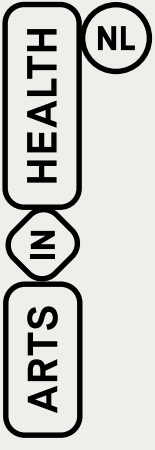


EVALUATION REPORT ON THE UMCg ARTS IN HEALTH PILOT



Seeing the Person at UMCg

I have a different
image of you

image of you

now UMCG staff

Like

a breathing space

in the middle of

the day. UMCG staff You're

allowed to

take the time

to see each

other. UMCG staff The

doctors and nurses

aren't really allowed

to play, so I tried

to work with

that. Artist Our artist



*In loving memory of our colleague, artist, and friend Wiesje Gunnink.
Your passion and commitment to this project will forever inspire us.*

Executive Summary	4
Introduction and Context	5
Pilot development	8
Pilot implementation	12
Evaluation conceptual framework	16
Evaluation findings	20
Interpretation, learning, and implications	26
Conclusions and recommendations	30
Endnotes	34

Executive Summary

This report presents the evaluation of the Arts in Health pilot conducted at the University Medical Center Groningen (UMCG) in 2025. The pilot explored how artistic practices, situated within UMCG departments, might contribute to staff wellbeing by supporting the lived experience of the organisational value *zie de mens*—seeing the person.

The pilot was not designed as a health intervention with predefined outcomes. Instead, it functioned as an enabling practice. Five professional artists were situated within five UMCG departments for five months, working on a weekly basis. Their practices emphasised attention, listening, and open-ended artistic engagement, developed in collaboration with staff and responsive to departmental contexts. The focus was on process and situated presence rather than standardisation or measurable impact.

The evaluation employed qualitative methods guided by a dedicated ethical framework developed prior to implementation. Participation was voluntary, clinical priorities were respected, and care was taken to avoid adding burden to already demanding work environments. The evaluation aimed to understand lived experiences and perceived value rather than to establish causal effects.

To interpret the pilot within the organisational context of UMCG, the evaluation drew on the Job Demands–Resources (JD–R) model. Within this framework, arts in health practices were understood as providing situational micro-resources: brief experiences of recognition, emotional relief, reflection, and connection that augment existing organisational resources without altering underlying job demands or structural conditions.

Findings indicate that the pilot created conditions in which staff experienced moments of being seen as people rather than solely as professional roles. Participants described brief but meaningful experiences of recognition, emotional relief, and reflection within demanding workdays. Artistic activities enabled staff to encounter colleagues differently, reflect on professional identity and values, and, in some cases, reconsider habitual staff–patient roles. Experiences varied across departments and levels of participation, reflecting the realities of hospital work.

The pilot did not aim to reduce workload, resolve systemic pressures, or replace organisational support. Its contribution lay in making *zie de mens* tangible in everyday practice through moments of attention, presence, and shared meaning. These experiences functioned as complementary supports within a constrained organisational context.

The report concludes that arts in health practices can play a meaningful, though necessarily limited, role in supporting staff wellbeing when grounded in modest expectations, strong ethical framing, and organisational alignment. Its value lies not in solving systemic challenges, but in creating conditions for recognition, reflection, and connection in daily work life. The report concludes with recommendations for future arts in health initiatives at UMCG, emphasising situated and long-term practice, preservation of open-endedness and ethical sensitivity, structured support for artists, clear communication of scope and expectations, and the integration of evaluation as an ongoing reflective practice.

Introduction and Context

Healthcare under pressure

Healthcare systems across Europe, including academic medical centres such as UMCG, are operating under sustained and complex pressure. Staff shortages, increasing administrative and technical demands, and a growing emphasis on efficiency and standardisation have intensified both the pace and emotional load of healthcare work. These pressures affect not only quality of care, but also staff wellbeing, motivation, and retention.^{1,2}

There is increasing recognition that strategies focused solely on efficiency, process optimisation, or individual resilience are insufficient responses to the current healthcare crisis. Many healthcare professionals enter the field because of its relational and human dimensions, yet report leaving because human connection becomes difficult to maintain within highly pressurised healthcare environments.^{3,4}

Zie de mens as a response

In response to these pressures, UMCG articulated *zie de mens*—seeing the person—as a guiding organisational value in its Koers 2025 and 2030 reports. This value emphasises recognition of patients, staff, and colleagues as whole persons rather than solely as diagnoses, functions, or professional roles. It reflects a commitment to dignity, relational care, and attentiveness to the human dimensions of healthcare.

The idea that sometimes you are simply allowed to be is important, that you're allowed to see each other, and take the time for that.

-UMCG staff

Zie de mens can be understood as a response to the increasing pressure, standardisation, and efficiency demands that characterise contemporary healthcare environments. While such demands are often necessary, they can also narrow attention to tasks, protocols, and outcomes, making it difficult for staff to sustain recognition of themselves and others as persons within everyday work.

Recognition has been identified in the literature as a crucial mechanism for supporting dignity, trust, and meaningful relationships in care contexts. Experiences of recognition are closely linked to professional motivation, resilience, and a sense of meaning at work, particularly in emotionally demanding environments.^{5,6}

Translating *zie de mens* into everyday practice, however, is challenging. In high-pressure clinical environments, there is a risk that such values remain abstract or symbolic, widening the gap between organisational aspirations and staff's lived experience.

Arts in health and *zie de mens*

Arts in health is an international field that uses artistic practices and arts professionals to support wellbeing in healthcare contexts. The field is guided by a growing body of research that demonstrates the potential of the arts to contribute to emotional regulation, social connection, reflection, and meaning-making in health-related settings.⁷

The UMCG community already has a long-standing commitment to arts in health,

since it has played a leading role in the development of the Dutch field through research, practice, and the extensive art collection that is managed by the Art Affairs department as part of the Thomassen à Thuessink committee.

