focus with which it was created within.

In a similar vein Anthony reflected on the numerous, non-verbal interactions that we shared in a process that was rich in purpose and intent. Anthony had initial misgivings at the prospect of sitting for his portrait, citing his traditional belief that being drawn or photographed 'toys with someone's spirits (personal communication 2008). However, in the end, he appreciated that the portrait would potentially survive into the future and be able to retell his story as a testament to the struggles he faced as he recovered from his surgery. His portraits were created in multiple medias and formats. These included drawings on canvas and paper, woodcut, as well as a coloured monotype of his resected tumour and a photogravure of his tongue and lower jaw suspended in the hands of the surgeon just before their surgical removal. The multiple images and vantage points from which we witnessed Anthony's journey, allowed us to see it more completely.

In my interactions with both Roger and Anthony, I witnessed them live with a grace that belied the physical and emotional challenges they each faced daily. The bonds we made were underpinned by the aesthetic interaction that permitted us to work together in the quest to create a portrait that allowed others to enter into a fragment of their world. It was a huge privilege to be able to witness the poise and strength that

emanated from both men. The interactions shared were an enduring gift. They were generous, empowering, fascinating and often profound. Their examples demonstrate an important factor applicable to all my interactions with all the project's participants; the silence in the portraiture process was as important as what was said and similarly, what is left out of the portrait was as significant was what was included. The purposeful process of sitting and co-creating in silence was instilled with an intimacy and power that was fundamental to the portraits created, the messages they conveyed and the experiences they exemplified.

**Figure 7: Robin and Mardi © Mark Gilbert**

**Figure 8: Daisy © Mark Gilbert**

Each image in POC differed in expressive nature because each individual patient and caregiver, his or her interactions and narratives, were different. The connections I made with each person were as diverse as the participants themselves. I relied on participants' voices, both silent and spoken, to guide and inform the image production. I approached POC in collaboration with the subjects, leaving space for and embracing the sitter's vulnerabilities and imperfections. I pondered how the stance that I took to interpret the sitters was appropriate and suitable. I wondered what I should include and what I should leave out. As I worked on POC, I was in a constant state of selfreflection; I asked numerous questions and sought a visual representation that would do justice to their experience and voice.

**Figure 9: Roger © Mark Gilbert**


My work with POC demonstrated that portraiture was more than capable of generating a relational aesthetic that was inclusive and could exist outside the established commercial art world, able to contribute to research and discourse in the medical sciences. POC made it clear to me that research and practice are mutually dependent and that art practice is, in itself, a form of research, albeit one that is distinct from traditional views of research that rely on scientific objectivity (Barone and Eisner 2011; Knowles and Cole 2008; McNiff 2012, 2013). The science lab that I had turned into an artist studio was still a setting for research. I gradually recognized and accepted

that my role in research was not antithetical to my practice as a painter. SF and POC images are devoid the cynicism and ennui of my earlier works; they are infused with an optimism that derived from my observations and dialogue with participants.

As I near completion of my Ph.D., which explores the experience of portraiture in a medical context the contrasts between art and science are vivid and challenging, yet, the capacity for both to coexist and complement one another, as I have experienced in abundance, is profound. Each portrait I complete, each mark I make, brings my journey up to date. As I draw and paint, I interpret and scrutinize the subject in an attempt coral the visual marks I leave on the canvas into some semblance of an aesthetic order. It is an iterative process, the product of innumerable glances between the subject and myself. As the paint builds, the image begins to breathe, literally expanding and contracting as I rework, alter and correct. The tension generated by the space surrounding the subject also presses and retreats as corrections are made. At the same time themes develop, focus shifts, information is established and new discoveries are made.

**Figure 10: Anthony © Mark Gilbert**

**Figure 11: Removed cancer (Anthony) © Mark Gilbert**

**Figure 12: Tumour (Anthony) © Mark Gilbert**

My artistic practice prior to entering into the medical field was framed by a more traditional aesthetic sensibility, where art, and especially portraits, was typically understood and perceived as a collection of prestigious, autonomous objects, depicting the great and the good, normally situated in museums and galleries, separated from society, everyday life, and action. My experiences with SF and POC stirred dissatisfaction with many of these notions of art and softened my resistance to the idea of a healing power of art. Consequently, art's potential function as a catalyst for interconnectedness and storytelling in its broadest forms has become fundamental to my practice and my research.

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## Contributor details

Scottish artist, Mark Gilbert graduated from Glasgow School of Art in 1991. After ten years of studio practice, The Royal London Hospital, England offered him a post as artist in resident. There he worked in collaboration with maxilla facial surgeon, Professor Iain Hutchison and his patients. The resultant exhibition, ‘Saving Faces’, was exhibited at the National Portrait Gallery, London. This led to his next project: a two-year research project and exhibition entitled, ‘Here I am and Nowhere Else: Portraits of Care’ at The University of Nebraska Medical Center, USA. He is currently a Ph.D. candidate and completing his dissertation at UNMC focusing on ‘The experience of portraiture in a clinical context’.

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