An exhibition by
Georgie Mattingley

TOPIAS III

Warrnambool Base Hospital
9—30 September 2017
Open Sat, Mon, Tues
11am—5pm

— TOPIAS

I. UTOPIA

noun

an imagined place or state of things in which everything is perfect.

II. DYSTOPIA

noun

an imagined place or state in which everything is unpleasant or bad.

III. HETEROTOPIA

noun

a place or space that functions in non-hegemonic conditions. An 'in-between' or 'other' space such as a hospital, prison, shopping centre or airport. A 'crisis heterotopia' is designed to conceal unruly or transformative processes from public sight so that society can remain respectably clean.

GEORGIE MATTINGLEY

TOPIAS III

BIRTH

When I started my residency in the hospital in early 2015, I was based in the Emergency Department (ED). There were no set tasks given to me, simply an invitation to observe and find inspiration. This is a brave initiative because allowing an artist to create work on their own accord within this space creates a glitch in the clinical process of treatment and healing.

Within the hospital, where medical analyses are made, diagnoses are given, treatment is administered and procedures are followed, artists are outsiders. Of course art has its place in hospitals, but only under specific conditions. Art in hospitals should typically calm, inspire, or distract its audience. It should take into consideration what is most appealing (and the least confronting) to the most amount of people. However, a contemporary arts practice does not necessarily follow these conditions.

Through my own art making I like to challenge these visual tropes that influence what we see and what is often avoided in everyday situations. I love art's power to change the way we see things. It helps us to think and feel in new ways and can bring a deeper understanding to life, the world around us and our place within it. While working as an artist in the hospital, I often felt wedged between two conflicting agendas. I wanted to create beautiful images that could appropriately be displayed in the hospital, which requires a sensitive consideration of its impact on patients. At the same time I wanted to draw back the curtain that hides the mess and the death in hospital and give value to some of the less appealing yet necessary aspects of hospital life.

I found my way through the early days of my residency in ED following the nurses around and chatting to patients. I would wait in the 'Fish Bowl' (a staff console area barricaded by glass windows overlooking each bed), while a doctor on duty would approach a patient to ask them if they were happy to chat with me. Patients would tell me their story of how they wound up in hospital. I'd ask them if they liked art and if so, what kind. I'd usually be sketching with pencils or watercolours while we chatted - anything from their portrait or their hand to a chair in the room. I was conscious to behave like people expect artists to behave, because without a pencil or brush in hand it is easy to be mistaken as a journalist.

One patient helped me reach a significant milestone of my residency at the hospital. This elderly patient lay in bed very unwell as we chatted quietly about art and beauty. I showed him my sketchbook, which was full of collages, drawings and ideas I'd collected over my time in ED. "I love this picture," he said, looking at an olden-day black and white photograph I had found and painted with watercolours. The photograph showed surgeons working in an old operating theatre, which I had coloured in soft pastel pinks and blues. "I like it because it reminds me of family photos from my childhood. Our black and white photographs were always hand-tinted like this. The colour in this photo of the hospital makes it looks like it's something we should cherish and remember." Although this patient didn't realise it at the time, he had helped give birth to an idea that would become the driving force behind my work at the hospital, a new body of photographs and this exhibition.

LIFE

Most art on display in the hospital makes some sort of reference to 'life'. Nature, plants, animals, flowers, scenery. Life. Surviving. Above all else.

My first project outside of the ED was to document all the artworks displayed throughout the hospital. I documented every single element of decoration I could find in each department. Anything from paintings and photographs to puzzles, stuffed teddy bears, greeting cards and many flowers. Flowers sit in vases at the reception area of each ward, in patients' rooms and workers' offices. In some wards, volunteers are assigned the task of transporting all the flowers to the 'Flower Room' where they are watered and rotated once they wilt. This process takes hours. It's a job that doctors and nurses wouldn't have the time to do but, nevertheless, is an important role that aids in making the space feel more alive and homely.

Through my investigations I came across some hospital highlights. One of these is a large outdoor mural painted on a brick wall in the courtyard of the Acute Mental Health unit. The mural depicts a waterfall within a thick green rainforest of shrubs and tall ferns that fill the wall, leaving only glimpses of painted sky peering through the treetops. In a space where patients' movements are monitored and where some patients may need to be contained, this waterfall offers a moment of respite from high walls, an illusion of larger, greener space and a reminder of nature in all its glory.

The most emotionally impacting space for me was the underground morgue reception area. The morgue is a quiet, mostly unvisited space that must be ready to receive the families of the deceased at any given time. Entering the morgue, there is a waiting room reception area with two green couches on either side of white flowers and tissues that rest on a small side table. A framed image on the wall depicts two horses wading through deep water amidst a soft purple and blue haze. It's quite ambiguous and melancholy, but I think it's the right choice of image given the heavy weight of events that unfold in this space. From the waiting room a door leads into a viewing room where a blue curtain can be drawn back or forth to reveal or conceal the deceased. A vase of flowers rests majestically atop a wooden pillar in the corner. One small, framed image - a birds' eye view of the Warrnambool coastline - floats almost lost in a large white wall. Bright white lights and the soft hum of refrigeration transports you to another place, which feels like a halfway house to heaven.

This meticulous attention to aesthetic detail does not occur in every hospital department. Generally the more labour-intensive departments (usually the departments patients do not see) are void of any artworks or decoration. This includes Warehousing and Logistics, Biomedical Engineering, the Theatre sterilisation room, the kitchen and Linen Services - where the focus is taken away from customer care and onto meticulous or mundane manual tasks.

These departments were the most enjoyable to photograph. Within these stark and utilitarian spaces I was able to play most with my imagination. As workers' hands moved through repetitive (almost ritualistic) movements, it reminded me of the delicate beauty of hands of religious figures in Renaissance paintings. Throughout art history hands have been used as a symbol of humanity, individuality, expression and creativity. I wanted to adopt this symbol by inviting hospital workers to pose with their hands in delicately poised positions, similar to the gestures of a ballet dancer. I imagined their palms like the hollow archways of a church interior, their fingers like rising spires, resembling a sacred and spiritual space for human prayer. During the Renaissance, religious iconography provided a spiritual solace, moral guidance and a meaning to life. Today, each hospital worker - from the midwife, doctor, surgeon and nurse, to the cook, cleaner and maintenance staff - provides us with their gift of labour that promotes healing and sustains human life.

My idea of photographing workers' feet floating mid-air intended to convey a similar sentiment of spiritual freedom and euphoria. Many workers have patiently jumped for me several (sometimes 20 or more) times, until I captured that perfectly ambiguous image. The series is titled 'Ascension'. Like the Assumption of Mary into Heaven, workers suddenly ascend - plucked from their earthly task and delivered to freedom. Mary avoided experiencing true physical death in this way. Without such a concession, I believe freedom should be sought through an acceptance of physical realities, the dirt and the mess that comes with life.

DEATH

I have often felt that when I exhibit my art it dies. I don't mean this in a bad way, just that the magic of creation is over.

