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## UK Arts in HealthCare: A Study in the Aesthetics of Community

Liz Schaller

*University of Kentucky*

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UK Arts in HealthCare

A Study in the Aesthetics of Community

Liz Schaller

Gaines Fellowship in the Humanities

Senior Thesis

2012-2013

Dr. Jane Peters (chair)

Dr. Robert Jensen

Jackie Hamilton, Director, UKAH

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## ***Introduction—History of Art in Healthcare***

The UK Arts in HealthCare initiative fits within a strong western tradition of visual arts programs in hospital settings concerned with holistic care. This western tradition began in ancient Greece, where architecturally-pleasing halls called Asklepieia promoted a sense of serenity and well-being for patients. The design of these spaces allowed patients to follow courses of treatment often outlined in their dreams by the god Asklepios.<sup>1</sup> With the establishment of monotheistic faiths in Europe, and the development of modern medicine, these dream-prescriptions soon became obsolete. However, the fifth century BCE Athenian tradition of aesthetically-pleasing hospital spaces, while seemingly forgotten for a time, was revived in the fourteenth century in Siena.<sup>2</sup>

The Spedale di Santa Maria della Scala was originally founded by the cathedral in Siena as a space to house pilgrims traveling to the city's many shrines. By 1100, Santa Maria della Scala had expanded from this original purpose and had begun to serve the population of Siena as a hospital for the treatment of all illnesses aside from leprosy. In the fourteenth century, city officials commissioned two frescoes for the façade of the structure that now functioned primarily as a hospital. These frescoes, painted by Simone Martini, depicted a *Marriage of the Virgin* and the *Return of the Virgin to the House of her Parents*. Other Marian scenes were painted decades later by Ambrogio and Pietro Lorenzetti. Although no longer extant, these images would have created a unified mural program on the exterior of the hospital. This mural program corresponded with other artistic tributes found throughout the city to the Virgin Mary,

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<sup>1</sup> Richard Cork, *The Healing Presence of Art: A History of Western Art in Hospitals* (New Haven: Yale University Press, 2012), 7.

<sup>2</sup> J.H. Baron, "Art in Hospitals," *Journal of the Royal Society of Medicine* 89, no. 9 (September 1996), 482.

the patron of Siena. The hospital façade visually connected with the cathedral and Palazzo Pubblico through artistic expression meant to inspire and instruct visitors seeking spiritual, emotional, or physical aid.<sup>3</sup>

In 1441, the new rector of the Spedale, Giovanni di Francesco Buzzichelli, commissioned frescoes for the interior of the space. These panels, painted by Lorenzo Vecchietta and Domenico di Bartolo, featured scenes commemorating the hospital's history while they also emphasized the charitable works performed by and within the Spedale. These murals appeared along the interior space used as an entry point, a space for congregating, as well as an infirmary for male patients.<sup>4</sup> The paintings engaged not only visitors to the city or hospital, who might stop and view the façade program, but also patients and staff within the hospital. Other visual art projects in the Spedale, including the decoration of the hospital chapel, were designed to improve the spiritual, emotional, and physical well-being of the patients, visitors, and staff.

The glorification of the wealthy patrons and directors of the Spedale certainly played a part in the development of the hospital's visual program. Rather than a spiritually-uplifting, religiously-themed set of murals for the interior space, for instance, the secular governing body of the institution settled on a set of images intended to present the viewer with the completely human acts of physical healing taking place within the hospital setting. Domenico di Bartolo's *Care of the Sick* is one such mural panel. Bartolo presents a framed view of a room in the hospital, featuring caregivers administering to the ill and wounded. The physicians' expressions are calm; several individuals are shown carefully attending to the patients' desire for comfort as

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<sup>3</sup> Diana Norman, *Siena and the Virgin: Art and Politics in a Late Medieval City State* (New Haven: Yale University Press, 1999), 101.

<sup>4</sup> Cork, *The Healing Presence of Art*, 8-10.

well as bodily healing. The composition as a whole encapsulates in one image both the profound beneficence and the remarkable success of the Spedale, qualities attributed visually to the wealthy donors shown in the background visiting the hospital.



1. Domenico di Bartolo, *Care of the Sick*, 1441-44, fresco, Spedale di Santa Maria della Scala

This glorification of patrons and donors embodies the first challenge faced by the UK Arts in HealthCare program. The trend in public and hospital arts projects to honor donors, often through representations of the individuals, is one that continued for centuries. While this trend is consistent with an established tradition to recognize and acknowledge patrons of the fine arts, for an audience that is unfamiliar with this tradition, the inclusion of donor names on particular spaces and identifying panels may result in an elitist overtone in the art collection. As art critic Lucy Lippard stated, “Public art in the United States...has been extraordinarily elitist

and boring.”<sup>5</sup> In order for the UK program to successfully serve the patients, visitors, and staff members in the hospital, it needs to create a collection that fosters a sense of communal identity and ownership. If and how UK Arts in HealthCare has avoided the exclusionary elitism of many public arts projects is one of the main focuses of this study.

The Spedale served as a model for other European hospitals. In 1458, for instance, the leaders building a hospital in Milan requested detailed descriptions of the physical structure of the Spedale.<sup>6</sup> Visual art programs similar to that of the Spedale began to appear throughout Europe in the fifteenth century. In 1443, the Hôtel-Dieu hospital in Beaune, Burgundy, was constructed to house and care for the poor. That same year, Chancellor Nicholas Rolin, founder of the hospital, commissioned Rogier van der Weyden to construct an altarpiece for the chapel.<sup>7</sup>



2. Rogier van der Weyden, *The Last Judgment*, 1443-51, altarpiece, Hôtel-Dieu

<sup>5</sup> Arlene Raven, ed. *Art in the Public Interest* (Ann Arbor: UMI Research Press, 1989), 26.

<sup>6</sup> Keith Christianson, *Painting in Renaissance Siena, 1420-1500* (New York: The Metropolitan Museum of Art, 1988), 47.

<sup>7</sup> Cork, *The Healing Presence of Art*, 35.



The reverse side of the altarpiece depicts *The Annunciation*, a biblical scene similar in subject to the original Marian frescoes in the art program at the Spedale in Siena. This image would have been viewed by patients during the week when the altarpiece was closed, and would have provided a serene sense of hope in the coming of Christ. The main panels of the altarpiece, however, display an entirely different theme: *The Last Judgment*. Two messages are inscribed in the center panel of the altarpiece. On the left side of Christ the Latin reads 'Come ye blessed of my Father, inherit the kingdom prepared for you from the foundation of the world;' the message on the right states 'Depart from me, ye cursed, into everlasting fire, prepared for the devil and his angels.'<sup>8</sup> The intention of this artwork was not only to reassure patients, but also to provide a constant reminder of the importance of the health of one's soul above that of the body.

Van der Weyden's vivid portrayals of saints and sinners reinforced this message for the largely illiterate patients. Figures along the lower register of the piece emerge from their graves and are weighed by a stoic St. Michael. The virtuous rise to the gates of Heaven, while the damned sink down into the fiery depths of Hell. Contorted bodies and hopeless, beseeching expressions characterize the individuals sentenced to eternal damnation. The souls of the saved, represented by calm countenances and prayerful demeanors, would have theoretically proved inspirational for patients viewing the altarpiece from their sickbeds.

Like many altarpieces of the time, van der Weyden's *The Last Judgment* also includes portraits of the couple who commissioned the work. Their devotion to God and the charitable work of the institution finds expression in their prayerful poses. The artwork honored their

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<sup>8</sup> Ibid, 38-9.

charity while providing patients an example to emulate in hopes of salvation. Their inclusion echoes the trend seen first in the Spedale fresco, and demonstrates how visual depictions of donors pervaded European hospital art programs for centuries. Van der Weyden's elaborate altarpiece represents the type of morally-instructive, religiously-themed art that was typical of early Renaissance hospital art programs.

Religious institutions were central to European communities at the time, and most hospitals were directly run by, or indirectly affiliated with, the Catholic Church. This trend continued for centuries in some parts of Europe. Yet the Protestant Reformation brought about shifts in power, particularly in northern Europe, that resulted in medical facilities and professionals being governed by secular institutions. Hospital art of the sixteenth and seventeenth centuries reflects this transition. Rembrandt, Bosch, Holbein, and many others painted scenes of beneficent donors administering to the poor and medical professionals conducting anatomy lessons. In France, the Catholic King Louis XIV glorified himself in the impressive art and architectural design of the Hôtel des Invalides (1671-1706), built to house and care for wounded soldiers.<sup>9</sup>

England sought to compete with Louis XIV and his successors in terms of the construction of impressive hospital edifices in the eighteenth century. These hospitals were funded by a combination of government support and private investment, and came to embody the financial strength and prowess of the nation. In 1695, King William and Queen Mary commissioned the Royal Hospital for Seamen in Greenwich.<sup>10</sup> Modeled after the French Hôtel

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<sup>9</sup> Cork, *The Healing Presence of Art*, 159.