Prior to this pilot, however, most UMCG arts in health initiatives primarily focused on patients. There has been no coordinated effort to develop multiple arts in health programs in support of staff wellbeing, especially in active collaboration with departments. The pilot addressed this by shifting attention toward staff as direct beneficiaries of arts in health practice. This positioning shaped both the design of the pilot and the expectations placed upon it. The following section describes how the pilot was developed, including its scope, staffing, and the principles that guided participation and open-endedness.

The pilot was designed not as a therapeutic intervention, but as a participatory and exploratory one. Its purpose was not to test whether the arts could reduce stress or burnout, but to investigate how arts in health practice might enable experiences of *zie de mens* in the forms of recognition, connection, and reflection for staff working in demanding healthcare environments.

Because the artists brought no predefined agenda, staff noted that simply being listened to without expectation felt like a shift from usual interactions.

Uses of this report

This document reports on how the arts in health pilot attempted to meaningfully support staff wellbeing with direct and embodied experiences of *zie de mens*. It presents a qualitative and institutional evaluation grounded in rigorous, methodical evaluation research on the processes and experiences of the pilot. It reports on the pilot's direct value to staff members, and evaluates its overall value to UMCG. The emphasis was on learning from practice rather than on demonstrating long-range health impacts.

The report is offered to the UMCG Board of Directors; UMCG staff who worked on or around the pilot; and other interested staff. We hope it will encourage all Dutch healthcare institutions to consider integrating arts in health programs into their ongoing support for staff and patients.

Finally, the report is offered in thanks to all our colleagues at UMCG and around the country, who supported and encouraged us during the pilot.



Pilot development

Envisioning and staffing the pilot

In 2023, the director of UMCG Human Resources began discussions with Arts in Health Groningen to explore how arts in health practices might support staff wellbeing within the medical centre. The organisational value *zie de mens* was identified as the central focus for a UMCG pilot.

A steering committee was assembled, bringing together representatives from UMCG administration, management, medicine, and nursing, as well as the co-directors of Arts in Health Groningen and a representative of the Dutch healthcare insurer Zilveren Kruis. The committee was responsible for developing the pilot plan, providing strategic oversight and expertise, and advising on the positioning and interpretation of the pilot within the broader healthcare context.

The pilot was designed to situate five professional artists within five UMCG departments, with a regular weekly presence for a period of five months. Artists were tasked with developing arts in health practices in collaboration with department staff, rather than delivering predefined activities.

To support the artists and ensure coherence across the pilot, Arts in Health Groningen provided two experienced program makers to manage the projects, facilitate integration within departments, and lead a learning community for the artists. In addition, an advisor and trainer with extensive arts in health experience participated in the learning community.

The costs of a project coordinator were shared equally between Arts in Health Groningen and UMCG. UMCG provided meeting spaces on the medical centre campus to support coordination and reflection throughout the pilot.

Three program evaluators accompanied the pilot from start to finish, gathering qualitative data to inform this report. The steering committee remained involved throughout the pilot, providing advice and oversight and supporting reflection on the pilot's outcomes and implications.

Scope of the pilot

The arts in health pilot was designed as a medium-scale exploratory initiative rather than as an intervention with predetermined health outcomes. Its aim was not to test whether art could reduce stress, burnout, or other indicators of stress, but to investigate how artistic practices might support staff wellbeing by enabling experiences of recognition, reflection, and connection in everyday work.

It was a premise of the pilot that hospitals and medical centres must change how they work in response to broader transitions in Dutch healthcare. However, it was beyond the scope of this pilot to alter structural conditions such as workload, time pressure, staffing levels, or the emotional demands of providing care. Instead, the pilot focused on creating conditions known from the scientific literature to support wellbeing in demanding work environments.

Through participatory artistic practices, the pilot sought to open moments of attention, expression, social connection, and reflection, without positioning these experiences as solutions to systemic challenges.

This scope shaped both the ambitions and limits of the pilot. The arts were positioned as a complementary practice rather than as a compensatory measure, or a substitute for organisational change.

Participation and open-endedness

The pilot was designed using *participatory* arts in health practices, emphasising active engagement by staff in artistic processes. Within the arts in health field, a distinction is commonly made between therapeutic and participatory practices. Therapeutic approaches aim for predictable health outcomes, while participatory practices create conditions in which the arts are known to support wellbeing.^{8,9}

Because the pilot was participatory rather than therapeutic, it did not aim to deliver standardised outcomes. Participation was always voluntary, and staff engagement varied according to individual interest, availability, and departmental context. This voluntary condition was treated as a core ethical principle rather than as a limitation of the pilot.

To support participation, the pilot incorporated a mandate for *open-endedness* in the development of artistic activities. Rather than implementing predefined programmes, artists were asked to develop their practices in dialogue with staff and in response to local conditions. This approach introduced a degree of uncertainty but also allowed staff to influence the form, timing, and meaning of the activities.

This sense of shared responsibility and agency was meant to support the experience of autonomy and ownership. It was also meant to distinguish the pilot from other staff initiatives that are delivered as predetermined activities. Staff participation in the pilot therefore referred not only to attendance, but also to engagement in shaping the artistic process.

Ethical considerations

Arts in health practice is not neutral or risk-free, particularly when situated within clinical environments. Embedding artists in hospital departments requires careful ethical framing, institutional support, and ongoing reflection, especially in the absence of predefined outcomes. Particular care was taken to ensure that the pilot did not add pressure to already demanding work environments.

The pilot was guided by an ethics framework developed prior to implementation by Arts in Health Groningen, with input from the steering committee. The framework emphasised doing no harm; respecting clinical protocols and privacy; minimising disruption to professional work; and prioritising the quality of participants' experience over predefined outcomes.

