

Call for multidisciplinary papers on:

**The role of art and culture in healthcare organisations
Fruitful dialogue and emotional experiences**

for the second 2024 issue of the RFAS

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Interdisciplinarity is a key aspect of this brief, which will involve approaches from multiple disciplines: sociology, anthropology, information and communication sciences, management and administration sciences, history, law, art, design, philosophy, medical and paramedical sciences, and political sciences.

Proposals should be submitted before Monday 3 July 2023.

Interested authors are invited to send a brief statement of intent (between 10 lines and 1 page max.) specifying the provisional title of their article, the field to be explored, the issue to be addressed and an indicative bibliography, in Word format.

Articles are due by Monday 16 October 2023.

Artistic presence has been a longstanding and consistent feature in healthcare establishments, yet has rarely been analysed. It was originally intended to entertain, occupy or calm patients and has taken on many different forms and meanings over the years. There are various factors that explain the development of these measures. Firstly, psychiatry has been playing a role in this sector since the 19th century. The romantic figure of the misunderstood artist has undoubtedly helped connect mental illness (and the sense of being on the fringes it embodies) with creativity (Prinzhorn, 1984). But above all, the psychoanalytical approach has explored the

possibilities offered by the non-verbal expression that art can represent. Thus, this approach has integrated artistic tools into a therapeutic approach (Brousta, 1996, Archambeau, 2010). Changes in patient care from the 1970s onwards, and in particular the institutional psychotherapy approach, resulted in an increased focus on their physical and social environment (Nardin, 2009). This is all about questioning the isolation of patients and the desocialisation induced by illness, as well as the stigmatisation to which patients are subjected (Goffman, 1975; Jeanson, 1987). More generally, artistic presence will increase as the need develops for people to be cared for in a way that is not purely technical and targeted at the disease or diseased organ, but that also considers the individual in respecting their beliefs, values and rights as a citizen¹ (Bergeron, Castel, 2018). In this context, artistic projects are used for their ability to take account of people's uniqueness and to foster the imagination that enables them to look ahead beyond their illness. By encouraging us to focus on our individual abilities rather than on our shortcomings and disabilities, artistic practice allows us to rework identities altered by being labelled with the status of sick, elderly or disabled (Goffman, 1968). Depending on the nature of the project, artistic projects are also oriented towards community involvement. They give people the chance to share their thoughts, to show a part of who they are and, based on their experience, to relate to social rather than specifically medical issues.

The end of the 1990s marked an important step in this encounter between art and healthcare establishments with the creation of an interministerial scheme. An interministerial agreement on "Culture in hospital" was signed in 1999². It advocates twinning programmes between healthcare establishments and cultural operators. It results in a professionalisation of measures and crossover of issues between the cultural and healthcare sectors. It thus offers a new project method, distinct from art therapy and, more generally, from a focus on specifically medical and curative issues (Liot, Langeard, Montero, 2020). The policies underline the Ministry of Culture's longstanding focus on the professionalisation of artists and access to art. In fact, for the Ministry of Culture, the development of interministerial cooperation is an evolution in cultural policies that tends to link widening access (democratisation of culture) and the consideration of individual expression (cultural democracy)³. The agreement was renewed in 2010 under the "Culture and Health" policy, and extended to the medico-social sector in line with the 2009 reform of the healthcare system⁴. The agreements lead to regional variations in the form of Regional Directorate of Cultural Affairs and Regional Health Authority (DRAC-ARS) agreements, sometimes also involving other regional or local authorities. They also bring about calls for projects that guide action to be taken in many establishments, with the appointment of cultural specialists and the inclusion of cultural action in school projects. From this perspective, it helps to firmly establish the artistic and cultural aspect in the school's strategy. Internally, this relates to the growing need to take better care of patients, but also, and more recently, to take better

¹ These transformations are part of a long process of "humanising" the hospital (Nardin, 2009), the first elements of which entered into law in the 1970s. The concept of patient rights was introduced by the decree of 14 January 1974, and reinforced in the law of 31 July 1991 and the law of 4 March 2002.

² "Culture in hospital" agreement between the Ministry of Culture and Communication and the Secretary of State for Health and Social Action, 4 May 1999.