<sup>10</sup> *Commission for Greenwich Hospital* (London: Charles Bill, 1695).

des Invalides, the hospital housed injured sailors. Like the French hospital, the Royal Hospital contained an artistic program intended in part to glorify the monarchy. In the central courtyard, for instance, a white marble sculpture of King George II—yet another example of donor portraiture—dominated the space and provided a constant reminder of royal beneficence to visitors and staff alike.<sup>11</sup> The Neoclassical façade of each hospital building featured a sculpture referencing both classical scenes as well as nautical themes.

Most of the sculptures honored the service of the men being treated in the hospital, as well as the power and strength of the nation. In John Cooke's description of the hospital, compiled from historical accounts on the centennial of the commissioning, he stated: "When we consider the beauty, solidity, and magnificence of this superb structure, and the excellent uses to which it is appropriated, it must ever be contemplated with reverence and admiration, as a work of national grandeur, and at the same time the noblest monument of wisdom and benevolence."<sup>12</sup> This sentiment encapsulates the purpose of the art and architectural programs of many hospital projects in seventeenth and eighteenth century Europe. Aside from a continued connection with spiritual well-being, most commonly found in hospitals in Italy and Spain, honoring the monarch and wealthy benefactors became increasingly more important. Between 1720 and 1745, for instance, five hospitals were established in London, all of which

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<sup>11</sup> John Cooke, *A concise description of the Royal Hospital for seamen at Greenwich. Extracted from the historical account published by the chaplains* (London, 1794), 2.

<sup>12</sup> Cooke, *A concise description of the Royal Hospital*, 9.

housed portraits of their philanthropic founders.<sup>13</sup> Patients and staff were not supposed to forget to whom they owed their lives and livelihoods.

The Painted Hall dining room at the Royal Hospital contained a sweeping mural program dedicated to the glorification of the nation and the British navy. James Thornhill painted the space that served as a dining hall for veterans staying at the hospital. The ceiling depicts William and Mary seated in splendor, attended by Prudence, Temperance, Fortitude, and Justice. Around the figures appear depictions of the four seasons, as well as the signs of the zodiac. The entire composition was intended to represent the triumph of Peace and Liberty over Tyranny.<sup>14</sup> The panels around the room portray numerous naval images and portraits of famed scientists whose work contributed to the development of naval power in England. As a whole, the Painted Hall presents an awe-inspiring vision of the country's power and promise, intended to comfort patients and honor the sacrifices of the veterans dining in the hall.

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<sup>13</sup> The five hospitals, Guy's, Westminster, London, St. George's, and Middlesex, are all discussed in chapter 15 of Cork, *The Healing Presence of Art*, 211-231.

<sup>14</sup> Cooke, *A concise description of the Royal Hospital*, 15.



3. Sir James Thornhill, *Triumph of Peace and Liberty*, 1712, Painted Hall

Over a century later, the Painted Hall became ‘The National Gallery of Naval Art.’ From 1824 to 1936, the space housed over 300 naval-themed paintings. These works, including Turner’s *Battle of Trafalgar*, were gifts to the hospital. King George IV presented the hospital with the foundation of the collection, and other donors followed his example. The collection remained on display in the space until it was presented to the National Maritime Museum as a permanent loan in 1936.<sup>15</sup> In 1939, the Painted Hall began to be used again as a dining hall; rather than serving hospital patients, however, the hall accommodated the officers of the Royal Naval College.

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<sup>15</sup> A history of the Hospital’s art collection during this period is available at “The Greenwich Hospital Collection,” *Greenwich Hospital*, accessed August 10, 2012, <http://www.grenhosp.org.uk/default.asp?page=260>.

The late nineteenth century also saw the expansion of the concept of holistic care through the efforts of Florence Nightingale. In her *Notes on Nursing*, first published in 1859, Nightingale claimed that “the effect in sickness of beautiful objects, of variety of objects, and especially of brilliancy of colour is hardly at all appreciated.”<sup>16</sup> Her observations on the state of medical care in England arose from a lifetime of nursing patients and studying the factors that impacted physical and emotional comfort as well as recovery. She found that little attention was paid to the caregiving environment, and that patients were often subjected to long stays in a single, poorly lit room that was typically free of visual interest and variety.

Nightingale encouraged hospitals to give patients opportunities to view nature. She also suggested that patients be allowed to have cut flowers in their rooms. Most importantly, however, she argued that mental pain and suffering due to immobility and unfriendly surroundings could severely impact overall health and wellness. She urged caregivers to consider the many ways in which variety could be incorporated into patients’ lives, whether through visual stimuli or simple physical activities, such as needle-work or writing. Nightingale encouraged hospitals to provide art in patients’ rooms, and above all to remain better aware of the emotional and psychological needs of their patients.<sup>17</sup>

Nightingale’s observations, particularly with regard to hospital management, influenced not only England but also much of Europe and the United States. In terms of hospital art programs, Nightingale inspired and encouraged the view that art might have a positive impact on patient health. Prior to her observations, art in hospitals typically fit in one of two

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<sup>16</sup> Florence Nightingale, *Notes on Nursing: what it is and what it is not* (New York: Dover Publications, 1969), 58.

<sup>17</sup> Nightingale’s thoughts on variety in visual experience and general awareness of patients’ psychological needs may be found in *Notes on Nursing*, 59-63.

categories: religious or spiritual instruction, exemplified by van der Weyden's altarpiece, or honorifics to the donors or leaders whose financial contributions facilitated the construction of the hospital, as seen in Thornhill's Painted Hall.

It is this interest in a more holistic approach to healthcare that provides the basis for the second point of analysis of the UK Arts in HealthCare program. The mission statement of the program, discussed later, emphasizes the humanizing effects of art in the hospital setting and describes concern for overall wellness. These ideas spring from the hospital art trends eventually popularized as a result of Nightingale's observations. The program at UK extends the concern with wellness to include visitors and staff members as well, individuals who were excluded in Nightingale's revision of attitudes toward healthcare. If and how effectively UK Arts in HealthCare addresses these concerns serves as the second main point of assessment in this study.

While certain of Nightingale's recommendations became popular policy, hospital art commissions declined after World War I in most parts of Europe. Throughout the continent, hospital art programs became confined to monumental sculpture on the exterior of buildings intended, once again, to honor hospital benefactors. A prime example of this is the Brugmann University Hospital in Brussels. Built in 1923, the hospital building was widely admired, yet the only significant artwork incorporated into the original plan was the *Monument to Georges Brugmann*, sculpted by Julien Dillen to honor the man whose generous donations funded the hospital's construction.<sup>18</sup>

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<sup>18</sup> Cork, *The Healing Presence of Art*, 376.

This phenomenon has been attributed at least in part to changes in architectural philosophy.<sup>19</sup> Le Corbusier, a pioneer of modern architecture, preached an aesthetic that emphasized the inherent beauty in the simplicity of functional design. His interest in functionalism, both in individual structural design as well as in urban planning, influenced architectural plans for public buildings throughout the world. Hospitals were no exception. In 1936, the Viipuri Hospital Maternity and Women's wards were designed by Uno Ullberg. The concrete exterior was simple and unadorned, clearly influenced by Le Corbusier and the Functionalists. Medical developments at the turn of the century also reflected this interest in a highly-functional, arguably dehumanizing approach.<sup>20</sup>



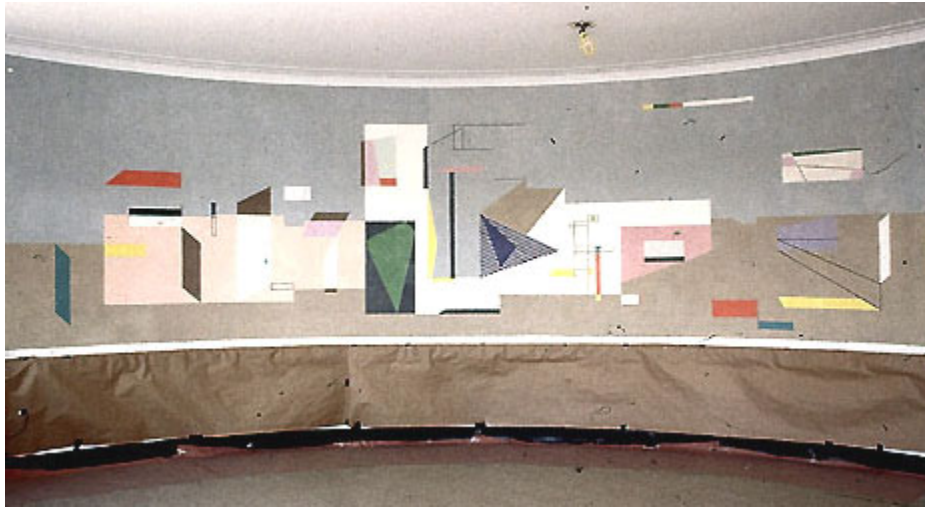
4. Uno Ullberg, *Viipuri Hospital Maternity and Women's Wards*, 1936-37, Vyborg, Russia

<sup>19</sup> Baron, "Art in Hospitals," 483.