These ethical principles supported the navigation of complex clinical realities, including time pressure, emotional intensity, and hierarchical structures within departments. They also provided guidance for artists in responding to unexpected situations, staff vulnerability, and shifting levels of participation.

Ethical attentiveness was closely linked to voluntary participation and open-endedness. Artists were encouraged to remain responsive to staff boundaries and to avoid instrumentalising artistic activities for organisational goals. This approach helped maintain trust and emotional safety throughout the pilot.



Pilot implementation

Recruiting departments

Arts in Health Groningen issued a UMCG-wide call inviting departments and staff to express interest in participating in the arts in health pilot. The call outlined the aims, scope, and participatory nature of the pilot, emphasising voluntary engagement and collaboration between artists and staff.

Fourteen UMCG departments responded to the call. Program makers met with representatives from each department to discuss expectations, working contexts, and readiness to support participatory arts in health practices. Based on these conversations, five departments were selected for participation in the pilot.

Departments were selected primarily on their readiness to support the pilot's emphasis on participation and open-endedness. A secondary criterion was that the set of departments should reflect a range of clinical and organisational contexts within UMCG.

The selected departments were not intended to represent a sample of UMCG as a whole. Instead, each department functioned as a case illustrating how arts in health practice might unfold under different conditions. Variation between departments was treated as a source of learning rather than as a limitation of the pilot.

Recruiting artists

Artists were selected based on professional experience, artistic quality, and demonstrated ability to work in socially engaged and context-sensitive ways. A defining feature of the role was that artists would not deliver predefined activities, but would develop arts in health practices collaboratively with department staff.

Arts in Health Groningen issued a national call for artists, to which 85 artists responded. From this pool, ten artists were shortlisted and invited for interviews with the program makers.

For each department, the applications of four shortlisted artists were shared for consideration. Departments were invited to indicate preferences and to discuss how different artists might align with the character, rhythms, and needs of their specific working contexts.

Each participating department was represented by at least one staff member during the selection process. Representatives attended interviews where possible and contributed to discussions about which artists would be most suitable. Final matches between artists and departments were made collaboratively by the program makers, with advice and approval from the steering committee.

Situating artists in departments

Initial contact between each artist and their assigned department was facilitated by the program makers and project coordinator. Where possible, these introductions were embedded within existing departmental structures such as team meetings or scheduled staff gatherings. Program staff were present at these first encounters to provide practical support and to introduce the artists and the aims of the pilot.

Rather than beginning immediately with arts activities, the artists initially focused on observing, listening, and learning about departmental routines, relationships, and constraints. This approach helped establish trust and ensured that artistic practices would emerge in response to the specific context of each department rather than being imposed as a predefined programme. Artists were situated within their departments for approximately four hours per week over a five-month period. In some cases, they became part of regular staff meetings or recurring moments in departmental life. This contributed to familiarity, credibility, and the gradual development of relationships.

As trust developed, artists were invited into a range of departmental activities, including

observing patient consultations, attending extended clinical procedures (including a 10-hour surgery), and participating in off-site team activities. These invitations reflected the degree to which artists were perceived as integrated participants rather than as external visitors.

Situatedness also required that artistic activities function alongside, rather than in competition with, clinical priorities. Artists adapted their practices to departmental rhythms, working in brief moments alongside routine care activities, or during times explicitly set aside for the arts. This flexibility was essential to maintaining relevance and ethical alignment within the clinical environment.

Artists were situated within departments on a regular basis, joining the department's daily rhythms.

The learning community

To support reflection, learning, and self-care, the five artists participated in a weekly learning community facilitated by the program makers, project coordinator, and advisor/trainer. This structure was meant to provide ongoing support for artists working in the emotionally complex and high-pressure healthcare environment.

The learning community functioned as a space for shared reflection, ethical discussion, and collective sense-making. Artists used these sessions to reflect on their experiences in departments, discuss challenges, and learn from one another's

practices across different contexts.

This approach aligns with practice-based learning models described in the literature on communities of practice and reflective learning in healthcare.^{10,11,12}



**That department is very playful
and the patients are all very young,
but the doctors and nurses aren't
really allowed to play. So I tried
to work with that.**

- Artist

This section outlines the conceptual framework used to understand key concepts and dynamics of the pilot. Insights were drawn from arts in health literature, as well as from theories of recognition and meaning in healthcare; scientific literature on staff wellbeing; and organisational health psychology. Together, these perspectives informed interpretation while remaining responsive to themes emerging from the data.¹³

Understanding *zie de mens*

Because the pilot sought to operationalise the organisational value *zie de mens*, evaluation focused on understanding how this value might be experienced in practice. Literature on arts in health highlights conditions under which artistic practices support wellbeing, including creative expression, social connection, emotional regulation, and meaning-making in demanding work environments.^{14,15}

Recognition was understood as a key mechanism through which *zie de mens* could be enacted. In care settings, recognition has been shown to support dignity, trust, professional motivation, and the quality of relationships. These elements are closely linked to experiences of meaning and resilience in healthcare work.^{16,17}

Given the emphasis on efficiency, protocol, and predictability in hospital environments, particular attention was paid to how artistic practices interacted with staff's experience of time, routine, and attentiveness. The evaluation considered whether moments of interruption, reflection, or altered pace were experienced as meaningful within the workday.¹⁸

Understanding job demands and staff resources

To understand staff experiences of the arts in health pilot within the organisational context of UMCG, the evaluation drew on the Job Demands-Resources (JD-R) model (see Figure 1). Given the pilot's emphasis on participation, relationship and process, the model was required in order to understand staff experience of art making in terms of coping, meaning-making, and resilience in a demanding work environment.¹⁹