³ The "Culture in hospital" agreement is part of a shift to broaden the Ministry of Culture's ways to take action, so that culture is present across many areas of public action: schools, the justice system, urban policy, etc. The origin of this policy goes back to the cultural planning of the 1960s-1970s, but became more pronounced under J. Lang's ministry in the 1980s-1990s. (Urfalino, 1996; Dubois, 1999; Blondel, 2001).

⁴ "Culture and Health" agreement between the Ministry of Health and Sports and the Ministry of Culture and Communication, 6 May 2009.

care of healthcare staff, who experience high stress levels in their work and sometimes disengagement. Therefore, art plays a part in remobilising healthcare staff, and even redefining the ethics of the profession (Liot, Langeard, Montero, 2020). However, artistic projects also depend on a relationship between the establishment and its environment, and form part of image and communication issues in a context where establishments are increasingly questioned about their operations and the quality of their services.

These interministerial agreements do not delineate all artistic projects in healthcare establishments with others also prospering outside this framework. For example, we have recently observed the development of new forms of artistic and cultural intervention in the healthcare sector that fall under the design sector and its skills. In this context, we are interested in social design, i.e. “a diffuse form of design that works, above all, on the conditions for the emergence of collective creation, thus deploying a specific discipline. In this respect, the designer is no longer the guarantor of the final form of the artefact, but the guarantor of the conditions of emergence of these collective creations.” (Royer, 2020). The emergence of design in hospitals and medico-social facilities is part of a continuing shift in focus from the industrial, commercial and luxury sectors towards public services and the issues of social justice and ecology. The question of the designer’s responsibility in view of the challenges facing the planet and society is not a new one. It was raised by William Morris, the Bauhaus, Victor Papanek and theorised in recent years by design researcher Alain Findeli. However, it is being reexamined and updated by each generation of designers looking to use their talents to make the world habitable for the most vulnerable. Design seeks to address the two major contemporary issues of health and ecology by using methods in keeping with the need for collaboration, complexity management and creativity. For Alain Findeli, “any practice claiming to be design is essentially social, in the sense that one of its fundamental problems is to implement a social and philosophical anthropology of the appreciation of everyday life in the world, that is, life in the company of objects, places, services, institutions and organisations.” (Findeli, Proulx, Vial, 2014). However, the implementation of design into the healthcare ecosystem is also driven by a discourse on managerial innovation and public policy. Evidently, redesigning the world around us from the point of view of aesthetics, environmental and social ethics and uses, implies fairly radical changes to the managerial and institutional models and practices that still currently take precedence.

The *Fabrique de l'hospitalité* at the University Hospitals of Strasbourg has been laying the foundations of this approach since 2010 by leveraging conception and participation methods used in design in order to improve the time and space experienced by hospital users and professionals. The lab-ah research centre for cultural innovation through hospital-integrated design was created in 2016 at the Paris Psychiatric & Neuroscience University Hospital Group. It aims to support hospital teams by involving service users in improving care quality. It also leverages the concepts, methods and tools of design, while combining them with those used in the context of cultural development. These two research centres represent a new way of experimenting with hospital transformations and are successors to the Culture and Health programme. They deal with an aesthetic requirement through the blending of stakeholders and skills in care and creation. Other design initiatives are currently thriving in a number of hospitals and are being structured into a national hospital design network⁵. They come from a variety of

⁵ This emergent network was set up in 2023 at the initiative of Montpellier University Hospital, with the AP-HP (Paris university hospital trust), Paris Psychiatric & Neuroscience University Hospital Group, University Hospitals

backgrounds, but the common feature is that they integrate design skills into social innovation strategies. This call for papers perceives both design and art as stakeholders in the cultural and institutional policies of our establishments.

Against this backdrop, this brief aims to examine in more depth these artistic and cultural projects when they are led by professionals (artists, designers, etc.). It seeks to help us understand how these practices are redefining the work involved in care, shaping the definition of illness and questioning the management of health and medico-social establishments. Thus, this call for papers focuses on the relationship between art and health at the organisational level, and is not intended to cover the otherwise diverse field of personalised care through art, or the abundant and varied practices of artistic therapies.