As I create art it shifts, it grows and it breathes fresh life. It feels like I'm bringing something new into the world and this is exciting. Once the artwork is complete and put on display, the magic dies and it's a time for reflection. Then, as people see the work and contemplate it through their own eyes and experiences, the work is imbued with meaning. It is given a new life through what it makes people think about and how it makes them feel. This is, ultimately, the joy of sharing my work with you.

Maybe life in general is not so different. As we live, we breathe, we shift and we grow. Then, at our death, people gather to contemplate the life we've lived and things we've done (whether big or small) that have changed the world. We are reborn into the memories of those around us.

I can say honestly that after all this time at the hospital, I'm not afraid to die. I've seen the faces of the people that will care for me. I've seen the hands of those that will comfort me, clean for me, roll me over, cook for me and give me medicine to reduce my pain.

When my time comes I'm happy to just relax into the cycle of the hospital - which is the cycle of life - and go along for the ride.

Dr. TIM BAKER

ABOUT EmbedED

I like the process of exaptation; taking an idea developed for one area and using it for a different purpose. The EmbedED artist-in-residence program had that sort of beginning. Could embedding an artist in an emergency department work like the well-known process of embedding a journalist or artist in a military unit? Since 2013 we have included artists as volunteer members of our Emergency Department at our Warrnambool Base Hospital. Over three months they interact with patients and staff. Their art is a response to what they have experienced. Georgie Mattingley is our fourth artist-in-residence for this unique project.

I thought artists could tell the hidden stories of patients and staff. The symptoms of injury or illness are only part of that story. The physician William Osler famously said 'It's more important to know what sort of person this disease has, than what sort of disease this person has'. Artists helped clinicians see the person and their fear. We remembered that our routine day could include the worst moment of someone's life or at least the most unfortunate event of their year. The artworks gave our community a window into what happens behind the emergency department door.

Every artist has taken a different approach. To me, Georgie's work focusses more on moments than stories. It's not what I expected in a setting prioritising movement and flow, but it is surprising and intriguing. Patterns repeat, but the details are always different, and nobody stops to consider them. To staff everything is routine. Georgie's work discovers moments of beauty in the repetitive and mundane. It does not shy away from discomfort, sterility and death. Recolouring black and white images invites us to give our tint to remembered events and environments.

Georgie has gone beyond what we usually see as the emergency department and moved on to embrace the hidden spaces of the hospital and the invisible staff. For every face that a patient sees, there is a community, another ten or more faces, providing support. She gives a backstage view.

Pretty art, pictures of open meadows, and relaxing themes have a role in calming patients in anxiety provoking situations. More challenging art also has a place. An episode of illness is only a small part of a large life. If a person or their carers are going to change, strengthen, and adapt, it is important for art to motivate, challenge, disrupt, and inspire.

I am proud to present to you this exhibition of Georgie Mattingley's work, which has been produced from her EmbedED experience.

AN INTERVIEW WITH JOHN MALSEED

COOK

Georgie: What does your role in the hospital entail?

John: I work in the kitchen in a number of roles. We often rotate roles week-by-week. This week I am in charge of dishing up the meals for patients and also for Meals on Wheels, which will be delivered to Macarthur, Lismore, Opal Gillin Park and anyone else who needs meals.

G: What's Meals on Wheels?

J: They are freshly packed meals that go out cold for those who need it. We serve up meat and two veggies with a soup, a sweet and an orange juice. We tray up about 80 – 90 of these meals a day mid-week and about 30 – 35 on weekends.

G: How many meals do you tray up altogether, including the meals for the inpatients?

J: Around 500 meals a day.

G: Can you describe the step-by-step process of preparing meals for the wards?

J: Well, we have about 18 staff working in the kitchen at a time and each person has a set task to do. We have a head chef, second chef, dining room cook, pastry and sweets chef, catering manager, service staff and admin. Everyone has a role. First of all, we start with food preparation, which might be cutting the veggies, cooking the veggies, cooking the meat, puréeing the food if we need to. We cook in large quantities, so this is done in large 'jackpots' *[industrial-sized cooking vats]*. Then the cooked food is put into the blast chillers so it can be chilled down to 4 degrees within a 90-minute period. When we need the food, we take it out of the chillers and begin traying it up. First the trays are placed out onto a race and several staff work together to build up the meal. One person will put the plate and menu on the tray then the next person will place on the meat and gravy. The next person will serve the veggies, the next person the sweets, then the sandwiches. The last person on the race is in charge of checking each meal to make sure everything is correctly in place before they are stacked onto trolleys that go up to the wards.

G: How is working in the hospital environment different to working in other restaurants?

J: Here at the hospital everything is cook-chill, whereas at a regular restaurant everything is cooked to order. We cook in bulk here, so you might make 100 serves of sweet and sour pork, or soup in a large 'jackpot'. At a restaurant you might only have one or two servings to make at a time. In this way it's very different.

G: Do you have much patient contact in your role?

J: No, not really. The kitchen is quite separated from the rest of the hospital. The service staff who deliver trolleys of food up to the wards do have direct interactions with the patients, of course. As a cook, I don't have any contact with patients unless I'm visiting my own family or friends who have been admitted into the hospital.

HOW MANY MEALS DO YOU TRAY UP ALTOGETHER, INCLUDING THE MEALS FOR THE INPATIENTS?

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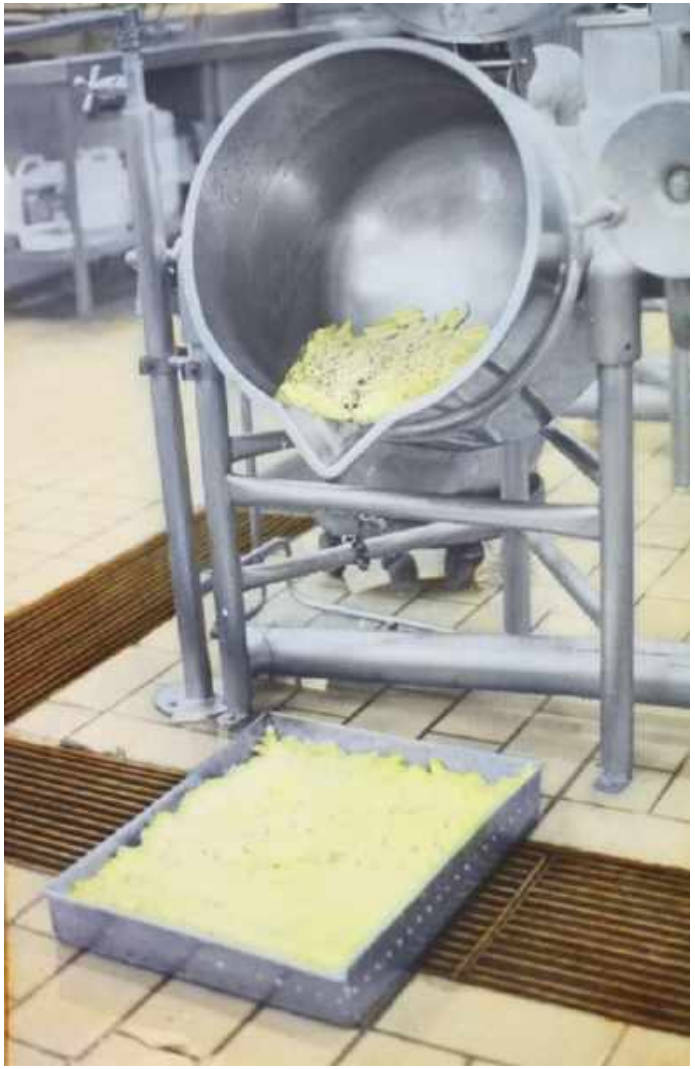


AN INTERVIEW WITH
AARON JARMYN & NICOLE DOWNIE

REGISTERED NURSES, ED

Georgie: What is your role in the hospital?