The widely used JD-R framework conceptualises staff wellbeing as shaped by the interaction between job demands (such as workload and emotional pressure), and available resources (such as autonomy, social support, or opportunities for recovery).^{20,21}

Evaluation conceptual framework



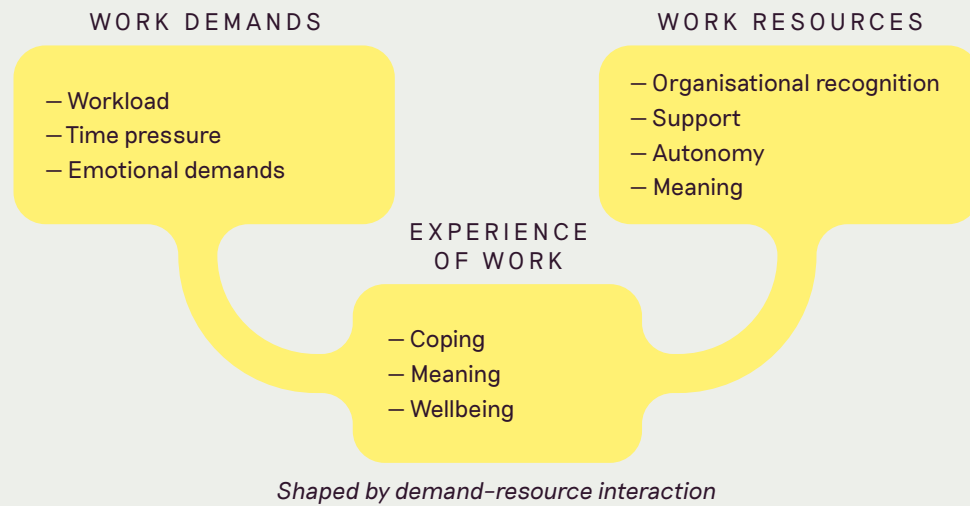


Figure 1. JD-R model with UMCG wellbeing goals as work resources.

The arts in health pilot did not aim to alter structural job demands or provide ongoing organisational support. Instead, it created situations in which staff experienced momentary forms of support through attention, recognition, shared activity, and reflection. Those situational experiences we name *micro-resources*: non-structural, relational, and emotional resources that temporarily augment the broader resource environment without changing underlying conditions.^{22,23,24}

Within the JD-R framework, particular attention was paid to how the pilot enabled experiences of autonomy, relief, and reflection. Staff were invited to determine their own levels of participation, engage without performance expectations, and momentarily step outside routine demands. Reflection was understood not as a structural job resource, but as a process through which available resources contribute to coping, recovery, and meaning-making under pressure.^{25,26}

This framing allowed the evaluators to interpret arts in health practice as a complementary support for staff wellbeing. The pilot was positioned as a practice that could make existing values and resources experientially available in everyday work.

Data and sources

The evaluation employed a qualitative, interpretive-phenomenological approach to document the experiences, processes, and perceived value of the pilot. This approach was appropriate given the pilot's exploratory nature and focus on lived experience rather than measurable outcomes.^{27,28}

Multiple qualitative data sources were used to capture perspectives from different positions within the pilot and to document how practices unfolded in situ. These included semi-structured interviews with artists and staff, observations of activities and informal interactions within departments, a focus group with UMCG

participants, researcher observations of the learning community, and analysis of documents related to the development and steering of the pilot.

These data were triangulated as an evaluative case study to capture recurring themes, contextual variation, and shared patterns across departments. Analysis focused on understanding the qualities of experience and the conditions under which arts in health practices supported recognition, connection, and reflection.

Department, staff and artists in the evaluation process

Staff participation in the evaluation, including interviews, focus group, and observations, was voluntary. Staff represented a range of professional roles and levels of involvement in the pilot, from departmental ambassadors to occasional or peripheral participants.

Artists participated in the evaluation as reflective practitioners and co-informants rather than as research subjects. Their contributions to the evaluative data focused on their experiences of working within clinical environments, ethical considerations, and reflections on artistic practice in context.

Departments differed in size, workflow, and intensity, which influenced patterns of participation and availability. This informed our understanding of the flexibility required to operate within diverse hospital contexts.

Analysis

Data were analysed thematically, with attention to recurring patterns, contrasts, and tensions across departments. All three researchers

participated in identifying themes, organising and coding data, and interpreting findings in relation to the aims of the pilot.

Analysis was guided by the conceptual framework outlined above, while remaining open to themes emerging from the data. This abductive approach allows empirical material and theory to iteratively inform one another.²⁹

Particular attention was paid to experiences of recognition, connection, and reflection; the interaction between artistic practices and everyday work routines; variations in participation and engagement; and the ethical and emotional dimensions of the work.

Reflexivity and limitations

The evaluation acknowledges the situated nature of the evaluation findings. The pilot involved only five departments and artists, and staff participation varied depending on time pressure, workload, and organisational context. The evaluation did not assess longer-term effects, and findings are not intended to be generalisable.

However, the evaluation presents a rigorous qualitative case study consistent with the exploratory aims of the pilot. Its value lies in its insight into how arts in health practices can function within complex healthcare environments, and it informs future practice, research, and organisational policy development.

Researchers accompanied the pilot over time and, to varying degrees, functioned as participant-observers. Reflexive discussions within the research team supported awareness of assumptions, positionality, and interpretive choices throughout the evaluation process.



Evaluation findings

This section presents the key processes and experiences observed across the five participating departments. While each department developed distinct artistic practices shaped by its own context, several recurring themes emerged. These findings reflect how the arts in health practices interacted with everyday work life and staff experience.

