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DO ANTHROPOLOGICAL, ANATOMICAL AND PATHOANATOMICAL EXHIBITS SPEAK?

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INTRODUCTION

The exhibits are spotlighted so that the visitor can see them from several sides. They are provided with explanations in several languages so that everyone interested would understand what they represent. Each exhibit has its own story about how it happened to be included in the exhibition and the story of the person behind it. In rare cases the story of the person is known, but mostly the exhibit and its case history have not moved together. Even if the patient's name is known, it is hidden, and the specimen has become just an object displayed at the exhibition.

"Allegedly it was the Ancient Greek physician Hippocrates who introduced the medical concept of a disease, the idea that diseases have their course which begins with the first symptoms and continues to the climax or turning point and thereafter their happy or fatal end. In medical science, this process is called pathology or the natural course of the disease. The natural course of the disease, however, does not tell us anything about the persons, their experiences of the disease, sufferings and emotions. In present-day case histories, the person is often objectified into the disease that the patient is suffering from, the patient's gender and age" (Sacks 2007). "Patient narratives, pathographies or simply case histories told or written by people on the basis of personal experience show that, when facing medical science, the problem of many patients is that they are not treated as individuals who have their story to tell but as objects carrying the diseases" (Paal 2010: 10–11).

"Different diseases have been predominant at different times, although some diseases have spread for millennia. Traces of cancerous tumours and cardiovascular diseases have been discovered in skeletons found in archaeological excavations and in Egyptian mummies, which means that conditions conducive to the existence and spread of those diseases have also existed in the past" (Paal 2010: 11).

"At present, people's life expectancy has increased; diagnostic technologies enable doctors to discover diseases at their early stages, and diseases are overcome. People can be offered purely preventive treatment, which enhances the quality of life or self-feeling without any obvious symptoms of a disease" (Kinnunen 2012 and Konsa 2012). Paradoxically, from the viewpoint of normative treatment of health, health risks can be substantiated if a value essential for the individual, e.g. pleasant appearance, is created. These procedures also reflect the society and culture. In T. Kinnunen's opinion, people have beauty operations of their own will but motivated by culture (Kinnunen 2010: 289). In other words, cultural discourses have formed people's vision of their bodies. Views on the healthy and the diseased body are changeable.

There also diseases that have a name (diagnosis) but no scientific explanations of their origin and no appropriate cure. If the symptoms of a disease have appeared, the question arises how to become well again. If home cure does not help, a professional is approached. While on a long waiting list, help is sought from various sources. Here an essential role belongs to the economic situation (whether I can afford to be ill) and the health policy of the society (whether the patients get sufficient support and if there are enough finances for treatment and rehabilitation).

The understanding of health and diseases is different in each culture, but nobody denies that health is an asset. Social pressure on biomedicine impels the application of ever better and more efficient medicines. The medicines and treatment methods that used to be considered the best are declared useless or outright harmful. People are in the centre of constant changes; pollution of the environment and the increasing significance of synthetic compounds in people's lives create health problems.

The current study observes why people come to see anthropological, anatomical and pathoanatomical exhibits, what kind of emotions these create in them, and whether certain specimens elicit a dialogue with the viewer and a wish to learn more about them. Are the exhibits and the contexts created by them recorded only in the visitor's short-time memory and forgotten in twenty

seconds, or are connections created between neurons in the visitor's brain, and in addition to the context offered by the curators of the exhibition, a story between the visitor and the exhibit is created, which is recorded in the visitor's long-time memory and can lead to changes in lifestyle?

THEORETICAL VIEWPOINTS OF MUSEUM WORKERS OF THE WORLD

"Responses to and experiences of medical objects on display are historically specific and widely varied. Even the anatomical and medical exhibitions between them today evoke all kinds of different intended and unintended reactions and experiences. … Medical museums displaying diseases and exhibiting patient histories and experiences can benefit from the debates around the display of disability. One of the core functions of the museum is to hold topics up for discussion, to reflect, and to pave the way for debate, learning and imagination" (te Hennepe 2012:101). "Exhibition can show how the fascination with the damaged body may be turned into a powerful experience and engagement with patient history. Without falling into the trap of stereotyping or discrimination, the display may invite people to stare, so as to reframe those suffering and excluded, and to become involved with the person, to know and let them be known" (te Hennepe 2012:101).