Aaron: We are registered nurses in the Emergency Department.

G: Do you need a tough stomach for your work?

A: Working in Emergency is mostly the same as being a nurse anywhere. It's the same sort of work, just a different approach. Sometimes we may see a few more traumatic things that may not go through to the ward, they may go straight to theatre, or go to a higher acuity hospital. So, there are a few injuries that are a little bit more graphic, but for the most part on an average day we wouldn't see anything more graphic than ward nurses.

G: Are you de-sensitised to the body and bodily functions?

Nicole: I think being a nurse anywhere does that. When it comes down to it, we put the tubes and needles into people, but all nurses on the ward do that same stuff too. In all sorts of nursing you learn to toughen your stomach.

A: Yeah, I remember first starting, which is nearly two decades ago now. I was tentative about touching people because, I guess, there's a stigma surrounding the things that people allow us to do to them. Procedures like inserting I.V. cannulas or urinary catheters can be very invasive procedures. These things are very straightforward to me now but you still have to remind yourself that they are very personal areas. Even the back of a hand is still a personal area, because it's someone else's body. Especially when there's that gender difference of male to female, too. Part of our role is undressing people. To listen to someone's lungs – you can't really listen through clothes so you need to expose their back and the patient may feel very vulnerable and exposed. That becomes very awkward and there may be times that it's more appropriate for a female nurse to take over. We must be constantly aware of what is most decent and respectful of the body and the patient's vulnerability.

G: What is it specifically that you like about working in Emergency?

N: The best thing about working in ED is that we work with 0 to 100 year-olds and we don't know what's going to come through the door. You're always on your toes no matter what. That's the best thing about it.

A: It's the unpredictability of it. It's the fact that there's something different each day. Inherently, if you look broadly at the patients coming in, it's always theme day. So you'll have a lot of road trauma. Or there are lots of chest pains – there are always a lot of abdo *[abdominal]* pains. But specific types of abdo pain will come in.

N: It's Pyelo *[Pyelonephritis]* Week at the moment. We've had three Pyelos in two days!

G: Wow, in a strange way maybe the community is connected in its illness.

A: Maybe, yes. And I think Emergency is renowned for its unpredictability. Anecdotally, there's a stigma here. People don't want to come down here because they seem to think that people are dying all the time, which isn't the case. It's not that everyone's having heart attacks. We're not defibrillating every 20 minutes. It's not that sort of environment.

G: What do you mean there's a stigma here? Is that among the staff or among the patients?

A: It seems there's a stigma among the staff that they don't want to come down to work here, because they think it's going to be something they can't handle. Because it's an unfamiliar environment and because it's "Emergency" – which is a pretty big word. There seems to be a stigma that there'll be a whole heap of stuff you're not qualified to deal with, so they think, "I'm gonna be useless". But in reality, most people who come down here find that it's generally a relaxed environment.

G: What are some of the challenges you face working in ED?

N: It's probably keeping up with the education and the new policies, new protocols, all that sort of stuff. ED is focused on a broad spectrum of nursing so you're dealing with everything that comes to the hospital. It's not like the wards that deal with specific areas, like acute, midwifery or paediatric. We deal with everything. Not necessarily midwifery, as that is deferred onto our Midwifery Unit... but we're still doing obs and gynae *[obstetrics and gynaecology]*, we're doing oncology, we're doing paediatrics. It's all different sorts of nursing all involved in one small area. We've got to keep on top of our education in everything. So, there are no boring moments in ED. There's always something to do.

AN INTERVIEW WITH HELEN HAND

ENVIRONMENTAL SERVICES

Georgie: What does your role in the hospital entail?

Helen: I work across two departments in the hospital, cleaning the Midwifery and Rehab Units. This involves cleaning patient rooms, non-patient rooms, public bathrooms, staff rooms and service rooms. I dust, mop, dry-mop, replenish rubbish bags and wipe down tables. In between cleaning these two units, I also rotate through cleaning the Pharmacy, and the Medical Library.

G: Do you feel that other people value the work you do in the hospital?

H: Yes, I think they genuinely value what I do. One day I went in to clean the room of a patient who had impaired vision, so I said, "Don't worry, it's just the cleaner." She replied, "You're not just a cleaner, don't call yourself 'just' the cleaner." We help people by cleaning their rooms and bathrooms, which is rewarding because a lot of people appreciate it and say 'thank you'. As the cleaner, my job is just as important as anyone else's here.

G: Is your job laborious or is it quite social?

H: It's both. Some days are harder than others when it's more monotonous. If patients are being moved around, there's less opportunity to chat and the work feels like it's the same thing, going over and over again. I like to see the patients. That's what breaks it up for me and makes each room special, because each patient is different. You get to talk to different people as you're cleaning their floors. I think it would be much harder to work in a place where there are no people, like offices after hours. It'd be a lot lonelier.

G: What differences do you notice working across the two units, Rehab and Midwifery?

H: Physically, there's a lot more equipment in Rehab, lots of chairs, walkers, crutches and lifting machines to work around, so the job is more difficult. But in Midwifery the spaces are open and the job's more free-going, as people are more inclined to do things for themselves. However, I find working in the Rehab Unit more rewarding. You get to see people get better and go home after a long time. It's great to see them go from a stretcher to a walker, to some crutches and improve to different levels over time. I find it rewarding to see people work hard on their recovery. In Midwifery, patients tend to be in and out within 48 hours. It's lovely to see them go home happy with these beautiful new babies, but there's less opportunity to get to know them over time.

G: Do you miss patients when they go home after a long time?

H: I do miss them when they go home and I wonder how they're going. Because you have a little chat with them each day as you clean and then one day they're not there. There have been times I've been very shocked to come to work and find the same person not there in the room anymore, because they've passed on.

G: How does being exposed to death, birth, illness and recovery on a daily basis affect you?

H: It makes me a more positive person. I have found that since working here I am doing a lot more with my time. If someone rings me and invites me somewhere, I'll go, because I don't know what tomorrow brings. I see how things can change so quickly in life, so I don't want to miss out on anything.

AN INTERVIEW WITH KUNLÉ AROGUNDADE

ORTHOPAEDIC SURGEON

Georgie: How long have you been an orthopaedic surgeon for?

Kunlé: About seven years now. But altogether I've been in orthopaedics for about 17 years.

G: What are your day-to-day activities working as a surgeon in this hospital?