The themes are presented separately for clarity, but in practice they frequently overlapped and reinforced one another.

Being seen as a person, not only as a professional

Across departments, staff described moments in which they felt recognised as people rather than solely as professional roles or functions. These experiences stood out precisely because they contrasted with the dominant rhythm of clinical work, which often prioritises efficiency, task completion, and role-based interaction.

Recognition was enacted through simple but deliberate practices: First, the artists took time to listen to staff without agenda, remembering details about personal interactions, and suspending judgement about participation or creative ability. Expectations were not imposed on staff, to perform, or produce meaningful outcomes, or to justify their participation. The absence of these expectations contributed to a sense of safety and openness. Moreover, the 'outsider' perspective that artists brought to the clinical environment made staff members look at their work in a new way.

For many participants, these moments resonated with the organisational value *zie de mens*. However, rather than being articulated explicitly, the value was experienced through attention to one's own state of being, mutual presence, and respect in interaction. Staff described feeling seen and acknowledged in ways that were rare within everyday clinical routines.

Staff described becoming more attentive to each other, and in some cases, to patients. These reciprocal dynamics suggest that experiences of being seen supported broader patterns of recognition within departments.

Staff described moments in which artists remembered names, preferences, or small details from previous encounters. These gestures were interpreted as signs of being taken seriously as individuals rather than only as professional roles.

Seeing colleagues and team dynamics differently

Across departments, the arts activities created situations in which staff encountered colleagues outside their usual professional roles. These encounters enabled staff to recognise one another in more personal and human ways, often disrupting habitual assumptions about roles and hierarchy.

Participants noticed qualities in colleagues that were not normally visible in everyday work, such as creativity, vulnerability, or leadership. Some staff were surprised when typically quiet colleagues took initiative during artistic activities, while others observed that assertive colleagues became more receptive and attentive during arts activities.

The temporary suspension of professional hierarchies appeared to create space for different forms of interaction. Without explicit discussion of team functioning, those experiences prompted reflection on collaboration, communication, and mutual understanding within teams.

The pilot also enabled informal interactions between colleagues who did not usually work closely together. Shared arts experiences fostered moments of connection that extended beyond formal roles, contributing to a sense of shared experience.

Some staff who initially felt they had no time to participate in arts activities found themselves lingering after the activity ended, seeming to enjoy the moment.



Moments of emotional relief within demanding work

A recurring theme across departments was the experience of brief moments of emotional relief within the otherwise intense and demanding workday. Staff described arts activities as moments of pause, lightness, or calm, which contrasted with the prevailing pace and pressure of work.

Laughter, playfulness, and shared attention were frequently mentioned as restorative elements, even when the arts activities were brief. These moments were not experienced as escape, but as opportunities to breathe, reset attention, or relate differently to colleagues.

Staff understood the pilot as offering temporary relief within existing constraints, rather than as an attempt to instrumentally alter working conditions. Even very brief interruptions of routine could be experienced as useful within the flow of the workday.

Surgeons invited an artist to observe a surgical procedure and to reflect for the team on what was observed. Hearing the artist's perspective, one surgeon described it as "seeing the familiar in a new way".

Reflection on professional identity, values, and meaning

Drawing, writing, looking at art, and conversation functioned as reflective practices rather than as problem-solving tools.

The open-ended nature of the arts activities and the sustained presence of the artists

created opportunities for informal reflection for staff. These moments allowed participants to step back from immediate demands, to articulate thoughts and emotions that might otherwise remain unspoken. For some, the reflections surfaced tensions between their personal ideals of care and the realities of everyday hospital work.

Staff reconnected with motivations that had been backgrounded by routine demands.

Shifts in staff–patient relationships and role hierarchies

In one department, staff enthusiasm for the arts activities led to including patients as participants. Staff reported that when patients were engaged as creators, interactions with them slowed and became more conversational. These moments encouraged attentiveness, curiosity, and different forms of engagement that contrasted with routine clinical interactions.

Experiencing their patients as active creators rather than as passive recipients of care allowed some staff to reconsider the traditional staff–patient roles. Staff also reported gaining new awareness of how patients perceive them.

While temporary, those shifts seemed to influence subsequent encounters by fostering attentiveness and patience. The example illustrates how arts in health practices can open brief spaces in which assumptions and interaction patterns might be experienced in unexpected ways.

It brought me a new perspective,
realising I can also use creative materials
to spark a deeper conversation.
I have more tools to reach that layer
in a different way.

- UMCG staff

Limits on participation

Not all staff engaged in the arts in health pilot, and levels of participation varied across departments and moments. Time pressure, workload, personal interest, and managerial support strongly influenced whether and how staff were able to participate.

Some UMCG staff chose not to engage because they did not perceive the relevance of the arts activities, while others participated peripherally or intermittently. Non-participation was not treated as a failure of the pilot, but as a reflection of the diverse conditions and constraints within hospital work, and diverse preferences of UMCG staff.

In one instance, an artist worked across groups that were initially approached as a single department, though in practice they functioned as distinct units, each with its own rhythms, hierarchies, and communication structures. This situation highlighted how organisational complexity shaped participation, and underscored the importance of clear organisational embedding in future initiatives.

Overall, the findings indicate that the pilot functioned well in creating temporary relational and emotional conditions, rather than by producing uniform outcomes. For such experiences to contribute to longer-term cultural change, they would need to be accompanied by structural developments beyond the scope of the pilot.



This section integrates interpretation and learning from the findings. It reflects on how and under what conditions the arts in health practices functioned within the departments, and what this might suggest for future practice at UMCG.

Arts in health functioned as an enabling practice

The pilot functioned as an enabling practice rather than as an intervention delivering predefined impacts. Artistic activities created brief conditions in which staff could relate differently to themselves, colleagues, and patients, without those moments being framed as treatment, performance, or problem-solving.