<sup>20</sup> In Foucault's *The Birth of the Clinic*, he expounds upon the term "medical gaze." This refers to the medical separation of the treatment of disease from the treatment of the patient. Foucault's critique of this development in the medical field had to do with a lack of concern with total wellness. In some ways his arguments reflect back on the humanizing approach advocated in Nightingale's *Notes on Nursing*.



During this same period, the United States saw a flourishing of art projects in hospitals generated by government investment in the arts through Roosevelt's WPA Federal Art Project. In 1940, Ilya Bolotowsky received a commission through the WPA mural division to create a wall-painting for the Men's Day Room of the Chronic Diseases Hospital in New York.



5. Ilya Bolotowsky, *Abstraction*, 1940-41, oil on canvas, Chronic Diseases Hospital, New York

The unusual space required a long canvas attached to a curving wall that extended fifteen meters around the perimeter. Bolotowsky approached the project as a means to improve the lives of patients during their hospital stay. He argued that the room's "roundness might give some patients a feeling of being walled-in and fenced off from the rest of the world. Therefore, in the mural I have sought to create a feeling of a free, open space."<sup>21</sup> In this statement he echoes the sentiments expressed nearly a century earlier by Florence Nightingale; her vision of holistic care had emerged as a dominant force in American healthcare. And rather than the

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<sup>21</sup> Bolotowsky made this statement to the New York City WPA Mural Division. As quoted in Cork, *The Healing Presence of Art*, 383.

religiously-themed art commissioned for American hospitals during the nineteenth century, the WPA period, characterized by Bolotowsky's *Abstraction*, ushered in an expanded definition of hospital arts programs in the United States.

Hospital arts programs continued to develop slowly over the next decade. In 1950, the American Music Therapy Association established the goals of "integrating psychological, physical, and social functioning and well-being."<sup>22</sup> The goals of the AMTA reflect the influence of Florence Nightingale and others who had encouraged a more comprehensive vision for the future of the healthcare field. The subsequent foundation of the National Endowment for the Arts, in 1965, helped to propel the hospital art movement into the 1970s.

One of the earliest and most influential programs, Project Art, emerged at the University of Iowa Hospitals and Clinics in 1976. Project Art director Joyce Summerwill coordinated with the School of Art and Art History to initiate monthly rotating exhibits in the public spaces in the main part of the hospital.<sup>23</sup> This emphasis on rotating art exhibits and other environmental art was emulated by many other programs. For instance, the University of Michigan Gifts of Art program, established in 1986, developed with the help of Summerwill and other leaders from Project Art.<sup>24</sup> The Gifts of Art program expanded over time to encompass other aspects of art therapy, but the Michigan-based program initially focused solely on art displays within the hospital environment.

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<sup>22</sup> Jill Sonke, "The State of the Arts in Healthcare in the United States," *Arts & Health* (2009), 108.

<sup>23</sup> University of Iowa Hospitals & Clinics, *Project Art*, accessed August 20, 2012, <http://www.uihealthcare.org/ProjectArt/>.

<sup>24</sup> Sonke, "The State of the Arts in Healthcare," 109.

In 1991, leaders of several such programs in the United States met at a conference that resulted in the foundation of the Society for the Arts in Healthcare. By 1990, hospital art programs had begun to appear in major cities throughout the U.S. The Society for the Arts in Healthcare (SAH) facilitated a dialogue among these various programs with the objective of establishing basic goals and principles for arts in healthcare initiatives. In 2008, the Society created a definition for the field:

Arts in Healthcare is a diverse, multidisciplinary field dedicated to humanizing the healthcare experience by connecting people with the power of the arts at key moments in their lives. This rapidly growing field integrates the arts, including literary, performing, and visual arts and design, into a wide variety of healthcare settings for therapeutic, educational, and recreational purposes.<sup>25</sup>

In addition to defining the field, the Society expanded upon Nightingale's claims that art could have a positive impact on patient recovery. They claimed that arts in healthcare also play an important role in improving the ability of healthcare providers and visitors to care for patients by contributing to a more dynamic, creative, and positive environment. Similar developments occurred simultaneously in Great Britain. By 1983, sixty-five British hospitals utilized some of their financial resources for visual arts programs, in addition to contributions from private donors.<sup>26</sup>

It is this expanded definition of hospital art presented by SAH that served as a basis for the development of UK Arts in HealthCare. This modern conception of using art to impact and improve the healthcare experience was ultimately influenced by the two main trends seen in

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<sup>25</sup> Sonke, "The State of the Arts in Healthcare," 110.

<sup>26</sup> Linda Moss, *Art for Health's Sake* (The Carnegie United Kingdom Trust, 1987).

the examples of hospital art over time: the importance of honoring and catering to donors, as seen in the Royal Hospital, which often leads to a decidedly elitist tone; and the gradual recognition of the value of attractive, calming hospital spaces on the treatment of patients and the experience of visitors and staff members, as demonstrated in Bolotowsky's painting for the Chronic Diseases Hospital in New York. These two themes can be seen throughout the development of the art collection at UK, and they serve as the basis for analysis of the program's efficacy.

### ***Development of UK Arts in HealthCare***

The UK Arts in HealthCare program began two decades after Michigan's Gifts of Art, and the coordinators of the program at UK looked to Michigan's successful growth and development as an example of how to sustain and grow a hospital arts program. Iowa's Project Art also served as a model for UK, particularly in terms of its emphasis on rotating art exhibits in the public spaces in the main part of the hospital.<sup>27</sup> While the Arts in HealthCare program ultimately came to include a combination of features unique to UK, both Michigan and Iowa provided significant initial inspiration.

The University of Kentucky was not the first institution in the state to become affiliated with the Society for the Arts in Healthcare. According to an internal survey of membership in 2009, SAH reported twenty-nine individual and thirteen organization members in the state. Kentucky ranked sixth among the states in the southern region for total membership.<sup>28</sup>

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<sup>27</sup> University of Iowa Hospitals & Clinics, *Project Art*, accessed August 20, 2012, <http://www.uihealthcare.org/ProjectArt/>.

<sup>28</sup> Sonke, "The State of the Arts in Healthcare," 118.

Therefore, while UK looked to models in other parts of the country for inspiration, interest in hospital art programs had already begun to expand throughout the state.

According to Victoria Myers, a fundraiser for UK HealthCare and one of the founders of the Arts in HealthCare initiative, no one at the university had any background in hospital arts programs when they first began discussing the project. UK HealthCare applied for a consultancy grant from SAH; consequently, Elaine Sims, Director of Michigan's Gifts of Art Program, visited the campus and helped define the start-up of the UK Arts in HealthCare Program. Elaine met for a day with representatives from the College of Fine Arts and the Art Museum at the University of Kentucky in addition to the UK Arts in HealthCare planning committee. She provided the group with extensive materials and background on the type of research and development typical for hospital arts programs like the one planned for Kentucky. Her most valuable advice, according to Myers, was to build on the arts resources available locally and to employ local artists whenever possible. This strategy was intended to engender support within the local community, as well as to bolster the regional art market.

Dr. Michael Karpf, Executive Vice President for Health Affairs, approached Myers and told her that they were going to raise money for hospital art. The arts project coincided with construction of the new hospital Pavilion A, and fundraising for UK Arts in HealthCare began at the new Pavilion groundbreaking gala.

This early momentum provided funding for some of the major pieces in the hospital collection. *Ginkgo*, a 32-foot stainless steel sculpture designed by Warren Seelig, is a focal point of the art collection, occupying the multi-story central atrium skylight. The sculpture was a gift

from the James F. Hardymon Family Foundation—part of the initial fundraising push—and it serves as the centerpiece of the art displayed on the ground floor.