K: My role in the hospital involves both clinical and teaching. I also conduct research projects. I'm a consultant orthopaedic surgeon and VMO *[Visiting Medical Officer]*. I operate, on average, once a week at the base hospital and a similar operating time at St John of God private hospital. I conduct a once-a-week fracture clinic and follow up post-operative patients. My weekly schedule involves consulting, teaching, operating and research. The work is absolutely rewarding. I am pleased to see patients regain their function and resolution of disabling pain. The joy of being a surgeon is to see patients you have operated on have a good outcome and see a smile on their faces. That puts a smile on my face as well.

G: I believe there's a stereotype of surgeons being typically awkward, anti-social or lacking empathy. What are your thoughts on this stereotype?

K: Surgeons do have empathy. The critical ingredient of the job is empathy. You only have to look at the patient and see that they are in pain or unwell, and your aim is to take them out of their misery or pain and give them back a normal fulfilling life. So, I don't think this stereotype is entirely true. I think yes, the training is long and we do occasionally work some ungodly hours. From that standpoint, the social abilities of doctors and surgeons are restricted because we work longer hours. However, we do socialise. Generally with work colleagues and friends, and we spend time with family. Surgeons in particular have a great responsibility of having other peoples' lives in their hands. We take the responsibility very seriously. People have entrusted you with their life and this is not something to be taken lightly so you have to be focused, dedicated and work hard to maintain this trust.

G: This is huge amount of pressure to carry around with you each day, having peoples' lives in your hands. How do you learn to cope with this pressure?

K: Some of it is inherent. You already have it in you. Most of it is environmental. You develop it as you go along in your training. The hours are long and you see people unwell and miserable due to their illnesses. Naturally, you develop that instinct to want to help and you build on that as you go on in your career.

G: Is it strange or uncomfortable to be working so intimately with other people's bodies and flesh?

K: No, not at all because that is what you have trained for all your life. That's like asking, "Does it feel strange that a pilot is flying a big plane?" It's just your job. All the years of training which involve you being exposed to every rudimentary aspect and the most advanced aspects of this job is what prepares you. Maybe at the beginning of your medical school career you might feel woozy the first few times you see blood or certain procedures but as you go along it becomes routine. It becomes normal, so that at the end of the day, you can face every situation. No, it's not strange to me, it's not unusual. It's actually a familiar territory.

G: How do you like to de-stress from the demands of your work?

K: I'm a family man. I enjoy getting home and spending time with my wife and children. So I leave work at work and home is home and the place I unwind.

AN INTERVIEW WITH
DEBBIE KELLY & KELLY DUBYNA

LINEN SERVICE

Georgie: How long have you been working at the Linen Service?

Debbie: I have worked here in the laundry for 13 years. I'm a bit of an all-rounder in the laundry. I move around as needed.

Kelly: I've been the Manager of the Linen Service for only 7 months. Prior to this I was also working at the hospital in IT, Finance and HR for 10 years. So I have been within the health sector for a long time.

G: Can you take me through a basic run down of how things work here in the laundry?

[Debbie and Kelly walk me through the two-storey linen production line from start to finish. We begin at the linen 'depot' outside.]

D: This is where our trucks get loaded with clean linen. Not only do we clean the linen at this hospital, we also deliver linen to other hospitals, medical clinics, childcare facilities, nursing homes and motels around the region. The area we deliver to stretches from Portland to Hamilton and Camperdown, covering the whole South West Victoria region. So we cover quite a big range of services.

G: How many items of linen would you clean in a day's work?

K: The standing order that we have from each of our customers adds up to about 100,000 products a week. Some of the linen that goes out does come back clean though. Even counting what comes back clean, we still turn over about 70,000 products a week. This is our average production in just five days.

G: What happens once the dirty linen is dropped off here at the depot?

D: Well, you can see the dirty linen sitting there, waiting to be sent upstairs. *[Debbie points to a row of trolleys filled with bags of dirty linen.]* That's from the hospital over the weekend. Once dirty linen is dropped off here, they unload it all onto that conveyor belt and the linen travels upstairs into the Sorting Room. Upstairs we go...

[The three of us walk upstairs together.]

D: The linen comes up here. *[Debbie points to the conveyor belt that delivers the dirty linen.]* The bloke on this post will pick up the bags and hang them on the hooks of the overhead rail one-by-one. The next bloke will 'drop' the bags, which is opening them and releasing all the linen onto the next conveyor belt.

G: Is this a job that only men do?

D: No. Actually, we all rotate around and take each job in turns. So, both men and women do it... Next, the dirty linen gets sorted into baskets. *[They look more like giant 2m tall cages than baskets.]* The worker standing below the baskets collects the sorted dirty linen and begins to load it into the Batch Washer. Batches are organised into 50kg washes at a time, sorted into the type of linen that's being washed. We wash all the bed linen, bath towels, tea towels, serviettes and gowns separately. Once linen is sorted into a batch, it drops down this hole into the Batch Washer on the floor below. *[We all peer down into the Batch Washer chute, which gives me vertigo. It's like looking into the abyss.]*

G: I can see the workers are wearing protective prick-safe gloves...

K: Yes, they are. It's a hospital requirement in case of needle-stick injuries, or from scissors.

D: You never know what you could find wrapped up in the linen. The fact that it can be really, really dirty means we also need to wear latex gloves underneath the prick-safe gloves.

G: I'm hoping that this exhibition might help people appreciate some of these more messy tasks. Can you share with us how you strengthen up to take on these tasks each day?

D: It's never really worried me. Never. The only thing that puts me off up here *[in the Sorting Room]* is the smell of vomit. Blood doesn't worry me. The faeces... well, we're pretty good at dealing with it. If it's bad mess, you just fold it over and you tell the next person that it's 'foul linen', so it goes to the end of the line for a special wash. We work together to make sure it's dealt with in a clean way. I know there are some people working downstairs who don't like to come up here, but it's never really bothered me.

G: Are there workers who opt out of coming up here *[to the Sorting Room]*?

K: Yes, there are, but it's probably only one or two.

G: How do you think others perceive the work that you do?

D: They don't really understand what we do at all. I don't think people know it's a very labour intensive job. They must think that we just wash linen in the machine and away it goes. Even some nurses may not know what we do here in the laundry.

G: Do other hospital staff come and see what happens here, even just to observe the scale of it all?

D: No, nobody ever visits. Some don't even know there's a laundry on site. They don't realise that you have to sort everything. When I say I work up here in the laundry, people say, "Oh, that'd be easy, don't you just fold stuff?"

G: I wonder if some people will be surprised to learn about the laundry from this exhibition.

K: I think they will. I've been based here at the hospital for 10 years and the first day I set foot in the laundry was the day I starting working in this department, seven months ago. I didn't even know how to get to the laundry. It's not a part of the induction tour of the hospital when you start working here, at the hospital.

G: I think it should be compulsory for everyone to see it, like an induction tour through the entire hospital - the kitchen, too.

K: Yes. Because if you think about Environmental Services, Food Services, Linen Services - without these three departments the hospital wouldn't function. Without the orderlies, having fresh linen for beds and feeding the patients, the hospital simply would not function.