"Museums have a responsibility to keep telling their stories and keep diverse audiences involved with human experiences over time" (te Hennepe 2012: 102).

The Dutch art theorist Hsiang-Ching Chuang finds, "Museum has always been a well-structured elaborating story, in my opinion. Every time when I enter a museum, I always have the feeling that I am walking into an epic. The curated route clearly delivers the core idea of the exhibition through the curator's view. On the way of this fascinating journey, the interwoven story line between the exhibition and the collection and also the various artifacts with perfectly refined elucidations always catch my eyes and bring my thoughts to a magic carpet ride. After the trip, most of the time, with my heart full of amazement, I told myself, "What an exhibition!" (Chuang 2012: 96)

"The strange thing is, I feel satisfied. I am satisfied with the stories of the collection that I have been told in the exhibition, and the concept that the exhibition tries to deliver. At the very same time, I notice that something is missing and the missing part baffles me. Such a feeling, in effect, results from

the fact that my thoughts are trapped in an invisible boundary called "selected information" (Chuang 2012: 96).

"According to my observation, there is always a very strong bond among objects, stories and exhibitions. Depending on the exhibition, selected collections and stories are presented together in a fixed context with their own unique roles. This collective information forms the exhibition, and it gives the core idea and values to the exhibition. In this context, the exhibition builds up a well-structured, narrative and effective presentation. … this way of presenting is merely a one-way linear communication with the visitors, which limits and scales down the possibility of exploring" (Chuang 2012: 96).

"But then, when we speak of the hidden stories behind (or beyond) the objective impression; they are often referred to as the unknown, the oblivion, the extinction or the uniqueness which are buried inside the object. Unfortunately, these stories and qualities are usually excluded in the range of selected information in exhibition. … I believe that the unknown, the oblivion, the extinction and the uniqueness are exactly the missing puzzle pieces which lead us forward to discover the true essence of these fascinating collections. Thus, in order to better reveal the hidden story, the current presentation dialogue of the museum needs to bee challenged, and the communication needs to be risen to a higher level" (Chuang 2012: 96).

Chuang also finds that "Medical objects and artifacts are beautiful in their appearances, gestures and pure functionalities. Their rich background can be traced long way back to the history. Yet, due to the differences of time, space, perception and the development of knowledge, the meaning of medical artifacts is hard to be properly translated in the modern era. Even if we try to put those stories and ideas into words, it would just be a limited translation of their breathtaking richness" (Chuang 2012: 97).

"Ruysch always insisted that with the anatomical preparations in his cabinet he wanted to stress even in dead specimens the beauty of life" (Huisman 2012: 111).

Mieneke te Hennepe, conservator of Leiden Boerhaave Museum specifies, "Horrifying images and objects have always attracted audiences in many ways. Between oddities of the freakshow, the curiosities of the nineteenth century anatomical museum and the current day television shows on medical extremities, the common attraction seems a desire to fulfil curiosity. An interest in observing the different, the deformed, the damaged – the other. A peculiar aesthetic pleasure. To reproach this feeling or urge to look, to stare, as a vulgar

human trait is too easy. Behind this interest in the representation and exhibition of damaged bodies lies a complex interplay between the power of the visual, feelings and meaning. Furthermore, it still drives many visitors to our medical collections today, as this extract from a blog on medical museums shows: "The gruesome appeal of medical museums is twofold. While dissected cadavers, preserved parasites, and diseased organs fulfil the sick fascination for human oddity in all of us, the fact that it is a "museum" makes visiting them a commendable act of self-education. A real win-win!" (NileGuide Travel Blog 2010) (te Hennepe 2012: 99).

"...many exhibitions are made to discuss a topical issue, present arguments in favour of an idea, and convince the visitors about something – or maybe just provoke visitors to think deeper about something, to urge them into action" (Jütte 2012: 9).

"These things stay quiet. Certainly they don't speak. They just pose, endowed with their own special aura, staying cool before our curios eyes. Little divas on the catwalk, we might think, walking in, walking out. Leaving us impressed, fascinated, clueless, puzzled".

"These objects do not talk. They cannot talk. But if they could, they would have a lot to say. So if we want to listen to their stories we would have to make them speak" (Schnalke 2012: 74).