Proposals being submitted should address how these projects have been integrated and deployed in public policies and healthcare organisations over the long term. What transformations have they brought about, and what societal and cultural changes have they supported in care settings? What are the creative and design processes involved in these projects, and how do they shed light on the culture of care in healthcare organisations? How can we understand and share the effects of these projects on organisations, interactions and service user health?

Focus area 1 – Integrating and deploying cultural projects in public policies and healthcare organisations

Which public policies and what funding?

Today, artistic presence in healthcare establishments is often supported by public authorities, who issue calls for projects to encourage artists to work in hospitals, residential care homes for the elderly (EHPAD) or other medico-social establishments (IME and ITEP special needs schools, specialised care and education centres, etc.). Papers on this focus area will explore the importance that public authorities attach to these projects: what do they expect from them? How do they evaluate them? These public funding arrangements are partly stem from the national “Culture and Health” agreement being implemented at a local level by the State’s decentralised agencies, but they are also part of départemental policies (for establishments under the responsibility of the départements) or sometimes of communal or intercommunal policies when the projects involve municipal cultural establishments or care coordination facilities operating on this territorial scale (such as Communal Centres for Social Action, for example), (Liot, Montero, 2019). In all cases, these policies involve new forms of public action that are cross-sectoral, partnership-based and multi-scalar. In the context of decentralisation, these changes are leading local authorities to advocate working less “in silos”, and instead develop crossovers between different areas of public intervention (Gaudin 1999; Nay, Smith, 2002). Calls for projects specifically promoting design approaches in healthcare establishments have recently started to appear alongside schemes to encourage the emergence of artistic projects. The “Disability and loss of autonomy: social innovation through design” call for projects of the French National Solidarity Fund for Autonomy (CNSA) has been seminal in this field since 2018 (Burgade, 2021).

of Strasbourg, Bordeaux University Hospital, Nantes University Hospital, Le Mans Public Institution of Mental Health, Angers University Hospital, Nîmes University Hospital – and is gradually welcoming new members.

How are these partnership policies being developed across the country and in institutions, and how are they managed? What are the inputs and strains in crossover between health and culture? How do these policies foster the emergence of new stakeholders (artistic contributors, cultural advisors, mediators, etc.) and how are they involved in implementing these interdisciplinary policies? More broadly, what role do these policies assign to co-construction with the stakeholders in the sectors involved?

These projects often combine public and private funding. How do these funding sources complement each other? What role does sponsorship play in these projects? How do beneficiaries take ownership of the multiple requirements of these partners? How do these funding methods and systems influence projects and stakeholders?

Papers do not need to exclusively focus on the French situation and it will also be interesting to see how other national contexts foster the emergence and development of these projects. How do they make use of public and private funding? What role do local authorities play in the development of these projects? How do they contribute to (re)defining ways to take action in the health and cultural sectors?

European projects can also shed meaningful light on this issue. Funding in this context often involves an interdisciplinary approach. What importance is given to projects on this scale, and what is the approach to health and culture? What is the proposed methodology and what impact does it have on projects?

What is the role in organisations?

Nowadays, creativity is part of healthcare establishment projects. How does this relate to the other objectives of our establishments, to the quality of our admissions and care, and to the challenges of innovation, openness to the community and partnerships? What role do cultural projects currently play in the *processes* throughout our healthcare establishments? For example, are they integrated into quality processes? How are they developed and evaluated? More specifically, we look at how projects are managed and governed. Which departments are they led under? In large hospitals, communications departments often lead these projects, as they relate to image and visibility issues. But they are also often overseen by hospital management, as they involve an interdisciplinary aspect and strategic management issues that warrant this approach. This means that the artistic aspect contributes to new forms of management in healthcare establishments. It is present in organisations characterised by strong silos and hierarchies, which cultural projects tend to deconstruct (Herreros, Milly, 2011). In fact, these cultural projects provide an opportunity to act outside the usual statutory frameworks, and for this reason, they create new relationship types between healthcare establishment staff. How are projects managed? Are there any panels or steering committees? What types of staff are involved in these projects? How are these projects shared, or rather how are they isolated within a department or centre?