6. Warren Seelig, *Ginkgo*, 2011, Painted steel and painted stainless mesh, Atrium, Pavilion A



7. John Reyntiens, *Springtime in Kentucky*, Glass and paint, Pavilion A

Myra Leigh Tobin also approached the hospital in the early stages to donate money for the *Springtime in Kentucky* stained glass adorning the new chapel. The chapel, which bears her name, seems to refer back to the religiously-themed hospital art of the fifteenth century, such as van der Weyden's *The Last Judgment*, that also served to honor donors. Additionally, a former patient of Dr. Karpf's approached him in order to facilitate construction of the ground floor auditorium, one of the key components of the Arts in HealthCare program that allows for incorporation of artistic expression beyond the visual arts.

Nearly a year into the planning process, Jackie Hamilton was hired as Development Communications Manager. In addition to developing communication materials around the new Pavilion, Jackie began staffing the Art Committee and eventually was named Director of the program when the Pavilion opened in the spring of 2011. In conjunction with supporting the local arts community, the Arts in HealthCare program had to address popular, often negative, conceptions of the program. There was a concern that the visual art collection could be perceived as elitist, that it might only appeal to a specific—highly educated and, therefore, cultured—audience. In order to combat this, the planning committee invited members of the local arts community to be part of the selection process for specific commissions. Expanding the number of opinions and perspectives factored into the decision-making process certainly led to a great deal of debate among committee members, but by including a wider array of individuals the program demonstrated to the public that it intended to serve every citizen of the Bluegrass.

The chapel commission is one example of these contested, community-wide debates. The donor had requested a specific theme, “Springtime in Kentucky,” for the commission. After lengthy debate, the request for proposals was expanded internationally and the committee received some sixty responses from around the world. Those sixty proposals were narrowed down to just five: four from Kentucky and one from England. Further debate ensued as to whether or not a European artist could truly capture the theme requested by the donor. In the end, the British artist John Reyntiens was chosen by a slim majority who felt that his vision “captures the spirit of rebirth and hope” of springtime in Kentucky.<sup>29</sup>

Specific departments also had the opportunity to participate in the decision-making process. Doctors, nurses, and other staff members in each part of the hospital contributed their perspectives. According to Myers, this rarely led to a consensus, but staff seemed to appreciate having the opportunity to be involved.

Patricia Howard, Operations Manager of Emergency Services at UK Chandler Medical Center, led the committee invited to contribute their opinions regarding the artwork for the Emergency Department. The art was chosen in conjunction with the design and construction of the space.<sup>30</sup> According to Howard, it was critical that the emergency department include a pediatric care unit that was visually as well as spatially distinct from the rest of the department.<sup>31</sup> Art served an important role in this delineation. The art chosen for the rooms in the pediatric care unit features bright colors and playful imagery, and two of the pieces chosen

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<sup>29</sup> From the description of the commission in the UK Arts in HealthCare self-guided tour literature.

<sup>30</sup> For a detailed account of the design and construction process see Patricia Kunz Howard, “Moving an Emergency Department: Lessons Learned,” *Journal of Emergency Nursing* (2012), 1-6.

<sup>31</sup> Howard, “Moving an Emergency Department,” 2.



were created by young students from the School for the Creative and Performing Arts in Lexington, Kentucky. The hospital intends these paintings, drawings, and photographs to make the patients and their families feel more comfortable and relaxed during often stressful visits to the emergency room. Howard has found that some children who visit the department more frequently even request rooms based on specific artworks, a clear indication that at least for some this new emphasis on creating a more comfortable environment has proved worthwhile.

While the art in the other patient rooms and waiting areas is less vibrant and playful, its intended function is still much the same as the pediatric care pieces. Howard assembled a group of staff members to participate in the selection process, and they were presented with a binder of images from which to choose. Rather than selecting specific pieces, however, Howard said that the planning committee used their input as a more general guide for styles and artists that might be appealing. The works of art chosen represent a variety of media and stylistic approaches, yet almost all fit within the landscape genre. According to Howard, the staff felt that landscape imagery would be most likely to calm patients and visitors, as well as themselves, in the often hectic environment of the emergency department.

Although rare, negative feedback has also helped to shape the collection. Myers mentioned that several pieces have been changed out as a result of complaints from patients, visitors, or staff members. At one point, Howard called a staff meeting to discuss a problematic photograph that was part of a gallery exhibit. The image in question, a doll with a condom on its head, had prompted several visitors as well as staff members to complain. When the controversial nature of the photograph was brought to the attention of the Arts in HealthCare

program it was quickly removed. This particular instance reflects a general interest in, and responsiveness to, feedback from patients, visitors, and staff that has helped to shape the current art collection in the hospital. It also indicates a desire to create a comfortable atmosphere for those who regularly encounter the art in Pavilion A.

There are over four hundred pieces currently on display as part of the permanent collection in the hospital. This includes the art in the waiting rooms and other open spaces in addition to the artwork in each individual patient room throughout the building; however, it does not factor in the diverse array of pieces featured in the two rotating gallery spaces. The collection includes paintings, photography, textiles, stained glass, and sculpture, in a variety of forms and media. The *Celebrate Kentucky Wall*, for instance, incorporates still photos as well as video of people, places, and scenes from across the state, changed out four times a year to reflect the seasons.



8. Tim Broekema, *Celebrate Kentucky Wall*, Mixed Media, First Floor, Pavilion A

In the surgical waiting room, several large-scale paintings and a weaving adorn the walls while blown glass, folk art woodcarvings, and interactive sculpture line the space.

This incredibly diverse collection is intended to reflect the arts traditions and culture of Kentucky. By including this variety, the planning committee hoped to create a welcoming environment for the wide array of patients, visitors, and staff who engage with the space. The initiative sought to support the regional arts community while also looking beyond the Bluegrass for several commissions. In soliciting opinions and feedback both internally and externally, UK Arts in HealthCare actively worked to avoid being labeled as elitist or disengaged from their audience. Aside from anecdotal evidence from individuals, however, the program had no way to assess if, and how, it managed to appeal to its audience. A focused evaluation that surveyed patients, visitors, and staff members regarding their response to the visual art in the hospital was critical in determining how effectively the Arts in HealthCare program works to create a communal, humanizing experience through the arts.

### ***The Evaluation***

Evaluation of the UK Arts in HealthCare program serves several different functions. First, it is an opportunity to assess if, and how effectively, the program is meeting its defined goals. These goals are outlined in the UK program's mission statement:

The Arts in HealthCare program will enhance this environment by recognizing the spiritual and healing effect of the arts. Art in all its forms humanizes an environment. Our mission is to focus on the spiritual and emotional well-being of our constituents. The program will support the art

and the artists as a powerful entity that can elicit calming creative resources from patients, families and care givers.<sup>32</sup>

The goals outlined in the statement fit with the models and formative organizations previously discussed. UK ultimately sought to mimic Iowa and Michigan in the depth and breadth of its offerings. Interactive projects and performance elements will continue to be incorporated as the program expands. For now, this assessment attempts to determine if and how UK Arts in HealthCare has developed a calming, creative environment for patients, families, and care givers through the visual arts collection.

Second, the gathered feedback points to areas where improvement may be made, particularly with regard to the accessibility of the collection for its audience. If the program is not currently meeting its established goals, what can and should be changed in order to better humanize and enhance the environment for everyone involved? If the existing program is impacting the community in a negative way—for instance, if the tone, content, and presentation of the art come across as elitist or inaccessible—how might this be corrected? What else do patients, families, and staff members want to see provided by the UK Arts in HealthCare program in terms of an expanded art collection or additional programming? These questions are important to consider at this stage in development, and will provide feedback that can be used to enhance the program and help it to more effectively serve the hospital patients, visitors, and staff.

Finally, this evaluation provides substantive support for the Arts in HealthCare program, regardless of whether the feedback is positive or negative. Although some of the assessments

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<sup>32</sup> The initial articulation of this mission statement appeared in UK Arts in HealthCare, “Arts in HealthCare Working Document,” 2007.

are negative, or point to particular areas that need to be addressed, this provides an opportunity for the program to grow and change to better meet the community's needs. Alternately, positive assessments can affirm the program's vital place within UK HealthCare and may encourage potential donors, new local artists, and other community members to become involved.