HEALTH AND RISK BEHAVIOUR

Nowadays health is considered something that can be restored if necessary, like a wall that can repeatedly be rebuilt. A stage has been reached where some people do not participate in the formation of their health, prevention of diseases and avoidance of risk behaviour but think that responsibility for their health lies with those who have been trained for it. A great number of people at various ages damage their health by various forms of risk behaviour and, by doing so, shorten their lifespan.

However, before we speak about damage to health, we should know what health is.

There are very different concepts of health, from the strictly technical viewpoint directed at diseases to philosophical approaches that stress positive health and well-being, self-actualisation and life quality. There is no correct answer to the question 'what is health?' that could universally be used for different cultures, contexts and lifestyles. Health, just like disease, is

experienced individually, but it is also influenced by numerous factors like living conditions, environment, socio-economic status, ethnic background, culture, age, gender, etc.

Thus, in 1947 the World Health Organisation defined health as "complete physical, mental and social well-being, not merely the lack of disease or infirmity" (WHO 1947, Simovska et al 2006). In 1986, however, the WHO declared, "Health is a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities" (WHO 1986, Simovska et al. 2006). An Arabian proverb, however, simply says, "He who has health has hope, and he who has hope has everything."

The holistic concept of health treats the body, the spirit and the individual in the society as a whole, thus closely connecting the different aspects of health. Health is a topic that concerns not only individuals but also the society as a whole. Health in its broadest meaning is equally affected by the way of life and living conditions. People's way of life includes their habits, the choices concerning their health, including the choice of food, physical activity, sexual behaviour, smoking, drug use, etc. People are able to change their ways of life.

The positive concept of health presupposes that health is more than the mere absence of disease. Health is not a static concept. Positive health or well-being shows which are the personal and social resources of the individual's life quality. Health is created where people live and love, work and play (Kickbusch 1997), but unfortunately, in the same situations, it can also be destroyed. In this article, such destruction of one's health is called risk behaviour. M. Harro has defined risk behaviour as behaviour that has or, under certain circumstances, can have an unfavourable effect on the health of the person who practises this kind of behaviour or on the fellow citizens. The consequences of risk behaviour incur, in addition to expenses on health care, expenses on economy, society, etc. Among the main categories of risk behaviour, she mentions smoking, (excessive) use of alcohol, trying and using of drugs, unprotected sexual intercourse with unreliable partners, violations of the highway code, not using protective means, ignoring safety rules, etc.) (Harro 2005). For example 300 people in the UK daily die of diseases caused by smoking, and diseases caused by smoking cost the country 1.7 billion pounds a year. Half of cancerous tumours could be prevented by lifestyle changes (Medical News Today 2006).

Like elsewhere in the world, risk behaviour is an increasingly common problem in Estonia too. The inhabitants of Estonia drink large quantities of

alcohol and smoke; 14,000 injecting drug addicts visit syringe exchange points (Postimees on-line 2007). According to some expert opinions, smoking is annually the cause behind 3000 disease cases in Estonia and accounts for one fifth of deaths. Numerically, this means approximately ten deaths per day (Paat et al. 2009). More disguised but not less serious problems are overwork, wrong nutrition and insufficient physical activity.

In Estonia, communication warning against risk behaviour has actively been promoted – several social advertising campaigns (Be smoke free; Health strategy: smoking; Health strategy: nutrition; Drug fairy-tales never have a happy end; Remain clean! narko.ee), schooling and prevention programmes have been launched. The central question is how to convey the message about the possible consequences of risk behaviour to the people who are prone to take risks. In the current article, the author attempts to discuss how the exhibition based on the Medical Collections of the Faculty of Medicine of the University of Tartu can contribute to this aim. The goal of the Medical Collections is to use its original specimens to provide information on human health and risk behaviour. By doing so, they attempt to be an institution providing out-of-school health promotional education. The specificity of the medical collection lies in its originality. For example, while social advertising uses a model to pose in a heap of vomit next to a toilet bowl, in the medical collection each specimen represents the story of an unknown real person. Just this real, human measure distinguishes the medical exhibition from social advertising; this is a message from one person to another via a disease specimen. The wish of the organizers of the exhibition is that each exhibit would convey the message: take care of yourselves, do not destroy your life. Nonetheless, the exhibits do not carry the slogan "don't smoke"; the visitors have to form their own opinion about what they have seen.