Artistic and cultural projects are partly supported by internal resources and rely on designated staff (social workers, therapists, cultural specialists, etc.) who organise the activities themselves and/or create the conditions for involving external professionals, particularly artists. How are these partnerships developed? How do professionals work together under these partnerships? How do these collaborations help change professional practices? Cultural projects examine the

standards of healthcare establishments, and sometimes pose hygiene and safety problems. They may stir up legal issues and create tensions and conflicts between uses.

Lastly, artistic projects require new skills and even new professions in healthcare establishments. These professions operate on the fringes of the professional healthcare world. How are these new skills and professions identified? How do they relate to the traditional professions at the heart of healthcare establishments?

Focus area 2 – Analysis of creative processes and experiences in health and medico-social settings

Cultural policies in hospitals have invited artists, cultural performers and designers to get involved in a variety of ways: showcasing cultural heritage, artistic dissemination while respecting the constitutional right to equal access to works of culture, artistic activities (usually in a participatory workshop format), artistic residencies, collaborative co-creation. In this context, we can also consider design as the latest form of institutional cultural policy, since it refers to the processes by which the environment and uses of a given community are transformed. It combines its ways of working with those of cultural action and art through the aesthetics of the forms produced, while casting a new light on the question of use at the heart of creation.

Among this abundance of initiatives, this call for papers focuses on experiences that are part of what we call artistic creation. According to the philosopher René Passeron (Passeron, 1985), artistic creation refers both to the processes involved in creating/conceiving a new work of art that comes into the world, and to the way in which these processes disrupt, question and displace in the social, cultural and organisational environment in which it takes place – in this case, in healthcare and medico-social establishments. Artistic creation is a core concept behind poietics and refers to both the creative process and the framework for analysing experiences in order to comprehend their multiple movements within themselves and with their environment.

Experiences likely to undergo this dual analysis are generally contextualised, in situ, participative and problematised. They create or at least highlight discrepancies and paradoxes in the representations, feelings, relationships and practices that norms and habits attribute to stakeholders, i.e. users and professionals. This epistemological approach stems from poietics, for which “it is the process of poetic composition rather than the poem itself” (Paul Valéry, 1937), and enables us to use the techniques of every available human and social discipline to establish facts and form descriptions and analyses. Where possible, the aim is to analyse for each experience the conditions, the translation and mediation mechanisms used, the design/creation processes, and the conditions of reception and appropriation of the work by relevant stakeholders.

In this train of thought, authors are invited to describe and analyse the creative behaviours, poetic operations and operational procedures of the proposed experiences. These can be in the fields of heritage, art and/or design i.e. key elements of cultural action. Creative behaviours are actions taken involving the creator(s), with a view to creating an object or generating a unique experience in sensory and aesthetic domain. They reflect the strategies adopted by the

creators/designers. Poetic operations refer to what the action makes the people who receive the work and are involved in its conception to feel, through their perception of the object, environment or experience. They also refer to how these experiences change people's emotional states, levels of consciousness and sometimes practices. They are centred on the perspective of users, patients and professionals and focus on transforming their relationship. Lastly, the operational procedures depend on the methods for taking action used by the artistic, cultural and mediation stakeholders in the healthcare establishment's organisational system. They relate to the strategies implemented by the cultural and institutional operator. Thus, the call for papers focuses on artistic interventions in all their diversity, whatever the discipline, as long as they are part of cultural policies. Papers can explore heritage and historical approaches, aesthetic and sensory experiences or design interventions for the collaborative conception of healthcare settings.

Heritage and history

One of the longest-standing creative behaviours in the field of culture in hospitals is the interest shown by healthcare professionals in history, remembrance and heritage. This tradition led to a number of museums being set up in old hospital buildings (Hôtel-Dieu and Charité) with varying resources and scientific requirements. For a long time, they exhibited what you would expect to find in a traditional museum, focusing on the objectified heritage value of objects, particularly technical healthcare objects, and on a history of scientific discoveries and prominent figures. It wasn't until the 2000s that an epistemological breakthrough happened in the museological, museographic and scenographic approach to hospital heritage. The Museum of the Public Hospital System of Paris (AP-HP) has paved the way for a radical reformulation of approaches to heritage in healthcare (Nardin, 2005). More broadly, it has leveraged socio-anthropological investigation methods, leading the hospital community – and on a wider scale, the general public – to be involved and question the gaps between reality and the expectations of the contemporary hospital in terms of non-specialised topics: the humanisation of healthcare establishments, charity and poverty, nursing training, internships. Most importantly, however, it should be noted that the museum has fully committed to an active and participative scenography with all AP-HP stakeholders. By filtering through the sieve of remembrance, heritage becomes something synthetic that essentially gives form to anxieties, attachments and practices to culture in hospitals.