That distinction clarifies both the value and limits of arts in health practice. The pilot did not aim to reduce workload, alter staffing levels, or resolve systemic pressures, but rather to operate at the level of lived experience within existing organisational and departmental contexts.

Zie de mens experienced

A central interpretive insight is that the pilot made the organisational value *zie de mens* tangible in everyday practice. Recognition was not communicated abstractly, but was experienced as attention, presence, and mutual regard, in the places where staff spend their work days.

Being situated within departments over time enabled the pilot to bridge perceived gaps between organisational values and staff's everyday experience. This suggests that continuity and embedded practice are more effective for realising *zie de mens* than symbols or mandates.

Interpretation, learning, and implications



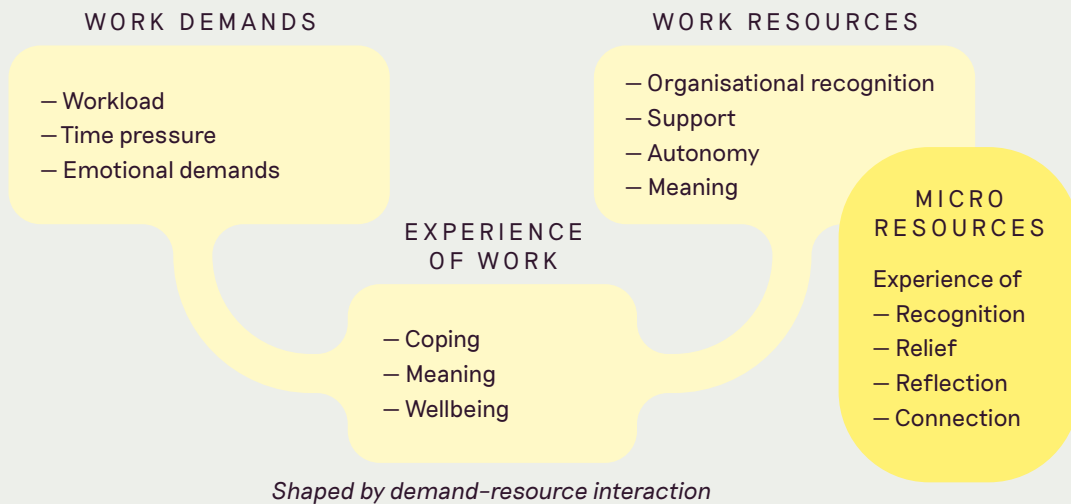


Figure 2. UMCG work resources + pilot micro-resources.

Micro-resources augmenting structural resources

The pilot can be understood as augmenting rather than replacing existing organisational resources. It supported staff wellbeing by providing micro-resources, including opportunities for recognition, emotional relief, reflection, and shared attention. Those micro-resources were situational, non-structural, and did not alter underlying job demands or workload. However, within the healthcare environment, such momentary support can meaningfully contribute to coping, meaning-making, and connection.

