BINAURAL

Survey on Location and context based media
#1 [winter2006]

conducted by Mark Mclaren

interview
with **Julian Weaver**

RESPIRER

JULIAN WEAVER's installation RESPIRER uses the medical practice of Auscultation (the practice of listening to sounds arising from within the organs) to play with the expectations of an audience submitting to a clinical frameworks within an art context. With a nurse employed to take down details and perform an examination, this situation provides a strange and disconcerting feeling that though we are in an art environment, the medical world and its rules prevail. So as soon as the examination is complete, there is an expectation of a diagnosis, to know that we are healthy. The disappointment of not receiving any reassurance is one of the more powerful aspects of this piece. The examination finished, you are asked to leave the enclosed space of the installation and move back into the gallery. Weaver explains that he is both interested in collecting lung sounds, as well as observing the participants suspending their aesthetic critique "in favour of physical analysis [that] suggests an investment in the beneficence of the medical institution as a whole. A view not entirely consonant with a socio-political view of the health service. This fallout between belief in the medical profession and its institutionalisation is underpinned by a differentiation between the political and the clinical; something that provides the clinical with a freedom not enjoyed in the political."

It some ways Respirer reflects the very invention of the Stethoscope itself. A young French physician called Laennec was examining a patient in 1816. Apparently the doctor was both embarrassed to place his ear onto female patients chests and also slightly squeamish of the sick and the epidemic of tuberculosis that he was employed to treat. In a flash of inspiration he remembered that "we hear the scratch of a pin at one end of a piece of wood, on applying the ear to the other." Making a paper cone he placed the large end on the patients chest and the other end at his ear. He was "not a little surprised and pleased, to find that I could thereby perceive the action of the heart in a manner much more clear and distinct than I had ever been able to do by the immediate application of the ear." Something of this moment remains in Respirer, the disgust and closure of the patient; the separateness of the artwork from the experience of taking part; the depository for collecting sounds without diagnoses. And of course the problems of diagnosis itself. Weaver informs me that though he would not want to, it would be illegal for even a registered medical practitioner to diagnose patients in a gallery.

It is true lung sounds are very evocative and full of the hidden interior of the body. Spaces usually too intimate even to examine ourselves. But they are also limited and hard to define. Weaver states that "Like other mechanisms (the car, the record, a water tap, etc), when in good condition, the lungs produce only a repetitive 'whooshing'. When damaged, however, there are a limited number of additional sounds that can be identified. These range, pathologically speaking, from the muffling of the common cold due to temporary consolidation of the lung cavity or the 'crackling' of the alveoli associated with asthma to the terminal gurgling of the 'death rattle' as the lungs slowly fill with fluid." Weaver examines the problems current even in contemporary medical practice where, wax in doctors ears and many other factors render auscultation a questionable practice it terms of locating illness. What we find here is a clever reading of both the effects of modern art's tradition method of negation coupled with critical questioning of the acceptance of institutional medical wisdom.

Mark McLaren (MM): Explain the version of Respirer that I saw in Tallin as part of the Isea2004 festival.

Julian Weaver (JW): The version of the installation of Respirer at Isea is a lung recording clinic, which you fill in a form and receive an examination from a nurse. the sound is routed out to a speaker and people who are outside can both watch the examination that is taking place and listen to the lung sounds coming out through the stethoscope.

MM: What reactions have you found from the people who take part, considering the clinical structure of the piece?

JW: Well it seems the people are readily available to submit themselves to the examination without really asking any questions about say, the validity of the nurse who's doing the examination. And they seem quite often to forget that it's a piece of art and become far more interested in their own health which is quiet peculiar.

MM: The installation seems to use to methods of disappointment. Firstly the fact that you don't receive a diagnosis and secondly that the person who is being examining cannot really hear their own lung sounds. Is this an intentional part of the piece.

JW: Well it started off with thinking about the levels by which people who are trained to auscultate actually hear any sound at all. There's a huge gap between the amount of sound that's left by the time it reaches the stethoscope from its point of original in the lung. And quite often there's a lot of extraneous noise to do with the handling of the stethoscope and various other physical attributes like cleanliness of the physician's ears. So there's a possible absence of sound coming through so there's this identification process in the stethoscope where the physician is attempting to discern between a framed noise, a noise that has a clinical definition and other extraneous noise. So going back to the question of disdain for the audience it's not really to do with stopping people listening to the sounds, because they're not going to be hearing them anyway in a normal situation when you go to the doctor. The Doctor doesn't invite you to listen to the sound yourself, it a pure clinical procedure that they are occupying.

MM: Are you planning to make any work with the depository of lung sounds that you have collected?

JW: The initial purpose of Respirer was just a sound work, it wasn't an installation as such. It was recordings I'd taken from other places and mixed together, where you wouldn't be able to distinguish between one persons breathing and other. And returning back to the diagnostics again, there's almost like a demographic of people from the installation which is designed to pick up, to get more people in to get there lungs recorded for more source material, and the diagnostics would be sort of further removed be the collapse of the all the different recordings by actually mixing them all down into one piece so you almost get like one demographic of visitors to the show. So for each show that's happened there's been a piece which I guess is a sort of cartophony of visitors, and audio map of people who've arrived in the gallery.

MM: I noticed that the more ill people are, the more interesting their lung sounds are. Is this drawing you to work with more obviously sick people in order to get less bland lung sounds?

JW: Well, as I remade the installation each time, it's become clearer that it's not entirely - the sound was the initial interest for me, or the origin of the sound - I read in an american medical journal and they were still arguing about the source for certain lung sounds were and no one could actually determine the origin, which was quite interesting to me that sounds were being produced but no one could actually identify the source -..... it became more about the framework within which the technique of listening in a clinical way has a very historical and fixed framework but it's layered in top of a series of unknown quantities, I think now it's more to do with now exploring the relation of medical listening to noise and how it organises into a logical framework linguistic system.

links:

look for photos of Laennec maybe here:
http://www.antiquemed.com/laennec_pic.jpg