This paradigm shift opens up new horizons for hospital heritage (Poisat, 2001). It thus becomes something through which we can reflect on the transformations of identities, organisations and professional practices in the hospital, and creates public spaces open to stakeholders and citizens to debate in detail the questions that shape how we care for our health. The ethnographic and heritage survey conducted by Marie-Christine Pouchelle on the occasion of the closure of the Broussais, Laennec and Boucicaut hospitals is testimony to this (Pouchelle, Vega, 1999).

Furthermore, in keeping with the museology of rupture theorised by Jacques Hainard (Hainard, 1985), objects and images are deconstructed, turned upside down, and their status and meaning questioned.

Lastly, the evolution of heritage approaches towards better integration of the memorial and ethnological aspect attributes value to "a small memory of everyday life" (Periot-Bled, 2014). The focus on the subjective accounts of both patients and professionals, sometimes linked to objects whose only value is to be appropriated by these accounts, allows us to reconstruct a

modest history of the hospital, one that has been experienced by the people actually involved. With this new perspective on the epistemology of hospital museology, it is clear to see how art and design have become part of heritage scenography. These disciplines have also covered this material and memorial heritage of hospitals in many of their projects. How can we describe the new paradigms of hospital museology in view of these developments? How do art and design transform and enrich the participatory methods and rendering forms of scenographic projects in healthcare establishments?

Aesthetic experience and restoring sensation

For the past twenty years, mainly thanks to the culture and health programme that has made it easier for artists to work in hospitals and medico-social establishments, the ways in which they can practise and experiment have continued to expand. There is a growing number of people focusing on the aesthetic experience and the sensitive, sensory perceptions of the people being cared for in these institutions. In these situations where people are admitted for their psychological, physiological and social vulnerability, designers and caregivers are driven by the prospect of the works' "existential enlightenment" power (Younès, 2012). In addition, the anthropological density of healthcare establishments necessarily calls for those in care to be thought about and healed through poetic attention given to form and meaning. How do art and design embody this ambition?

To explore this further, we will refer to aesthesia insofar as "*aisthesis* constitutes the existential fabric of our awareness of things, people, institutions and ourselves.⁶" (Passeron, 1985). Aesthesia is a concept that relates to the dimension of sensation (perception) and of meaning (understanding). This definition aligns with the concept of "milieu" defined as the co-presence of individuals and the relationships, objects and driving forces attached to them (Dautrey, 2019). Despite the consensus among researchers in the humanities and social sciences, designers and caregivers on the paramount importance of this "milieu" for health and quality of care, sensory qualities are still too rarely used in hospital settings. These qualities usually result from functional, technical and hygienic specifications rather than attention actually being given to the sensory perception of those who will use these settings. However, the ambition to find the "spirit of the place" haunts architects and spatial designers. Is the "spirit of the place" in healthcare settings not primarily the manifestation of a dynamic therapeutic alliance? How can we translate our care intentions into material means? How can we maintain links through our focus on places (Pierron, 2018)?

Contextual art (Ardenne, 2002) and relational aesthetics (Bourriaud, 2018) explore this huge diversity of creative behaviours for which the expression of the creator's singularity is no longer the main driving force. These behaviours are usually characterised by the participation and involvement of the relevant people in the intervention setting. Whether it's live art, graphic arts or design, the experiences offered to people admitted to hospital, receiving care or in residential care are based on a double axiom: supporting the existential feeling of living and developing caring relationships. Investing the aesthetic quality of and how we perceive forms guarantees the ontological aspect of art, i.e. the experience of sublimation and empathy for those who are involved. But these experiences build bridges to help us endure suffering and react (Ricoeur, 1990). They make patients stakeholders in their care experience, because their emotions are made known to the environment in which they occur. How and in what way do

⁶ Passeron, p.30

artistic, cultural and design experiences restore a spatial and temporal environment that triggers aesthetic emotions and encourages caring relationships (Delanoë-Vieux, 2022)?