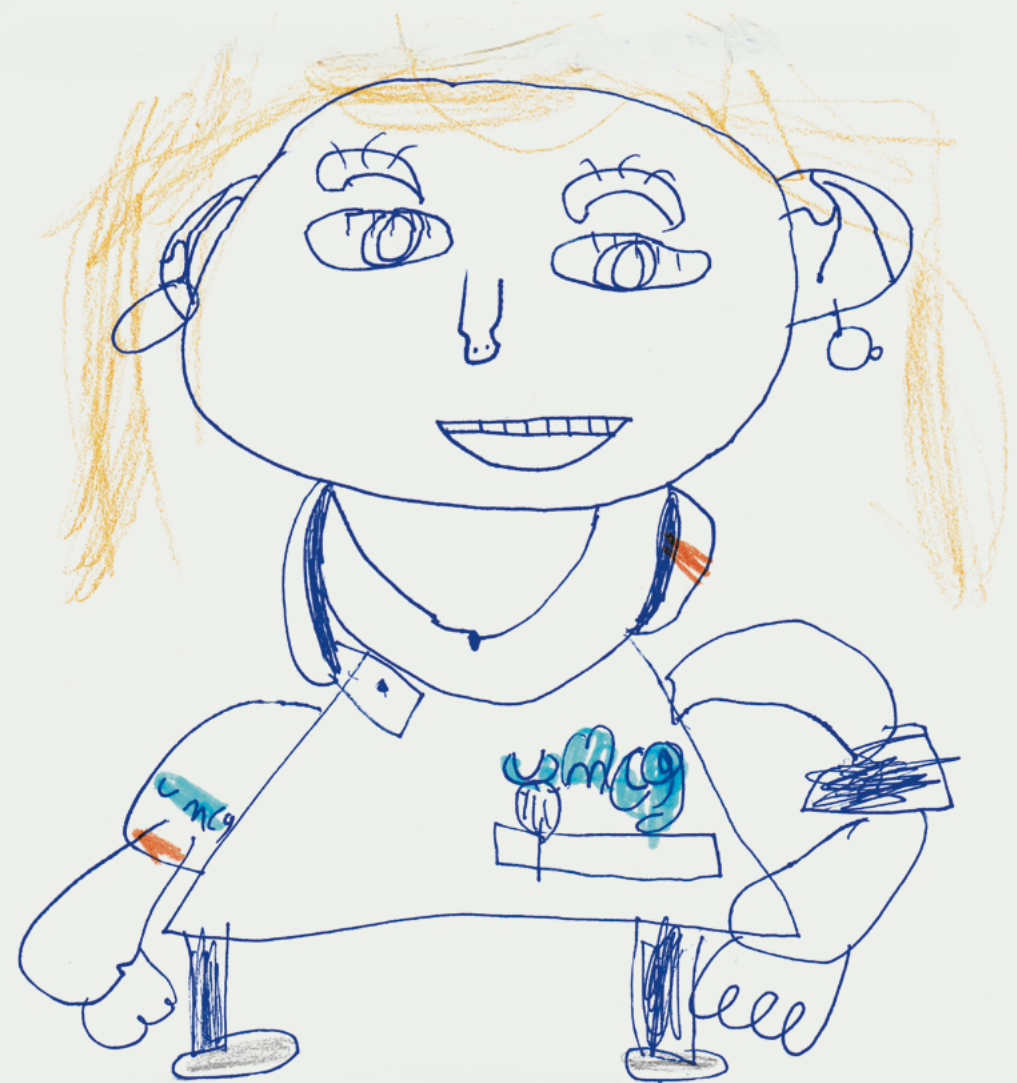
Organisational alignment is necessary

The importance of organisational alignment within the departments was evident at many points in the pilot. Managerial support and realistic expectations about staff

participation were essential for success when working with staff. Department time pressures and workload contributed to uneven engagement across the departments. In most cases the artists were able to respond with flexibility, and staff also found ways to be flexible and help the artist adapt, particularly when there was support from management. The perception by staff that the pilot was offered by the UMCG was important to integration.

Situated artists require ongoing support

The pilot involved substantial emotional engagement from the artists, who experienced the stress of the healthcare environment in many cases for the first time. The pilot's provision for regular oversight and structured peer reflection were useful in supporting resilience and adaptability through the process.





Conclusions and recom- mendations

Conclusions

The pilot demonstrated how artistic practices can function meaningfully within the hospital setting, situated within departments and supported by ethical, organisational, and reflective structures.

Rather than operating as an intervention designed to deliver predefined outcomes, the pilot functioned as an enabling practice. It created conditions in which recognition, reflection, connection, and moments of emotional relief became possible for staff within the demanding medical center environment. The value of the pilot lay in the quality of experiences it enabled, and in its ability to make the organisational value *zie de mens* tangible.

At the same time, the pilot underscored clear limits: arts in health cannot compensate for structural pressures in healthcare and should be positioned as a complementary, rather than a corrective, practice.

Recommendations

Maintain a situated, long-term approach

Future arts in health initiatives at UMCG should prioritise continuity and a sustained presence in departments. A minimum duration of six to twelve months, with regular on-site engagement, is recommended to support trust-building, relationship development, and meaningful participation. Clear agreements should be in place regarding time commitment, coordination, and the details of situating artists in a department.

Preserve open-endedness and ethical sensitivity

Open-endedness should remain a defining feature of arts in health practice with staff. Open-endedness makes it possible for the artist to be responsive to the context, and to help staff feel ownership of the project. Ethical principles and boundaries should also be clearly articulated at the start of an initiative and should be revisited through structured reflection during the project.

Support artists through reflection and peer exchange

Artists working within healthcare environments should be supported through regular peer reflection and supervision structures, such as a learning community. Ongoing reflective support is essential for ethical attentiveness, artistic development, and sustainability of practice.

Ensure organisational alignment and support

Making the health benefits of the arts sustainable at UMCG may depend upon UMCG's commitment to the practice. Staff perceived that the pilot was being offered by UMCG, and so it was easier to situate the program into the departments. Also, UMCG's ownership of the pilot may have helped some staff feel their own sense of ownership.

Future arts in health programs for staff will require coordination to facilitate schedules and resources, to align expectations, and to support integration into departments. A central arts in health coordinator is necessary. Also, a program maker can support the artists, artistic values, and strategies.

Clear communication is important to the staff experience of a project. Each participating department should have a designated management level liaison, who is briefed on the project and serves as the contact person.

Integrate evaluation as an ongoing practice

Evaluation should be understood as an ongoing reflective practice rather than a one-time assessment. Continued qualitative evaluation can support ethical attentiveness, organisational learning, and informed decision-making as arts in health initiatives evolve.

Pilot Participants

PROGRAM EVALUATORS	Ferdinand Lewis Nina van den Berg Twan Tromp	PROJECT COORDINATOR	Nina van den Berg	ADVISOR/ TRAINER	Ferdinand Lewis	PROGRAM MAKERS	Kirsten Krans Dirk Bruinsma	PILOT STEERING COMMITTEE	Michiel Kahmann (Chair) Prof. Dr. Barbara van Leeuwen Dr. Hanneke van der Wal-Huisman Prof. Dr. Jaap Tulleken Dr. Joke Fleer Dr. Edwina Doting Bertrand de Jong Ferdinand Lewis, Ph.D. Kirsten Krans Mark Dessing	UMCG DEPARTMENTS	Hepato-Pancreato-Biliair Surgery Orthopaedics Geestelijke Verzorging Beatrix Kinderziekenhuis Marketing & Communication	ARTISTS	Emma Berentsen Wiesje Gunnink Eva Koopmans Morgan Ton Anne Varekamp	SPECIAL THANKS TO	Aletta Jacobs School of Public Health Rijksuniversiteit Groningen Nationaal Programma Groningen Theatre company Peergroup
--------------------	--	---------------------	-------------------	---------------------	-----------------	----------------	--------------------------------	--------------------------	--	------------------	---	---------	---	-------------------	--