The visitors can be different. Some walk around with a list of their own and their family's diagnoses and ask to be shown exhibits and given explanations. Others walk quietly and furtively, and when leaving, are absorbed in thoughts or glad that they have fared well until now. There are also visitors who boast of their risk behaviour and want to speak about it. I have been told, "You are showing a smoker's lung here; mine is definitely blacker, as I use more than two packets of cigarettes daily. I know this is harmful but I don't care. In our family everyone has always smoked." After a few minutes' talk, it becomes evident that such people do not know anything about their risks, and the other heavy smokers in the family have already passed away long ago.

HOW TO ADDRESS RISKERS?

Although smoking has been related to at least 25 diseases and causes the greatest harm in Estonia in the form of tumours, many people continue taking high risks. Conveying the health promotion message to riskers has become a separate theme of research, as for several reasons, the message does not reach them or reaches them too late.

Definitely, one of the causes of risk behaviour is ignorance. During the 2006 campaign *Smoke is poison*, British researchers questioned 1600 people, including 500 smokers, at different places of England, and 61% of smokers did not know which chemical compounds a cigarette contained; only nicotine could be mentioned. Many were shocked when hearing that 67 substances out of 4700 were known to cause cancer (Medical News Today 2006). A visitor study at the Medical Collections of the University of Tartu showed that health awareness was much lower in riskers (smokers and/or habitual users of alcohol) than in non-riskers – every third risker claimed that smoking was not harmful for health (Toomsalu 2009).

Herzlich (1973) interviewed 80 people asking them about the causes of good and bad health. The study revealed that health was perceived as internal (something that naturally exists within a person), but the causes of diseases were seen as located outside the organism (the disease comes form outside; it is not caused by the person) (Harro 2002). Therefore, many people with risk behaviour do not realise that they harm their own health but attribute their diseases to some other reasons.

Weinstein (1983, 1984) has tried to explain why people continue practising unhealthy behaviour. He asked his subjects to assess to what extent different health disorders might affect them compared to other persons of the same age and gender (more, equally or less). The study revealed that most subjects believed that health disorders would affect them less often than their peers. Weinstein called this phenomenon unrealistic optimism, as it is impossible that everyone is less threatened by health disorders than the others are. The author mentions four cognitive factors conducive to such unrealistic optimism: (1) lack of personal experience related to the corresponding health disorder; (2) the belief that the health disorder can be prevented or balanced by some other way of behaviour; (3) the belief that if this disorder has not occurred up to now, it will not happen in the future either (thus – it will not affect me) and (4) the belief that this health disorder occurs seldom (therefore – it will not affect me). These factors indicate that the cognition of one's own risk is not

purely a rational process. The study reveals that people perceive their own and other people's behaviour differently.

Studies and theories of human behaviour indicate the following ways of changing risk behaviour. According to the Health Belief Model, people are most likely to change their risk behaviour if they believe that they are endangered by a certain disease, that getting this disease would lead to severe consequences, and healthy behaviour would diminish the risk. Thus, they are convinced that the benefits of the new (preventive) behaviour will outweigh the disadvantages and expenses (Goldberg et al 1997). To form such a conviction, the person has to be reasonably well informed, self-critical and imaginative. Still, in many cases the change in behaviour does not happen, as some of the conditions described above do not function. An essential component is self-efficacy – the belief that one is able to behave in the desired way (Höglund 2008).

Studies of smokers' personal characteristics reveal connections with extroversion (sociality and impulsivity and the use of risky behaviour to achieve the desired level of excitement), neuroticism (emotional instability) and aggressiveness (recklessness and a trend towards ignoring social norms) (von Knorring and Oreland 1985, Eysenck 1990, Flay et al 1998, Adalbjarnardottir and Rafnsson 2002, Costa, McCrae 1985). A study of Estonian teenagers shows that smoking is related to high extroversion and lower firmness of mind, which can be the strongest factor in revolting behaviour, which also includes smoking (Liiv 2003, Gullone and Moore 2000).