G: Once the linen goes to wash, what happens next?

[We head downstairs. Debbie shows me 10 giant washing machines which are called 'Chambers'.]

D: Dirty linen drops down into one of these Chambers from upstairs. Each Chamber has been automatically programmed to apply the correct chemicals, temperature and wash time for each batch. Once the wash is done the load then goes into the giant press, which squashes all the excess water out of the linen. They come out looking like huge rice cakes. Then it travels into one of our three dryers. All our product goes through three washes. If it's not clean after the first wash it'll go through a second wash. If it's still not clean after the second wash we'll put it through a third wash. If it's still not clean after the third wash it will get condemned. Once the linen is clean and dried it's dropped out of the dryer and travels along an allocated conveyor to the correct place for ironing and folding. We put them on a trolley and they go out to packing. We call the packing room the 'Engine Room' of the hospital. This is the room that drives every department. It's a never-ending circle. You never finish your job, it just keeps going. And that's the life cycle of our laundry.

LAUNDRY LIFE

AN INTERVIEW WITH STEVEN MORGAN

PATIENT ADMITTED IN THE MEDICAL UNIT

Georgie: How long have you been in hospital?

Steven: I've been coming in and out of hospital for 19 years.

G: What are you being treated for?

S: I've got a rare kidney condition called Gitelman Syndrome which requires me to have potassium and magnesium replacements. I'm admitted into hospital when I have depleted cells and I'm treated with 16 eight-hourly intravenous bags of potassium and magnesium.

G: Does this treatment make you feel unwell?

S: Sometimes I get what's called a 'fluid shift' which gives me a severe migraine. But the nursing staff know how to minimise this and I am extremely well looked after.

G: How do you pass the long days and weeks you spend in hospital?

S: I read and I walk. I sometimes read from 8 in the morning until 10 o'clock at night. I skim read pretty fast so I can get through an entire book in a day-and-a-half. I also go for evening walks, doing laps around the hospital. This is how I got to know the hospital space so well. I have even watched this ward (the Medical Unit) being built around me from my hospital bed.

G: What do you think about the art and flowers that are used to decorate the hospital space?

S: Oh yes I like art. I think art brightens up the place because the rooms are fairly bland. They are the typical 'battleship grey', without much colour. In fact, I arrange the Christmas decorations in this ward every year. Last Christmas, a resident doctor in Rehab put up a lot of decorations too, so I said, 'Are you asking for a competition?' So we made a trophy for the ward with the best Christmas decorations. This created a good energy around the place. It gave a good feeling.

G: Do you think it's good to be distracted from the fact that you are in hospital?

S: Oh, yes. I believe you are only as sick as you want to be. So, any distraction that can make you more positive, the better it is.

G: If you had to lie here and stare at one artwork all day from your hospital bed, what artwork would you choose it to be?

S: Various things... Probably a photograph of countryside or something nice like that. Or perhaps some really nice glasswork. I'm also fascinated with jewellery. Or even an abstract sculpture that makes you think.

[A nurse enters to change over the intravenous bag.]

G: Are you used to having invasive procedures done to your body?

S: I find this 10 times easier than being cannulated. Putting a cannula in hurts, in my opinion. I used to do every treatment with a cannula, which they sometimes had to mix with an anaesthetic because potassium is not a gentle drug in your veins – it does burn. Now they can't cannulate me anymore because my veins are too raggy. Now I have a 'port' in under my skin, where the drip goes. This doesn't hurt at all. I can totally tune it out. Do you mind if I show you?

G: Go for it.

[Steven shows me where the tube enters a 'port' in his chest.]

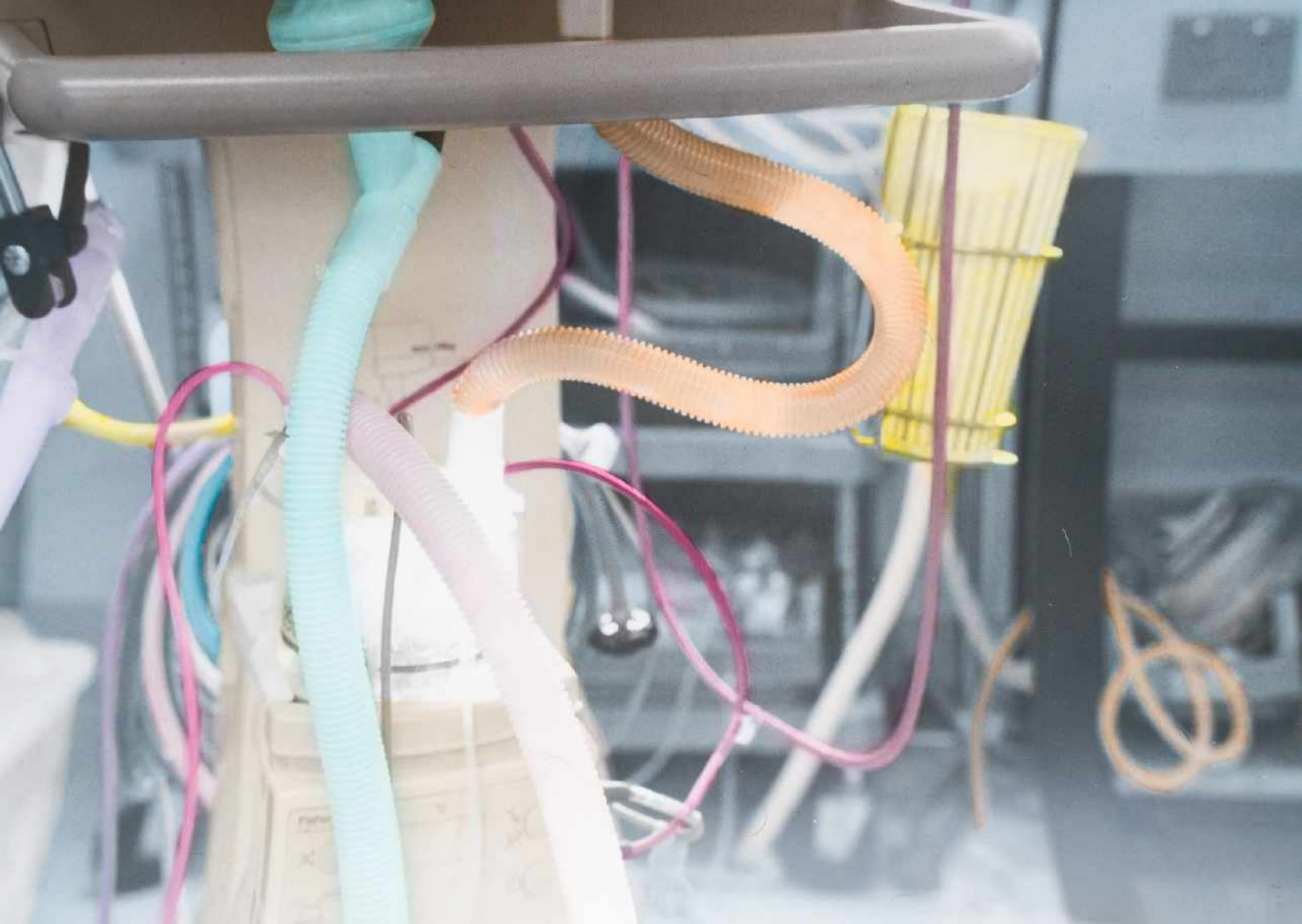
S: If you press down hard on my skin here you can feel it. It's totally under the skin, like a top hat. The tube goes around the collarbone and into the vena cava. So there's a needle that pushes fluid straight into the port. Before they pull the needle out they use Heparin to stop clots forming in the port. I can watch them performing the procedure. It doesn't worry me. I've had nurses come in some mornings to do a set of obs. They've rolled me over, taken my blood pressure and my temperature and I don't even wake up.