Determining the mechanisms by which to evaluate the program became much simpler after the goals and functions of the process were established. It was evident that collecting feedback from a variety of individuals—patients, visitors, and staff—would be essential to obtaining the type of guidance and assessment critical to improving the program for the entire community. Surveys therefore seemed like the logical choice. A survey format permitted me to ask both specifically-formatted questions with response choices, as well as open-ended queries that allowed for more personal, narrative feedback. Having explored books and articles on conducting surveys, it became clear that these deliberately-crafted questions were going to be essential to the success of this data collection endeavor.<sup>33</sup>

Although many new medical arts programs have developed over the past few decades, a consensus has yet to be reached regarding evaluation methodology. Some scientists have teamed with architects and designers to facilitate studies that have contributed to a growing body of research on the proven health effects of aesthetically-pleasing healthcare facilities. These studies have yielded many connections between thoughtfully-designed, visually-

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<sup>33</sup> Peter Scher and Peter Senior, "Research and Evaluation of the Exeter Health Care Arts Project," *Journal of Medical Ethics* 26, no.2 (December 2000): 71-78.

stimulating surroundings and successful patient care.<sup>34</sup> Yet this type of quantitative research is not feasible for many programs. Many do not have the financial means or required resources at their disposal to conduct such an investigation. Instead, hospital art initiatives have relied heavily on the comparatively more tenuous validation of qualitative studies to support their endeavors.

UK Arts in HealthCare certainly fits in the category of programs unable to fund or facilitate in-depth quantitative studies. The funding that the program does receive is mostly in the form of private donations with specified purposes; therefore, it would be challenging to come up with the necessary means to carry out an extensive evaluation. Both time and resources thus dictated a qualitative, survey-based mode of assessment. Surveys would, as stated earlier, accomplish the goals outlined for the study, while also fitting within the parameters of the project. The program often received feedback from individuals in the hospital who sought to praise or critique the collection; however, this informal commentary had yet to be compiled and studied. This data collection was, therefore, merely a continuation of an unofficial process already in progress rather than the implementation of an entirely new mode of inquiry.

Because no codified method of evaluation existed for hospital arts programs, several different sources proved to be useful when drafting the surveys. In 2002, The Creative Center,

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<sup>34</sup> For more details on various studies connecting successful healthcare service with physical surroundings, see Rosalia Staricoff, "Arts in Health: the value of evaluation," *Perspectives in Public Health* 126, no.3 (May 2006): 116-120. For instance, Staricoff cites a 2003 research project conducted for the NHS titled "The architectural healthcare environment and its effects on patient outcomes" which found that 'a well-designed healthcare service can contribute to a reduction in drug consumption and length of stay in hospital.' (116) Another significant study that provided quantitative feedback for the field was Roger Ulrich's 1984 research "View from a Window," in which he studied patient recovery time in connection with being exposed to a window view.

which serves people with cancer in New York City, compiled a report titled “Satisfaction and Outcomes Assessment: Hospital Artist-in-Residence Program.” This program has served patients at several New York hospitals for many years by providing patients with the opportunity to create art. The assessment of this program provided me with a framework for my study. Although this research involved an artist residency program, rather than a visual art collection, the structure of the study fit well within the scope of the evaluation for UK. The report carefully outlined the goals and mission of The Creative Center as well as the desired outcomes and general purpose of the study. When determining the study sample, The Creative Center worked with patients and staff on an opportunistic basis, rather than having a small group of specially-identified participants. In all, they surveyed sixty patients and fifty-six staff.<sup>35</sup>

The report contained extensive description and analysis of the data collected. It was the appendix of the report, however, that proved most useful. In the appendix, the individuals who designed the surveys for The Creative Center outlined the various criteria they sought to evaluate and the variables or measures they utilized to do so. Many of these criteria, and the corresponding measures, were easily adapted to work for this project. Self-expressed level of satisfaction, areas for improvement, and program awareness were a few of the key criteria measured for both patients and staff at The Creative Center, criteria that served as the foundation for the UK Arts in HealthCare study.<sup>36</sup>

Another important evaluation model was the set of questionnaires used for the Exeter Health Care Arts Project in 2000. This evaluative study was particularly valuable to the

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<sup>35</sup> KCI Research and Evaluation, “Satisfaction and Outcomes Assessment: Hospital Artist-in-Residence Program,” (New York: The Creative Center, 2002), 2.

<sup>36</sup> Ibid., 16-18.

development of the field because “for the first time the responses of clinical staff about the effects of art on the healing process, on therapeutic benefit and on morale [were] independently assessed.”<sup>37</sup> This study was especially relevant because it focused specifically on the visual art collection in the hospital rather than on a participatory, art therapy-based program. Separate questionnaires were distributed to patients/visitors and staff. One point that seemed especially important from the staff surveys was a series of questions that asked staff to explain how they perceive the art impacts patients.<sup>38</sup> This perception would certainly impact caregivers’ overall opinions regarding the art program, and I therefore thought it important to include in the surveys for UK Arts in HealthCare. The other aspect of the Exeter evaluations that I adopted was a series of questions in which they asked patients and visitors about specific artworks in the collection.<sup>39</sup> A discussion with Elaine Sims, director of University of Michigan’s Gifts of Art program, also highlighted the importance of asking about specific artworks. On both surveys about the art collection at UK, therefore, we included a question that listed several of the major pieces and asked which they had encountered, as well as which pieces most stood out to them.

A third evaluation model came in the form of the HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) Survey. Also known as the CAHPS Hospital Survey, this standardized form was approved in 2005 as a national survey of hospital care. The survey has three main goals: to allow for objective comparisons among hospitals for consumers, to create incentives to improve quality of care, and to enhance accountability by

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<sup>37</sup> Scher and Senior, “Research and the Evaluation of the Exeter Health Care Arts Project,” 71.

<sup>38</sup> Ibid., 73. This topic was also discussed by Rosalia Staricoff in “Arts in Health: the value of evaluation,” 117.

<sup>39</sup> Scher and Senior, “Exeter Health Care Arts Project,” 75.



increasing transparency.<sup>40</sup> While this survey is not specifically designed for hospital art programs, the question structure and general design provided a template for the UK Arts in HealthCare surveys.

It quickly became apparent both from the model evaluations as well as observation that the groups impacted by the art collection encountered it in distinct ways. This led to the creation of two separate surveys—one for patients and visitors, and one for staff—modeled after the methods utilized by The Creative Center.<sup>41</sup> A third set of questions was also developed for individuals who had been extremely involved in the development process. These separate sets of questions took into account frequency of exposure to the collection, the medical or customer care perspective, and feelings of ownership or involvement.

Acknowledging these varying perspectives provided more nuanced qualitative feedback.

The surveys (see Appendix 1) contain a series of questions intended to create a better understanding of the program's audience. The first two questions on both surveys ask about the respondent's interest in the creative arts. The patient/visitor survey then transitions to questions specifically about UK Arts in HealthCare, measuring familiarity with the program and asking about specific artworks. The next questions focus on mood and how the respondent perceives the art impacts patients and families, followed by an open-ended query regarding what they think should be added to the collection. The final few questions provide demographic data, including reason for the visit, gender, age, and county of residence.

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<sup>40</sup> Agency for Healthcare Research and Quality, "HCAHPS Fact Sheet," *CAHPS Hospital Survey* (2012), <http://www.hcahponline.org/files/HCAHPS%20Fact%20Sheet%20May%202012.pdf>.

<sup>41</sup> KCI Research and Evaluation, "Satisfaction and Outcomes Assessment," 3.

The staff survey is fairly similar. There is an additional question toward the beginning that asks about involvement with the program, and there are several questions that address topics such as the importance of art in healthcare facilities, how the art collection has impacted their work, and how this work environment compares to other healthcare facilities at which they have been employed. The question regarding reason for the visit at the end of the patient/visitor survey was replaced with a request for their specific role in the hospital, data that allowed for comparison across different departments and spaces.

These two surveys required careful manipulation after initial research and writing. Once I had a draft of the surveys put together I sent them to Jason Britt, Marketing Research Manager for UK HealthCare. He analyzed the structure and content based upon his own experience conducting similar evaluations at UK. He also presented the survey drafts to a campus research committee who provided feedback regarding clarity—they considered everything from word choice to survey content to overall tone. This set of resources allowed me to apply what I had derived from my research and other similar studies to this unique setting. UK Chandler Hospital serves a diverse segment of Kentucky's population, and the patients and visitors in Pavilion A are quite different from those found in New York City or Exeter. With Jason Britt's input we were able to craft two surveys that served as the basis for a successful evaluation of the UK Arts in HealthCare program.

In addition to formulating the surveys, I was presented with the challenge of administering them to our two target groups: patients/visitors and staff. I drew heavily upon Jackie Hamilton's knowledge of the hospital and access to the facilities in order to accomplish

this task. Our goal was to select parts of the hospital with a steady stream of patients, visitors, and staff who would be inclined to stop for several minutes to complete the surveys. After careful consideration, two spaces were identified for the purpose of conducting intercept surveys: the intersection of hallways connecting the old and new pavilions, and the surgical waiting room.