The Theory of Reasoned Action (Goldberg et al 1997) states that the realisation of individuals' behaviour depends primarily on their intention to behave in the corresponding way. This, in its turn, depends on how the individuals imagine the good and bad consequences of the new way of behaviour (for example, giving up smoking), how they imagine other people's attitudes to the changed behaviour (e.g. whether friends will mind if one gives up smoking). Studies conducted in Estonia also demonstrate that, in order to change one's behaviour, personal conviction is needed that one's friends and family support the attempt to change the behaviour and other members of the society change their behaviour as well (Höglund 2008). Thus, when alcohol advertising is shown on television, or teachers and doctors smoke, this gives people a signal that part of the society has a favourable attitude towards this; therefore, there is no need to change one's behaviour.

The Theory of Social Cognition proposes that people can be influenced to behave in the desirable way if they are presented with a model they can identify with – either negatively (the potential negative consequences are shown) or positively (by showing the benefits of correct behaviour) (Goldberg et al. 1997).

The exhibits of the Medical Collections are negative models that are direct embodiments of the adverse effects of risk behaviour. Definitely, they do not have the same impact on everyone. A feedback study of visitors of the Medical Collections of the University of Tartu showed that visitors who practised risk behaviour (smokers and frequent users of alcohol) considered the exhibition less novel and exciting and more often gave the answer "I know it anyhow." However, namely in riskers, the exhibition produced a more unpleasant feeling – they mentioned more often that they felt sick. This may be a repulsive reaction – one tries to diminish the significance of the unpleasant message – I already know this/this is one more sermon – and does not pay attention to the medical aspects (Toomsalu 2009). The question *Did the exhibition or lecture make you think about your health?* was answered negatively by each fourth young visitor who practised risk behaviour, and only 16% responded that they would like to correct their behaviour (Toomsalu 2009). Obviously, the communicative impact of medical exhibits as negative models can be increased. To get a more precise overview about the impact of the exhibits to different types of visitors, I conducted interviews with young viewers of the exhibition.

THE PALETTE OF VISITORS

Qualitative research was based on 11 unstructured in-depth interviews conducted in the rooms of the Medical Collections on different dates from February 2007 to April 2008 after unguided individual visits of the medical exhibition. The subjects were students at different ages, as young people are an age group whose value judgements and thought patterns can be very different, but the representatives of this age group are creative and eager to make proposals, thus giving us interesting material.

In the preparatory stage, the following research questions were posed:

- Why do young people visit such an exhibition?
- What new information did they get during their visit, and did this make them think?

- What are the young people's own and their friends' attitudes to their health?

The results of the interviews were analysed from the health promotional viewpoint. From the respondents' attitudes, estimations, mental images and visions, we expected to understand the role of the medical exhibition in shaping their ideas about health.

The strategy for selecting the sample was the principle of homogeneity. In the case of a homogeneous sample, one or two characteristics of the sample are deliberately similar. The similar characteristics of this homogeneous sample were:

1) all the subjects were students;
2) all the subjects visited the medical exhibition without a guide.

A great part of the subjects of this study were students of different faculties of the University of Tartu, although there were also some vocational school students, Estonian secondary school students, an Austrian secondary school student and an Austrian university student. Two of the eleven interviewees were men and nine were women.

Two interviewees were medical students – one of them from Estonia, the other from Austria; the others studied non-medical subjects – economics, semiotics, communication, English language and literature, or were secondary school and vocational school students. Five respondents had been born and lived in Tartu; two descended from Tallinn but studied in Tartu; one was an inhabitant of Pärnu and also studied there; two were Austrians studying in Vienna. The medical student, the student of English and one vocational school student had visited the exhibition earlier; the others visited it for the first time.

In the analysis of interviews was based on qualitative content analysis. The analysis consists of a descriptive text, direct quotes from the interviews and their interpretation. Risk behaviour is understood in this study as smoking, abuse of alcohol and use of drugs.

Before the in-depth analysis of interviews, we studied the respondents' health behaviour and classified them into four groups: knowledgeable non-riskers, ignorant non-riskers, knowledgeable riskers, ignorant riskers.