Endnotes

1. Lafortune, G., Balestat, G., Canaud, M.-C., & Di Paolantonio, G. (2023). Health workforce (Chapter 8). In *Health at a glance 2023: OECD indicators* (pp. 173–196). OECD Publishing.
2. WHO Regional Office for Europe (2022). *Health and care workforce in Europe: Time to act*. Copenhagen: WHO Regional Office for Europe.
3. Mol, A. (2008). *The logic of care: Health and the problem of patient choice*. Routledge.
4. Tronto, J.C. (1993). *Moral boundaries*. Routledge.
5. Honneth, A. (1995). *The struggle for recognition*. Polity Press.
6. Baart, A. (2001). *Een theorie van de presentie*. Lemma.
7. Fancourt, D., & Finn, S. (2019). *What is the evidence on the role of the arts in improving health and well-being?: A scoping review*. WHO Regional Office for Europe.
8. Clift, S. (2012). Creative arts as a public health resource. *Perspectives in Public Health*, 132(3), pp. 120–127.
9. Fancourt, D., & Finn, S. (2019). *What is the evidence on the role of the arts in improving health and well-being?: A scoping review*. WHO Regional Office for Europe.
10. Wenger, E. (1998). *Communities of Practice: Learning, Meaning, and Identity*. Cambridge University Press, esp. pp. 72–85.
11. Wenger, E., McDermott, R. A., & Snyder, W. (2002). *Cultivating Communities of Practice*. Harvard Business School Press, esp. pp. 4–15.
12. West, M., Eckert, R., Steward, K., & Pasmore, B. (2014). *Developing collective leadership for healthcare*. The King's Fund, esp. pp. 21–27.
13. Fancourt, D. (2017). *Arts in health: Designing and researching interventions*. Oxford University Press, esp. pp. 9–14.
14. Clift, S. (2012). Creative arts as a public health resource. *Perspectives in Public Health*, 132(3), pp. 120–127.
15. Jean-Berluce, D. (2024). Creative expression and mental health. *Journal of Creativity*, 34(2), Article 100083.
16. Honneth, A. (1995). *The struggle for recognition*. Polity Press, esp. pp. 92–130.
17. Baart, A. (2001). *Een theorie van de presentie*. Lemma, esp. pp. 57–75.
18. McNiff, S. (2009). *Integrating the arts in therapy*. Charles C. Thomas, LTD, esp. pp. 45–52.
19. Bakker and Demerouti are the canonical texts on this, though helpful for integrating the notion of meaning is Rosso, B. D., Dekas, K. H., & Wrzesniewski, A. (2010). On the meaning of work: A theoretical integration and review. *Research in Organizational Behavior*, 30, 91–127.
20. Demerouti, E., Bakker, A. B., Nachreiner, F., & Schaufeli, W. B. (2001). The job demands–resources model of burnout. *Journal of Applied Psychology*, 86(3), pp. 499–512.
21. Bakker, A. B., & Demerouti, E. (2017). Job demands–resources theory. *Journal of Occupational Health Psychology*, 22(3), pp. 273–285.
22. Bakker, A. B., & Demerouti, E. (2007). The Job Demands–Resources model: State of the art. *Journal of Managerial Psychology*, 22(3), esp. pp. 312–315.
23. Bakker, A. B., & Demerouti, E. (2007). The Job Demands–Resources model: State of the art. *Journal of Managerial Psychology*, 22(3), pp. 309–328.
24. Demerouti, E., Bakker, A. B., Nachreiner, F., & Schaufeli, W. B. (2001). The job demands–resources model of burnout. *Journal of Applied Psychology*, 86(3), pp. 499–512.
25. Demerouti, E., Bakker, A. B., Nachreiner, F., & Schaufeli, W. B. (2001). The job demands–resources model of burnout. *Journal of Applied Psychology*, 86(3), esp. pp. 507.
26. Within the JD–R framework, reflection is understood not as a job resource in its own right, but as a process through which available resources contribute to coping, recovery, and meaning-making. See Bakker & Demerouti 2007, pp. 312–315.
27. Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. Sage publications.
28. Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology & Health*, 15(2), pp. 215–228.
29. Tavory, I., & Timmermans, S. (2014). *Abductive analysis: Theorizing qualitative research*. Chicago: University of Chicago Press.

30. The term micro-resources is used to distinguish situational, emotional, and relational resources from more structural organisational resources. The set of concepts to which it refers are from the organisational behaviour literature concerning small-scale interactions, sense-making, and momentary experiences at work. See Demerouti et al., 2001; and Bakker & Demerouti, 2017.
31. Rosso, B. D., Dekas, K. H., & Wrzesniewski, A. (2010). On the meaning of work. *Research in Organizational Behavior*, 30, pp. 91–127.
32. West, M., et al. (2016). Interventions to prevent and reduce physician burnout: A systematic review and meta-analysis. *The Lancet*, 388(10057), pp. 2272–2281.



Colophon

© 2026 Arts in Health Groningen

This report is published as open access and can be downloaded free of charge via www.artsinhealth.nl.

Photos by Jan Klug.

Artwork created by UMCG employees and patients.

Graphic design by JUST – www.just.agency

Cite as:

Arts in Health Groningen, Lewis, F., Van den Berg, N., Tromp, T. (2026).

Seeing the Person: Evaluation report on the UMCG arts in health pilot.

Arts in Health Groningen. www.artsinhealth.nl

Development of this publication was supported by the following partners:

UMCG:



rijksuniversiteit
 groningen



Aletta Jacobs
SCHOOL OF PUBLIC HEALTH

nationaal programma
 groningen



me why I chose
this work.

UMCG staff

Because of the
procedures I do
I assumed the
patient drawing
me thought of
me as evil,
but they
painted me
as quite nice.

UMCG staff

Making art doesn't
fix everything,
but it shows

out it challenges
how the day
feels. •

UMCG staff

seen as a person,
not just as a
function. •

UMCG staff

Development of this publication was supported by the following partners:

umcg:



rijksuniversiteit
 groningen



Aletta Jacobs
SCHOOL OF PUBLIC HEALTH

nationaal programma
 groningen