Collaborative conception and design in healthcare settings

Design as a creative and transformative discipline has been emerging in the field of healthcare for just over a decade.

What design brings to these aesthetic and relational experiences is the concept of using and thus that of users. It is a discipline that puts the user at the heart of the design process by incorporating their experience. In this respect, it focuses specifically on users' ability to act *by doing* through facilitation, participation and involvement in projects that are inclusive of all stakeholders. To a certain extent, design makes a health *demopraxis* effective, in which the challenge is no longer just the aesthetic experience as a sublimation and social transmutation of emotions, but also to tangibly transform the material means and service of institutions. Its holistic and comprehensive approach integrates all the spatial, informational, sensory and technical dimensions of the environment in which our subjectivities and relationships occur. Design is a discipline that involves planning, problem solving and improving the habitability of the world. How are hospital players getting to grips with this new discipline? What are the processes involved in implementing hospital design? What topics does it cover? How is design itself questioned and transformed by the existential characteristics and health requirements of the hospital?

Focus area 3 – Evidence, evaluation and sensitive approach to the effects of creation projects in healthcare facilities

In 2019, a synthesis report by Health Evidence Network 67 for the World Health Organisation (Fancourt and Finn, 2019) concluded that the arts have a positive impact on health, based on a review of over 900 publications from more than 3,000 studies. Against the backdrop of more studies being conducted on the impact of art on health, the RFAS call for papers is particularly interested in studies correlated to an experience or project in art or design demonstrating the link between creation and health. In its broadest sense, we see health as something that integrates improvements in physiological and emotional states, increased chances of remission, psychosocial rehabilitation and self-esteem. This holistic approach to health formulated in the recovery philosophies (Gilliot, 2017) aligns with that of design in that they share the same hope: that of improving the habitability of the world and the everyday life of every person regardless of their condition.

Various projects at the interface of design, art and research are also helping to expand the therapeutic arsenal of healthcare professionals. Papers could assess the effects of artistic experiences in health and medico-social establishments, in particular by using tools that can provide clear evidence, both in terms of the quality of the experience by collecting the uses and feelings of participants, and in terms of the therapeutic impacts for users.

From a dialectical perspective, papers may also consider how the medical and medico-social framework disrupts artistic practices and experiences. How does including users in the creative process affect the artistic act, its production and its implementation? Papers could also

examine the form(s) produced, the possibility or necessity of non-completion (Oury, 1989), and the need to adapt the creative process to psychological or physical suffering, as well as to the setting of healthcare establishments.

A cross-sectoral evaluation

While it is difficult to reduce art and artistic practice to the production of evidence or the construction of a utilitarian relationship between institutions (Maldiney, 1985), their encounters with public health and medical and nursing sciences mean there is a need for evaluation processes (Duran, 2010). The development of cultural action, particularly as a result of the shift in funding for cultural policies from the State to territorialities, has pushed artists out of the defined scope of cultural structures (Langeard, 2019). Artistic and cultural initiatives are now widespread in schools, prisons, hospitals and, more generally, in the social field. This shift has various consequences including evaluation becoming a key issue that needs to be rethought in the light of this cross-sectoral nature. This also applies to the legitimacy of these projects, which can be perceived as trivial.

Beyond the effects of artistic experiences on medical and medico-social practices, we can thus examine evaluation tools both in the artistic and cultural sector (Langeard, 2016) and in the medical and medico-social sector (Benamouzig, 2010), with a view to identifying which evaluation methods can capture such different practices and sectors.

Can we apply evaluation methods from the healthcare sector to the artistic one? What criteria should be used to define the effectiveness of an artistic experience in a healthcare facility? What are the specific features of these experiences and how can we understand them?

Articles being submitted may take the form of scientific contributions, studies and evaluations, testimonials, experiences and experiments, or points of view.

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