Knowledgeable non-riskers (KNR) state firmly that they take care of their health and do not take risks. They do not smoke, do not use alcohol in excessive quantities and do not use drugs. KNR1: *I think about my health anyhow.* KNR5: *Don't use; my parents don't use. ... I have behaved in the right way*

and should continue doing so. KNR2: *Healthy lifestyle, healthy nutrition, sport and so on. At least I follow this.*

Ignorant non-riskers (INR) do not practise risk behaviour themselves, but they have friends who take risks, and they are unable to talk to them about health hazards (e.g. passive smoking). INR1: *I have never smoked, haven't tried drugs either; I use alcohol sometimes. I have really fared well in this respect that very few in my circle of friends smoke, but I am unable to say much about this topic.*

Knowledgeable riskers (KR) know that what they do is bad; they have intended to give up their behaviour. KR1: *I really abuse alcohol and cigarettes. I'm not proud of it. But I have really planned to quit smoking.* KR2: *I've been smoking for years; I know this is unhealthy; I've tried to quit but have failed.*

Ignorant riskers (IR) do not know how harmful their risk behaviour is. They need additional guidance. IR1: *Alcohol ... I think you can drink, at least on Friday nights. To drink with your friends sometimes – I don't think this can be very bad. I don't know quite well how harmful it is and what it does to me. Well, I don't smoke very regularly and...*

The exhibition is the same for everyone, but starts to live its own life for each visitor. Each visitor actually creates his/her own exhibition. The exhibits can be interpreted in several ways, and they develop differently in different contexts. The visitors can learn from them, more or less, whatever they like. In the case of a medical exhibition, a lot depends on the visitor's previous knowledge. When looking at the visitors' responses about their health behaviour and reception of the exhibition, we can see that a knowledgeable non-risker (KNR3) already takes preventive actions: *Healthy nutrition, taking care of myself and my body.* The exhibition elicits emotions: *Interesting, exciting and made me wish to learn more and to know more*, but it also increased awareness about potential diseases and their connection with the body: *you see what these diseases are like in reality and what happens to your own body.*

A knowledgeable non-risker (KNR4) finds that health is, in addition to preventive actions, a mental and emotional state: *Sport, healthy nutrition, and joy, joy.* The exhibition made the visitor aware of different diseases: *It was somewhat repulsive at a few moments; it made me shiver with cold.* The exhibition activates the existing fear of cancer: *I, personally, am afraid of cancer as a lot of my relatives have it*, and makes the visitor take action in this respect: *I should have a medical check-up more often.*

A knowledgeable non-risker (KNR5) finds that health is both mental and physical harmony; the exhibition, however, gives her self-confidence. *It makes*

me think that it's good that I don't use any pleasure substances, that I still have behaved the right way.

Although the ignorant non-risker is aware of preventive actions: *Today, it is first of all sport, and to a certain extent choice of food*, for her the health promotional message of the exhibition is hampered by the age barrier: *The exhibition did not directly make me think about my own health; this is perhaps a theme for higher age; at present health is not so topical.*

A knowledgeable risker (KR1) feels guilty about his health behaviour, *At my age, I already start feeling pangs of conscience about health-related topics. Particularly, if you know that you should behave more wisely towards your body. You tend to think that you're a fool when you do things one or another way, and then you mentally scold yourself for being so lazy and weak.* The exhibition, however, made him elaborate on this thought: *I didn't expect that many things can make a relatively cynical and cold-hearted person like me think about my health. I have lived my life in the wrong way.* Simultaneously, the exhibition elicits a strong positive emotion: … *I've been awfully lucky to have been born healthy and managed to avoid severe diseases during my life up to now*, and leads to the conclusion, *in some sense, it* [the exhibition] *makes you evaluate more highly what you've got.* Although the exhibition does not teach the risker anything new, as he knows that he treats himself badly, he finds confirmation to his doubts, *the exhibition seems to have confirmed some of my doubts.*

For another knowledgeable risker (TR2), health means primarily *the prevention of health risks*. The exhibition invites her to come back: *Obviously, everything here should be viewed once again as it creates such interest and excitement. I think I would need hours, and more than once*, but the exhibition also makes her aware of her own health problems: *Most probably, I would like to have a closer look at various things about the heart, as I have problems with the heart myself; how serious this could be and how it might finish.*

An ignorant risker (IR1) finds: *Either you have good health or you haven't*, and sees only one aspect – sensation – in the exhibition: *got a good emotion as I could see something again and told the others about it or shared something with the others*, but she feels left aside, *you see those obscenities as if from aside; it does not influence me so much that I would start thinking about myself.*