The hallway intersection presented several advantages. First, the intersection serves as the juncture between the old and new hospital pavilions, connecting two main arteries in the hospital space. This, in addition to the intersection being close to the cafeteria, guaranteed that there would be a steady, diverse stream of patients, visitors, and staff to be surveyed, particularly during the lunch hour. The downside to this flow of traffic, however, was that it might have been less likely that people would have the time or inclination to stop and fill out a survey. This location also connects two focus areas for the Arts in HealthCare program: the Kentucky Wall and a rotating gallery space. Ideally, then, not only would there be a large audience to survey, but also that audience would be guaranteed to have seen at least some of the art in the hospital space.

The surgical waiting room also seemed to be a suitable place to conduct surveys. The long, well-lit waiting room houses many highlights of the art collection, including examples of work by several important Kentucky artists. Like the hallway intersection, the space therefore suggests that individuals within would have some familiarity with the hospital's art program. An added advantage of the waiting room is that, because they were often sitting and not otherwise occupied, people would be more inclined to complete the survey. This location did

have its drawbacks, however. The audience for these surveys was almost exclusively individuals visiting patients, permitting a much more limited sample in scope. Also, because many of the people in the waiting room would be experiencing high levels of stress, anxiety, and exhaustion, they might not always be inclined to complete the survey. Despite these challenges, though, the surgical waiting room seemed to be a strong alternative to the hallway intersection for the purpose of conducting intercept surveys.

In order to collect data from staff members, many of whom are too busy to stop and complete a survey at work, we sent out an electronic version of the survey to a select group of employees. This electronic version of the survey duplicated the format and wording of the questions on the staff survey. Jackie received approval for the survey to be emailed to all managers, nurses, technicians, secretaries, and other staff on the sixth and seventh floors of Pavilion A of Chandler Hospital. These individuals represent a wide range of occupations and interests and are all exposed to the same art every day; the comparison among their responses to the Arts in HealthCare program would be a valuable tool for assessing and understanding the overall staff response to the initiative.

Determining sample size was one of the final steps necessary before beginning to administer the surveys. As mentioned earlier, The Creative Center surveyed a total of sixty patients and fifty-six staff members across several hospitals. This evaluation was an extension of an initial study conducted in 2000 and 2001 to assess employee training and other programs. The initial objective of the study was to interview at minimum fifty patients and twenty staff

members; both of these goals were exceeded.<sup>42</sup> The evaluation for UK, because it is functioning as a preliminary model with no examples to emulate, could not base its target sample size on prior experience. Instead, drawing upon his extensive experience with research at the UK Chandler Medical Center, Jason Britt suggested that thirty patient/visitor and thirty staff surveys would be a strong target, but that fifty or more of each would be ideal.

### **Results**

With the goals formulated, I proceeded to conduct intercept surveys at both the hallway intersection as well as in the surgical waiting room. On two separate occasions, I set up a table just past the gallery space along the connecting corridor during the peak time for lunch traffic, and I collected surveys from a wide variety of patients/visitors and staff. On two other days I spent time in the surgical waiting room, approaching family members and friends of patients while they waited. The electronic version of the staff survey was also distributed at this time. In all, I collected eighty-one completed patient/visitor surveys and sixty-three staff responses, including both intercept surveys as well as electronic submissions.

Of the eighty-one patient/visitor surveys, forty-three were collected in the gallery space and thirty-eight were administered in the surgical waiting room. Fifty-eight of those surveyed indicated that they are female, nineteen male, and four left the question unanswered. Sixty-seven individuals identified as visitors, eight as patients, two as employees, and four chose not to respond. The spaces accessible for this survey project did not allow access to a large number of patients, and the process for gaining access to patients was too intensive for this initial

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<sup>42</sup> KCI Research and Evaluation, "Satisfaction and Outcomes Assessment," 2.

survey. Therefore, the responses for this data collection are heavily skewed toward visitors. Finally, nine of the patients/visitors surveyed indicated that it was their first time in the hospital; thirteen have visited once or twice in the past five years; sixteen have visited two to five times; thirteen have visited five to ten times; and twenty-six responded that they have been to the hospital ten or more times in the past five years, while four individuals did not respond.

The sixty-three staff responses represent twenty-three online surveys, thirty-eight conducted in the gallery space, and two surveys completed in the lobby of Pavilion A. Forty-two respondents identified themselves as female, sixteen as male, and five left the question blank. The staff members surveyed play a variety of roles in the hospital. Twenty of those surveyed are nurses, three are physicians, two are volunteers, and six hold a managerial or administrative position. Other responses included student, medical librarian, customer relations, clerical, and IT. In total, fifty-four provided their department or position and nine chose not to respond.

In order to compare and analyze responses, I grouped several categories of data into specific ranges or headings. For instance, for both sets of surveys I grouped the ages from the free response question into ranges: under twenty, twenty-one to thirty, thirty-one to forty—then each subsequent decade—followed by seventy-one and over, for a total of seven categories. I also asked individuals completing the patient/visitor survey to provide their county of residence. The responses included thirty-two Kentucky counties in addition to several out of state. I sorted these counties by population density, and grouped the results into

six categories: less than forty people/mile<sup>2</sup>, forty to eighty people/mile<sup>2</sup>, eighty to one hundred twenty people/mile<sup>2</sup>, one hundred twenty to one hundred sixty people/mile<sup>2</sup>, over one hundred sixty people/mile<sup>2</sup>, and out of state.<sup>43</sup> In order to compare the various ways in which respondents indicated their moods had been affected by the art collection, I sorted their responses into five categories: calming, distracting, positive, stimulating, and uplifting. These various groupings and categories allow me to make clearer, more effective comparisons.

I evaluated the survey results by organizing the questions and responses according to the two main issues I sought to address. First, I looked at how patients, visitors, and staff responded to the collection in terms of ownership. This included familiarity with the art, involvement in the art selection process, as well as qualitative feedback on favorite pieces and suggestions on how to expand the collection. The second focus of my assessment of the data was if and how the UK Arts in HealthCare program is meeting its goals. Perceived impact of the collection in terms of mood, work, and patient experience, as well as interest level, provided the basis of this analysis.

Concern with ownership has been a central feature of hospital art programs for centuries. From the wealthy donors shown in the background of the Spedale di Santa Maria della Scala fresco (Figure 1) to the 1923 *Monument to Georges Brugmann*, a sculpture of the wealthy benefactor of the Brugmann University Hospital in Brussels, names and images of donors are ubiquitous in hospital art collections. UK's Pavilion A is no exception. The chapel space, featuring the *Springtime in Kentucky* stained glass, bears the name of donor Myra Leigh

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<sup>43</sup> The population density figures I utilized were derived from the 2010 Census and were accessed through the United States Census Bureau.

Tobin, while many smaller pieces in the collection include the names of donors on the accompanying labels. While there are no examples of benefactor portraits in the new hospital, the presence of donor names throughout the space serves a similar function in terms of acknowledging the wealthy, elite patrons of the collection. This practice certainly conforms with the methods commonly used to display visual art in museums and other public venues. But as Victoria Myers explained in an interview, concern arose early on that the collection could be perceived as elitist, and that this perception might limit its appeal for patients, visitors, and staff. It is this issue, this concern with elitism and ownership, which I sought to explore through the surveys.

One of the most important factors in terms of collective ownership was the involvement of staff members during the art selection process. On the staff survey I asked how involved the respondent was in the UK Arts in HealthCare program, from not to somewhat to very.

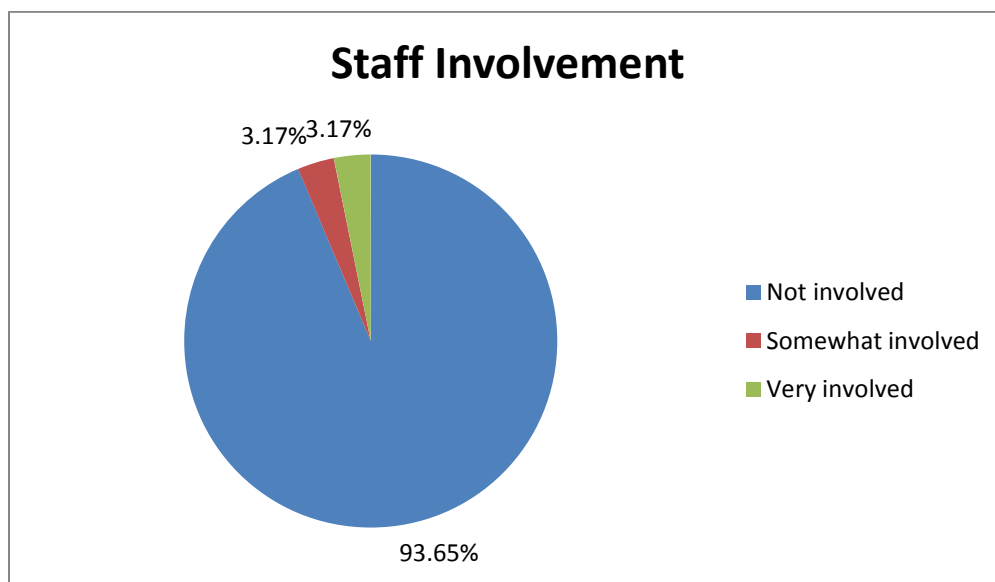


Figure 1. Represents staff involvement in UK Arts in HealthCare by percentage of total responses to the question. This graph also appears in Appendix 2 as Figure 1.