G: Has spending so much time in hospital made you think more about death?

S: I suppose I try to avoid thinking about it. It's something I don't deal with well. I like to think about the violin-maker, Stradavarius. He lived until he was 93 and continued working right up until his death. My goal is to outlive him and be productive until I die. It's something that's not nice to think about, but there's every possibility that someone has died in this bed before me. So there's always that awareness of the 'silver trolley'. That's the trolley they pop you on to take you down to the morgue. It's the only trolley that's extremely quiet when they push it. But I think life is too short to contemplate this.

G: I'm interested in asking these sorts of questions because I'm not sure how people will take my exhibition. Unlike most art in hospitals, which distracts from death and illness, my work sometimes references these themes directly – which some people might find distasteful or uncomfortable to think about.

S: Some people just dislike hospitals and this could be for various reasons. Maybe they've lost a family member and being in the hospital evokes those memories. The hospital means different things to different people. I have been very fortunate to always look on the bright side of my time in hospital. Hospitals aren't always sad places. While this place was being built, I was sharing a room with this chap on the floor beneath where we are now. One day his wife came in to visit him. She came over to me and said, 'I don't know why I bothered to come in. He's had a massive stroke and he doesn't recognise me.' This man just lay there with a tube in his stomach, feeding him. Then, I watched him slowly recover over 12 months. He virtually went from having no mobility to become a husband again and I watched him and his wife walk out of the hospital together talking and laughing. After seeing things like this, I'm now a firm believer that while there's life there's hope. I have seen some sad things, too, of course, but these are the stories I choose to think about and remember. I believe hospital is what you make of it.



...WHEN A BABY IS BEING BIRTHED, SOMETIMES IT'S VERY QUICK AND YOU LITERALLY JUST CATCH IT!

AN INTERVIEW WITH KASEY MARRIS

MIDWIFE

Georgie: What is your role in the hospital?

Kasey: I'm a midwife and one of five Associate Unit Managers within the Maternity Unit. My main role is to manage the unit on a day-to-day basis. Although the role is management-based I still try to be very hands on. That may be assisting other midwives when a woman is birthing by being a support or being the second midwife involved. I still try to get my hands on some catches and have lots of patient contact, which is great.

G: What's a 'catch'? Is that when the baby comes out?

K: Yes, it's when a baby is being birthed, sometimes it's very quick and you literally just catch it!

G: What's it like bringing babies into the world?

K: It's amazing. It doesn't matter how many births you've done, they're all just so brilliant. And to be part of a family's experience, especially if you're with them through the labour and right there at the end, it's amazing. It doesn't get boring. Each birth is as beautiful as the one before. It's a very special role.

G: How many babies do you deliver in a week?

K: Sometimes there may be four or five births in 24 hours and then you may go a day or two without any. It just depends. In this hospital about 670 babies were born over the past 12 months. Over the years I've been involved in 100's of births.

G: You mentioned you have three kids of your own. So, being a midwife didn't deter you from having children?

K: No, not at all! Birth is really the unknown until you experience it yourself. I remember being in labour and not caring about what was going on around me, you just have to be really focused. Being a mum has definitely changed my practice as a midwife. I guess your own experiences influence how you practice to a degree. Labour and birth is so different for everyone.

G: Does being a midwife affect how you see the world, or how does it impact you on a day-to-day basis?

K: Having a baby is such a special time in a family's life, most of the time. Sometimes you'll receive a thank you card or message in the mail, which is really nice. It's wonderful to know that the care they received has had a positive impact on their experience. Living in a smaller town too, you do see the women and their families around the streets and often you'll know them. So I guess it does impact on your day-to-day life to a degree. It definitely impacts how I see the world. The closeness that birth brings is incredible. Birth is not always a happy time. As a midwife you see and are involved in loss and you experience the grief. It can be really hard to stay emotionally grounded. Fortunately, the birth of a baby is most often a wonderful time in a family's life, but sometimes it's incredibly sad, and sometimes it's emotionally tough and stressful. But that's all part of the job and your role is to support the woman and her family in the best way you know how. When loss happens, it really puts life into perspective and you realise just how lucky you are.

AN INTERVIEW WITH
GORDON SZEGI & DON STEWART

BIOMEDICAL ENGINEERING

Georgie M: What is your role at the hospital?

Gordon S: I'm the Manager of Biomedical Engineering. Primarily what we do here is look after any medical devices that contain electronics and are attachable to a patient. We work with critical devices like ventilators, infusion pumps, defibrillators and life support machines... all the way through to simple mechanics such as bed remote controls.

Don: And I'm the Deputy Manager of the Biomed department. Gordon and I have worked here together for over 20 years.

GM: How long have you worked in this role at the hospital?

GS: I started at the hospital in 1990 as a junior Biomedical Engineer and 5 years later moved back to Melbourne. In 1997 I returned back to Warrnambool to a new role in Biomedical Engineering and have been here ever since. I've been in my current role since 2006 as Manager of Biomedical Engineering, the time when Don and I swapped roles.

D: I've been here for about 28 years too, since 1989.

GM: Wow, that's almost three decades! What is it about this job that's kept you here for so long?

D: Well, of course, it's because I enjoy the job. It's never boring. It's always challenging and interesting. I can honestly say I've never been bored in this role. It also helps me to keep a good lifestyle, because the job has nice working conditions. I can work part-time and this is not something you can easily organise in other places.

GM: How many people work in Biomed and what's the average work flow like?

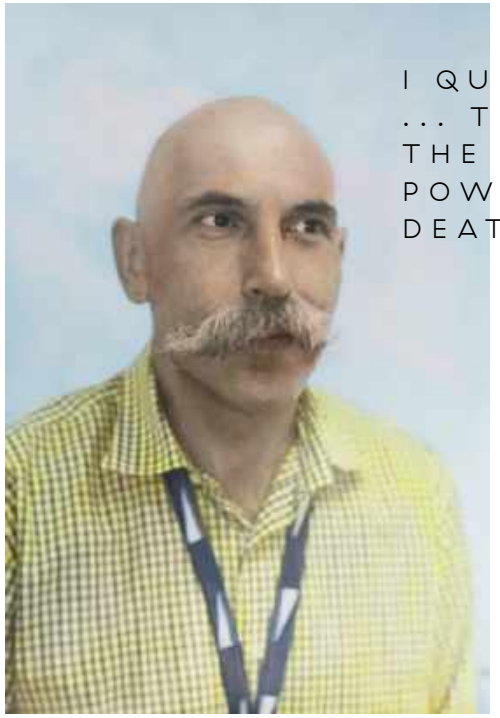
GS: We have 6 staff working in the Biomed department and we're always busy. Equipment is dropped off to us when it needs repairing. A big part of the job is safety testing and performance testing. It's a medical industry, so everything has to get tested once a year. Especially things like defibrillators... they need to be tested every 6 months. Most of the work we do is with nursing equipment. We get a lot of calls from Theatre and ED, requesting repairs on equipment. Basically, our role is to look after the hospital's equipment to make sure it's safe for the patients and operating correctly.