Another ignorant risker (IR2) views health in a very narrow way: *being well, not being ill*, and she views the exhibition as a natural picture book *it is seriously interesting; it is one thing to look at pictures in a book, but if you see things in reality, it is quite a different matter*. She does not relate the exhibition to her own health

behaviour – she has used drugs, and like the knowledgeable risker, feels some relief, *Thank God that everything is all right with me.*

According to their health behaviour, we classified the informants into four groups, but based on the manner of reception we can speak about five groups:

I. Those who feel guilty about their risk behaviour but are relieved as everything is all right: *I eat regrettably unhealthy things ... I abuse alcohol and cigarettes and I'm not proud of it ... I've been awfully lucky as I've had no severe illnesses in my life up to now.*
II. Seeing diseases makes them aware of their own ailments: *... I would like to see more closely various things about the heart, as I have problems with the heart myself.*
III. For those who practise prevention activities, the exhibition confirms their own convictions: *... I have behaved in the right way and should continue doing so.*
IV. For some, the exhibition is not exciting, as the theme of health is not topical for them: *I'm still relatively young ... At present the theme of health is not so topical.*
V. Some take the exhibition as a curiosity: *It was quite awesome. And this one with children and embryos that we saw – this was also quite awesome.*

When the exhibition is visited without a guide, the communication is asymmetrical and one-sided. Although the participants in communication are not forced to be passive, they do not receive guidance about the content and form of the exhibits and cannot enter into a discussion with the representatives of the source of information. It seems to researchers that the visit to an exhibition influences the visitor afterwards through two-step-flow or three-step-flow of communication. This means that what has been seen at the exhibition becomes essential if it is discussed with reliable people once or for several times.

When viewing Gunther von Hagens' exhibition *Body Worlds I* in Edmonton (http:www.hsaa.ca/news_and_media/new_releases/gunther_von_hagens_body_works_i_quit_campaign), smokers immediately left their half-finished packets of cigarettes near the exhibit of a smoker's lungs. The results of our analysis also confirm the rightness of the theory. The exhibits are perceived as confirmation to what is already known; for that moment, they form a new background, a new context for the existing knowledge, which can become associated with the viewer. Seeing states of disease makes the viewers aware of

their healthy organisms and draws attention to harmful behaviour – smoking and excessive consumption of alcohol. Thus, viewing the medical exhibition makes the viewers appreciate their health, to see its great benefits – he who has health, has hope; he who has hope has everything. After the research results had become known, the layout of exhibits in the Medical Collections was changed, and a wall of risk behaviour was created, where, after explanations, the visitors are left on their own. People look at the exhibits carefully and sometimes speak to themselves. By the next series of interviews, we attempt to find whether they talk about themselves or the exhibit tells its sad story that has been known for generations. In conclusion, we can say that a health promotional lecture in its usual form, with a slide programme and original specimens, followed by a guided tour of exhibition, addresses mostly the non-riskers who get confirmation to their right behaviour. In the case of those, however, who have already practised harmful behaviour, communication depends on their openness and readiness to acquire new knowledge, draw conclusions from their experience or to change their behaviour. However, when a riskers, having listened to the lecture and looked at the exhibition, lock themselves up for communication, the conveyed message does not reach them and they continue their risk behaviour. Thus, in the case of riskers, their greater involvement is needed, and they should be given opportunities to excel at non-risk behaviour.

In the case of individual visitors, we can see that the impact of the exhibition is based on earlier knowledge to which the exhibition creates a new background or a new context. Against the background of diseases, people start to see the value of the healthy organism. For knowledgeable riskers, this can amplify their earlier knowledge about their harmful behaviour and make them appreciate the lack of diseases as a benefit that they would receive from changing of their behaviour. If, however, the reception of the message is blocked, either by communicating with only one part of the exhibition or by the age barrier, the message does not reach the visitor. Thus, for those visitor types the display of exhibits and explanations should be arranged in such a way that it would create a context addressing them and drawing their attention to general themes of health in order to raise their health awareness. This would particularly apply to the visitors who saw the exhibition as a curiosity, as there were several themes about which, in their opinion, there was too little information and they risked their health out of ignorance: *I think that more*

could be spoken ... about smoking and the bad influence of alcohol ... where the ... abuse of alcohol begins.

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