Despite the fact that many of the staff members surveyed had indeed been involved in the art selection process, as explained by Jackie when determining the survey sample group, nearly ninety-four percent of the sixty-three individuals surveyed indicated that they were not involved with UK Arts in HealthCare. Two respondents—both female—claimed that they were somewhat involved, and two others—again, both female—stated that they were very involved. Those who indicated a lack of involvement seem to be distributed across many age ranges, with no individuals in the 21-30, 31-40, 41-50, and 61-70 categories involved in the program.

(Appendix 2, Figure 2)

It is possible that the staff members surveyed did not associate their participation in selecting the art for their departments with the UK Arts in HealthCare program, so perhaps it would have been more effective to simply ask about their involvement in the art selection process. However, the response to this question does seem to strongly indicate either a disconnect between the hospital staff and the art program or a lack of brand awareness of the name “UK Arts in HealthCare.” It appears, based on the results of this survey, that participating in the Arts in HealthCare initiative does not constitute a recognized component of the work being done by hospital staff.

Awareness of the program is another indicator of how the hospital community has reacted to the art collection. Both surveys asked respondents to indicate how familiar they were with the UK Arts in HealthCare program. There were four answer choices: never heard of it, not familiar, somewhat familiar, and very familiar. (Appendix 2, Figures 3 and 4) Overall, the staff appeared to be more familiar with the art program than the patients and visitors, who

spend much less time in the space. Forty-nine percent of staff respondents indicated that they have either never heard of or are not familiar with the art program, compared to sixty-eight percent of patients and visitors. I would argue, however, that just fifty-one percent of staff members having some familiarity with the program does not demonstrate an effective presence in the hospital setting in terms of brand awareness, nor does it suggest that the hospital staff feels any sense of pride or ownership with regard to the art selected for their respective departments.

The percentage of patients and visitors grouped by number of visits indicates certain trends in terms of familiarity with the UK Arts in HealthCare program.

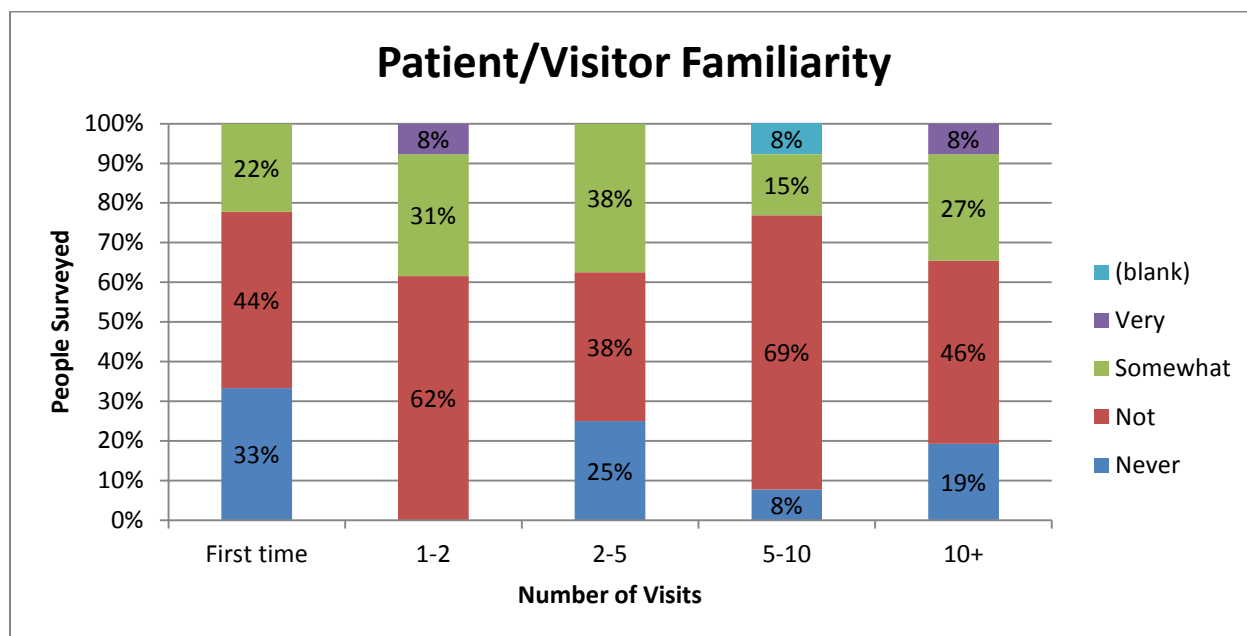


Figure 5. Represents patient/visitor familiarity with UK Arts in HealthCare as a percentage of total responses grouped by number of visits. For example, among first time patients and visitors, thirty-three percent had “never heard of it,” forty-four percent were “not familiar,” and twenty-two percent were “somewhat familiar.” This graph also appears in Appendix 2 as Figure 5.

No clear pattern emerges regarding an increase in familiarity corresponding with an increase in number of visits, nor is the inverse true. However, when we compare the first time visitors to the respondents with ten or more visits, the percentage of people who have never heard of the program diminishes with more visits, while the percentage of people who are somewhat familiar with the program increases with more visits. Unfortunately, these results do not present any obvious patterns, and are therefore inconclusive, neither supporting nor negating any argument with regard to a sense of communal ownership of the art collection.

The open-response questions provided additional feedback that, while not definitive, does serve as an indicator of community engagement and pride. For instance, the staff survey included a space for respondents to identify their favorite piece in the collection. Over half of those surveyed, thirty-five in total, responded to this question. This compares favorably to a related question posed on the survey, “do you have a favorite piece of art in the collection?” Only twelve respondents indicated “yes,” while eleven said “no” and the remaining forty left the question blank. Out of the thirty-five staff members who chose a favorite piece in the collection, fifteen indicated that the Kentucky Wall was their favorite feature of the art collection, while four others chose folk art pieces, including the walking sticks. Other favorites included the blown glass in the surgical waiting room, the *Ginkgo* sculpture in the atrium, as well as various paintings and photographs displayed throughout the hospital. Additionally, three individuals chose past or present gallery exhibits: Albert Moser’s panoramic photography and a quilt installation. Interestingly, fifty-five percent of the staff members who claimed to be unfamiliar with the UK Arts in HealthCare program selected a favorite artwork, while fifty-six percent of those who stated familiarity with the program also responded to the question. This

comparison seems to suggest that staff members connect with and appreciate the artwork without regard to their awareness of the UK Arts in HealthCare initiative, that for some the visual art has simply become a fixed and understood component of their environment.

Beyond assessing the pieces currently in the collection, patients, visitors, and staff were all asked to identify the type(s) of art they would like to see incorporated in an expanded collection. Fifty-seven percent of patients and visitors surveyed (forty-six respondents) either did not respond or did not provide a specific suggestion for improvement; two respondents simply offered positive feedback on the collection and any future decisions to expand. The other forty-three percent (thirty-five respondents) provided a wide range of responses: eight individuals suggested incorporating more art by and for children, five wanted to see more local artists and local subject matter represented, while three requested more scenes of nature and landscapes. Other suggestions included more photography, UK- or Wildcat-related art, animals, sculptures, and wood work. Only one specific request—for images of classic cars—is not currently represented in the collection. This would seem to suggest that the current collection embodies the types of art that appeal to the patients and visitors served by the hospital. Because fewer than fifty percent of respondents provided some sort of suggestion for expansion, however, the results might indicate that patients and visitors are disconnected from the artwork and do not necessarily see it as a collection assembled for them.