GM: Do you find it's a high-pressure job knowing that so many lives depend on the work you do?

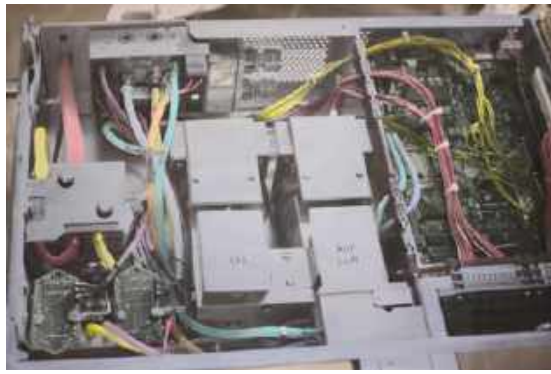
D: Yes and no. Yes, in the sense that there is a high level of responsibility and we're aware of that. But we're also aware that we're part of a team so you're not on your own. When things go wrong people deal with it together and work through the best scenario. So there is pressure, but it's shared pressure.

GM: Do you have any interesting stories to share from your experience? Like, have you ever had a really high-pressure critical moment at work, where someone's life has depended directly on you fixing a piece of equipment in time?

D: Yes actually, I had an experience like this at another hospital I worked in before this one. It was a fairly large hospital in Melbourne that works with some very serious cardiac conditions. I was the only biomed engineer at this hospital and I had to be on-call. I got called in to assist with what's called an Intra-Aortic Balloon Pump. This was a fairly new piece of equipment at the time and no one really knew how to work it confidently. The machine has a long sausage-like pump with a catheter that gets put up through your leg, through the femoral artery and up into your aorta before it gets to your heart. For someone with a poor output from their heart or bad blood circulation, the pump is blown up and then deflated in time with their heart. This helps to keep the blood circulation going. Basically, when I was called up to fix this machine, I realised there wasn't anything wrong with the equipment; it was just that the patient wasn't doing well. This was a high-pressure situation for me because I had this difficult situation where I had to explain this to the nurses and doctors. We don't do quite as high intense cases here in Warrnambool, so those situations are less common. There's always some sort of back up that can be put in place.



I QUITE LIKE VENTILATORS ... THEY'RE INTERESTING IN THE WAY THEY HOLD THE POWER OF BOTH LIFE AND DEATH AT THE SAME TIME.



GM: Can you tell me about one of your favourite or the most interesting pieces of hospital equipment that you've work on?

D: I quite like ventilators; the machines that keep you breathing if you can't breathe yourself. They're interesting in the way they hold the power of both life and death at the same time. I know I'd like to be on a ventilator if I couldn't breathe, but then they also present that complex scenario of keeping people alive and the difficult decisions that people make around this.

GM: And what are you fixing at the moment?

GS: This is called an Alpha XL. It's a mattress pump that creates alternating pressures so someone lying in bed long term can avoid getting bedsores. The pump is broken which is why it's come here.

GM: Having worked for so many years with electronics and machines that support life do you believe that ultimately nature and biology win, or machines win?

D: Nature and biology of course win. Having spent a lot of time in this job, I actually feel a little more cynical about the value of technology. There have been some great technological advances that have happened in the medical field that help people and help the healing process but I think the balance has swung a little bit the other way. Now there's a lot of technology and time that is perhaps not always as beneficial as it should be. I also have worked in pastoral care, which is completely opposite to what I do now. Carrying this experience with me, I can also see how technology can also be a barrier to some people getting the human care that is most important.

AN INTERVIEW WITH
MARTIN FLEMING, GARY TOOHEY,
NEVILLE HOGAN & TIM VANDERSTARRE

STORES & FLEET

Georgie M: What happens here in Warehousing & Logistics?

Martin: It's basically like a big supermarket for the hospital. Goods come in, we receive them, delegate them to areas according to what region they are going to. We then pack them up, box them up and shift them on accordingly. That's just within the wards of our hospital, here. We also cover a big area all the way down to Apollo Bay, Colac, up to Hamilton, Portland and anywhere in between. So we have dedicated runs and routes we go on. And that's a very basic summary of what we do.

GM: Earlier I was shown through the Sterile Area and the Non-Sterile Area of the warehouse. Can you explain the difference between these two areas?

Gary: 'Sterile' is basically sterile stuff that goes in the theatres and to other places where sterile stuff is required; things that have to be contained, temperature-controlled and packed separately from the rest of the goods – separately from the 'non-sterile'.

GM: It's the first time I've been into a Sterile Area like that and it's quite eerie. It's like stepping into another world. What makes it feel like this?

M: It is climate controlled so there are three doors to get into this area. There's no outside air in there, which keeps it at 19 degrees all year round. In summer it's beautiful and in winter it's not bad either. But it does take some getting used to this.

GM: Which area is more fun to work in?

M: Downstairs [Non-Sterile Area] is probably the more fun place to work. There's normally between four to six of us working down there, so there's a bit more conversation. There are only two people working in the Sterile Room (upstairs), as a rule. You have to concentrate a bit more up there because there's lots of bits and pieces, which are smaller and worth a lot of money, so it's a bit more serious and more focused up there.

GM: How do you think others perceive the work you do in the hospital? Do people acknowledge your role as playing an important part in the process of healing and treatment in the hospital?

GT: We have a very good relationship with all the departments. They have respect for what we do. They come to us for equipment and product information so we need to have a very good relationship with all departments.

M: They understand we are very busy in our role, but we also understand they need us to function properly for their jobs to work, as well. We are actually isolated from the main part of the hospital but we all work together as a team really well.

GM: I'm curious about this volunteer role that you do, Neville.

Neville: I keep all the hospital cars nice and clean. I clean about 500 cars a year and I've been doing this for six years so that's 3000 cars I've cleaned for the hospital.

GM: What are all the cars used for?

Tim: We've got 120 cars in total. Twenty are private use for employees as part of their employment package. The other hundred are scattered through Camperdown, Lismore, Macarthur, Portland, our Mental Health Services and also what's called our general pool. If a nurse is going on a study day they'll book a car from us. We have about 20 cars in Warehousing & Logistics and Mental Health Services has about 20. Then there's Community Health, District Nursing, Food Services, our Linen Services trucks as well... they're all classified as our fleet. We're very lucky here at this hospital because we have Neville, the volunteer who comes in two days a week and volunteers his time to wash our cars. He gets through about 20 cars a day and this takes a lot of the workload off our other workers. We'd be at a real loss without our volunteers.

AN INTERVIEW WITH
HEATHER FOLEY & ANDREA JANES

PALLIATIVE CARE

Georgie: What are your roles at the hospital?

Andrea: I am the Nurse Consultant Coordinator of the South Western Regional Palliative Care Team, but usually I just say 'Manager'.

Heather: I am currently working across three roles in the Medical Unit, the Palliative Care Unit and Community Palliative Care.

G: What exactly is the process of treatment in Palliative Care?

A: When we assess palliative care patients, we assess about 23 different domains of the patient. Firstly we look at the physical domain of the patient which is any physical symptom that may need managing. Then we look at the psychological domain of the patient which includes spirituality, supports, anxiety and sleeping. Then we assess more personal aspects of the patient such as their values and what's important to them. We also talk with patients about their preferred place of death. We have a number of volunteers who are trained in giving hand and foot massages to patients. Patients enjoy this. We also spend a lot of time working with the families to teach them the importance of simple things such as touch, or other enjoyable activities for patients such as picking flowers from the garden, walks outside and family dinners.

G: Heather, can you describe what it's like working in the Palliative Care Unit?

H: In the Palliative Care Unit it's a really busy ward, so it varies. In fact, we have some patients that are not actually palliative, so it's a mix of patient types. At any time, we may have a mix of palliative patients, patients who are post-operation and maybe someone who has had a fall, for example. So you have to be really diverse and have good time management. With palliative patients there are generally more pain issues and family members to attend to. We support the family through this stage as well and try to answer all their questions as well as educating them along the way. Overall, I see my role with palliative patients as giving the best end-of-life care that I can.

G: Can I ask how often patients pass away at the hospital?

A: We encounter about 10 deaths in a month on average in Palliative Care, which includes inpatients and outpatients in Community Palliative Care.

G: How do you go about making the Palliative Unit feel less clinical and more homely?

H: We encourage family to bring in familiar things for the patient, such as photos, music, or the patient's own bedding; doona, pillow, rug. The palliative care rooms also have fridges, so we encourage family to bring in meals the patient likes, or their favourite slice, for example. Sometimes patients may have lost their sense of taste from chemotherapy or become tired of hospital food from so many admissions. We have a little area in the ward where patients can have tea and coffee and there's a big table where as a family they can all sit and eat together.

A: We also try to think of other things outside the square, things that are special to the patient that they will cherish and remember. We once had a patient who every night would have a glass of wine and her husband a beer. So on the last night of her life, they still did that. She couldn't swallow it, so we put the wine on a mouth swab and we put it in her mouth. It's the little things we do that people always remember. Sometimes it's as simple as bringing in their favourite pillow or their own doona from home, because it's got their smell on it. We let the family guide things with what they treasure and what's important to them.

G: How does being surrounded by illness and death affect you?

A: Sometimes I find it difficult, depending on the situation. I find it harder to see patients with children the same age as my own, or people with a parent dying that is the same age as my parents. It's harder to switch off when you can relate personally to the situation, because you think, "that could be me". In the unit, we run a debriefing session where we talk about each person that has died. We talk about their death and we question, "Was it OK? Could we have done something better?" This process really helps through the difficult times.

H: I feel like it's a real privilege to work in this role. I find it rewarding to help someone and do things for them that they cannot do for themselves. Sometimes it can be challenging but we've got a fantastic team of doctors that are really dedicated in what they do. You do go home thinking about it sometimes, but if you've done the best you can do to help that person to have a good death and die with dignity, then this is also very fulfilling for me.

G: How do you define a 'good death'?

H: The ideal situation that I see is when someone comes in and they're full of pain or nauseated and anxious, and the doctors can order the medication that we can give so they settle and die really peacefully. That's the ideal situation, not for me but for the family. Unfortunately, we do see some patients that are really anxious and frightened about death. But if they can deal with issues they've had in their life, or family members they haven't spoken to and have everything in order, then this can help them have a good death. If a person's had a really good death, you can see it when they die.

G: What is the process you follow after someone passes away?

H: With the patients on the ward after they die, we leave family with them. We let them stay there as long as they want to. Then the doctor comes down to certify the death. We always leave the body resting before we do anything, just to... I don't know. It's just a feeling you get that you have to do it, just to let them settle. As we are sending them off the ward we tend to talk to them still, even though they're gone. When we're preparing them to go to the hospital morgue I still treat them with that respect and say, "Alright, I'm going to roll you over this way." We always still call them by their name and we say "Goodbye" as they leave.

G: Do you think we fear death too much?

A: We're getting better at it, but I think we're still scared. It can often depend on the age of the patient. People in their 90's are more likely to say, "my time's up, I've had a good life," and they're OK with it, but as people get younger those conversations become more difficult. I'd say that 50's and under is really tricky. Patients' families can be in more denial when they're younger. But I think, on the whole, we're getting better at it from how it used to be. We used to be known as the "death nurses". A lot of people relate palliative care just to death, but it's not, it's more about living well with an illness. We've also done a lot of positive media work to take the word "death" out of palliative care. We like to say we're dealing with a "life-limiting illness" rather than a "terminal illness". And we try to focus on the last 12 months of life, rather than only the final three months.

G: Having worked around death do you have any advice on how to live a good life?

H: Yes. One thing that my husband and I always used to do was update our car. But working around death has made me realise that when I'm on my deathbed and my memories come flying back to me, I won't be thinking of all the nice cars I've had, I'll be thinking about the life I've lived. That's why now we go on a holiday every year and we do something different. I think it's important to travel and do it while you're young. Just go for it! If you want to do something, just do it, do it while you can and do it while you're young. Cancer is hitting people at such a young age now, and unfortunately even children who haven't even had a life yet. Whatever it is that you want to do, just plan it and just say, "nup, I'm doing it".

WE ALWAYS LEAVE THE BODY RESTING BEFORE WE DO ANYTHING, JUST TO... I DON'T KNOW. IT'S JUST A FEELING YOU GET THAT YOU HAVE TO DO IT, JUST TO LET THEM SETTLE.


Flower
Room

ACKNOWLEDGMENTS

While I intended to provide a holistic representation of each hospital department, the enormous scale of the hospital made this a very difficult task. Therefore, the work of many staff members and departments have not been documented in this exhibition, despite their integral contribution to the hospital work flow.

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If any images or themes in this catalogue cause distress for you or a loved one, please call Lifeline on 13 11 14 for support or assistance with a referral to an appropriate counselling service.

ARTIST BIO

Georgie Mattingley is a Melbourne-based artist who works predominantly with photography, video and painting. Her practice uses beauty and colour to make society's hidden spaces more visible. By visually transforming these spaces, her work unravels the value systems that repress them and proposes a more holistic acceptance of realities that Western society encourages us to avoid. Georgie has exhibited in galleries in Australia and overseas, including the Shepparton Art Museum (2016), TRAMA Centro in Guadalajara, Mexico (2015), The Ferry Gallery in Bangkok, Thailand (2014) and JAUS in Los Angeles, USA (2013) and as part of the Next Wave Festival (2014).

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