By contrast, fifty-one percent of the staff members surveyed (thirty-two respondents) provided feedback on how to expand the visual art collection. One respondent did indicate that rather than expand the art collection, more money should be invested in hospital

improvements. This type of response is one that UK Arts in HealthCare has often encountered, despite the fact that the art collection has been funded by donations. Aside from this comment, several individuals provided specific suggestions—art in patients’ rooms in Pavilion H, more photography collections like the *Celebrate Kentucky Wall*, murals in the older part of the hospital—while others indicated general categories of art or subject matter, such as more painting or sculpture, quilts, flowers, and more African art. Three artists were mentioned by name: LaVon Williams, Arturo Sandoval, and John Lackey. One staff member suggested that some pieces be hung or displayed on a sight line appropriate for children and patients in wheelchairs. Nine responses included a reference to local or Kentucky artists or subject matter, and two indicated an interest in incorporating employee art within the collection. These enthusiastic, sometimes detailed responses demonstrate interest in and a willingness to participate in ownership of the art collection among staff, yet the arguably low percentage of total responses follows the established trend that seems to indicate a widespread lack of interest in the artwork.

Patterns in the data collected demonstrate that across both of the groups surveyed, patients/visitors and staff, the art collection falls short in terms of fostering a sense of communal ownership, pride, and interest. These trends, seen first in staff involvement in the program and then in patient/visitor and staff familiarity with UK Arts in HealthCare, were also supported by the quantity and type of feedback received on the open-response questions on both surveys. Only about half of the staff members surveyed, and an even smaller percentage of patients and visitors, responded in a manner to indicate engagement with the collection. While the sample size of this survey is by no means a significant portion of the hospital

population, a response to the feedback received from those surveyed, perhaps through utilizing the suggestions to expand the collection, could assist UK Arts in HealthCare in encouraging a sense of communal ownership of and participation in the visual art collection.

The second function of this data assessment was to find indications of the level at which the UK Arts in HealthCare program is succeeding. As mentioned in Section 2 (page 21), the mission statement of the program claims that it will “enhance the environment” of the hospital by “recognizing the spiritual and healing effect of the arts.” The program will “focus on the spiritual and emotional well-being of [its] constituents,” while acknowledging “the art and the artists as a powerful entity that can elicit calming creative resources from patients, families, and caregivers.” I utilized responses to questions dealing with mood, interest level, impact, and work/patient experience to determine the level at which UK Arts in HealthCare is meeting its goals.

The UK Arts in HealthCare program cannot meet the needs of its constituents if it does not first assess what those needs might be with regard to the arts. One of the first questions posed on both surveys was how interested the respondent was in creative arts. The answer choices were “not interested at all,” “somewhat interested,” and “very interested.” Fifty-three percent of patients and visitors indicated having some interest in creative arts, forty-one percent claimed to be very interested, while six percent responded “not interested.”

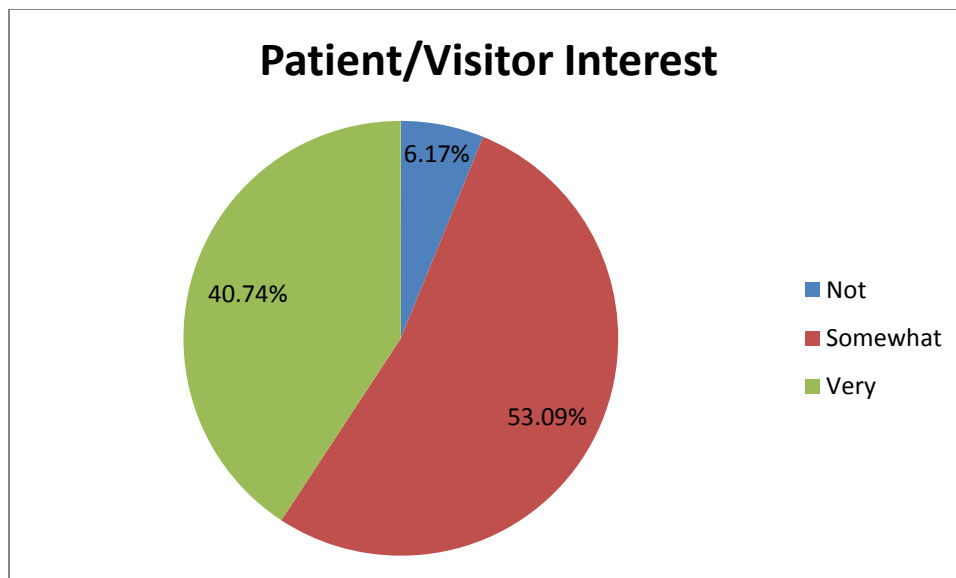


Figure 6. Represents patient/visitor interest in the creative arts as a percentage of total responses. This graph also appears in Appendix 2 as Figure 6.

The staff responses were similar: forty-eight percent responded “very interested,” forty-six percent indicated that they were somewhat interested, and six percent were “not interested.”

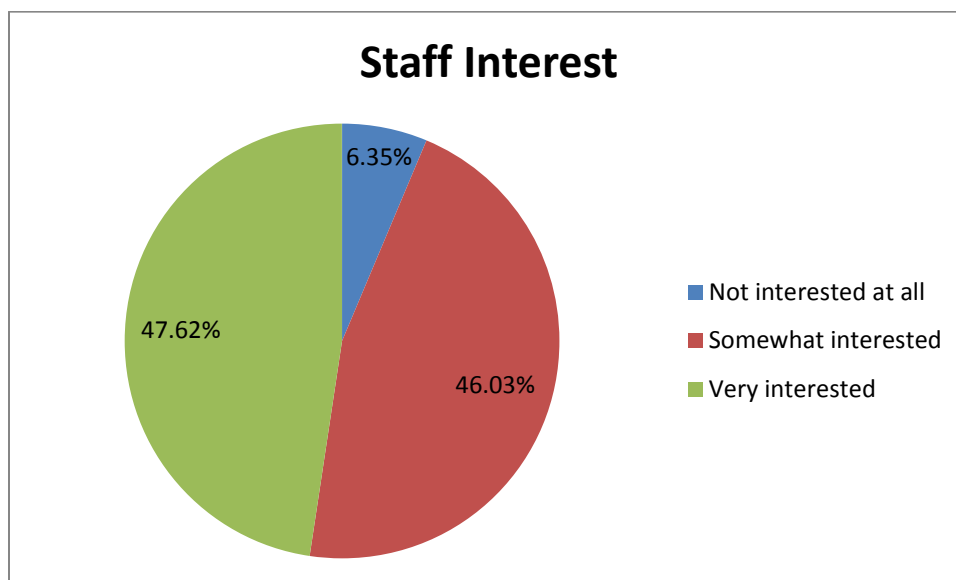


Figure 7. Represents staff interest in the creative arts as a percentage of total responses. This graph also appears in Appendix 2 as Figure 7.

I was also able to compare these interest levels across different demographics. For instance, the gender breakdown of patients and visitors yielded results similar to those for the interest level of the group as a whole. (Appendix 2, Figure 8) The only slight difference is that eleven percent of men were uninterested in creative arts, compared to just six percent in the overall survey population. The gender breakdown of staff yielded significantly different results from those of the total survey group. (Appendix 2, Figure 9) Sixty and thirty-one percent of women and men, respectively, were “very interested” in creative arts, as compared to forty-eight percent of total staff respondents. Thirty-eight percent of women were “somewhat interested,” compared to fifty-six percent of men and forty-six percent of the total. Just two percent of women were “not interested,” compared to thirteen percent of men and six percent of the total. These results indicate that significantly more female staff members are interested in the creative arts. Other factors, including age and county of residence, either produced results similar to those across the total population or did not yield useful or distinctive findings among the demographic categories.

Having confirmed that a significant portion of patients, visitors, and staff are interested in creative arts, it can be assumed that those surveyed, and by extension the hospital population as a whole, would welcome visual arts as a way to “humanize the environment” of the hospital setting. An open-response question on the staff survey asked whether or not they perceived art to be an important element in a hospital. A significant portion of those surveyed, seventy-five percent, indicated that art is an important element in a healthcare facility. In fact, one staff member remarked that “It is humanizing for the space. It brings people together to discuss how it affects them,” while another felt it gives the space “a more humanitarian feel.”



Some respondents also referenced the healing capacity of art. One individual claimed that “it accelerates the healing process,” while another stated that “the senses are an important part of healing. When they are stimulated in a positive way, it leads to a better experience.” Three individuals responded that art is not important in hospitals, one respondent said “I don’t know,” and twelve left the question blank. All three of the negative responses included a reference to the wastefulness of spending money on art as opposed to medical care, a common argument against the program. Overall, these results seem to indicate that the art is being perceived positively by those who work in the hospital.

Yet, when compared with the data on familiarity with UK Arts in HealthCare, all of the individuals who responded “no” to the importance of art (three respondents) were somewhat familiar with the program.

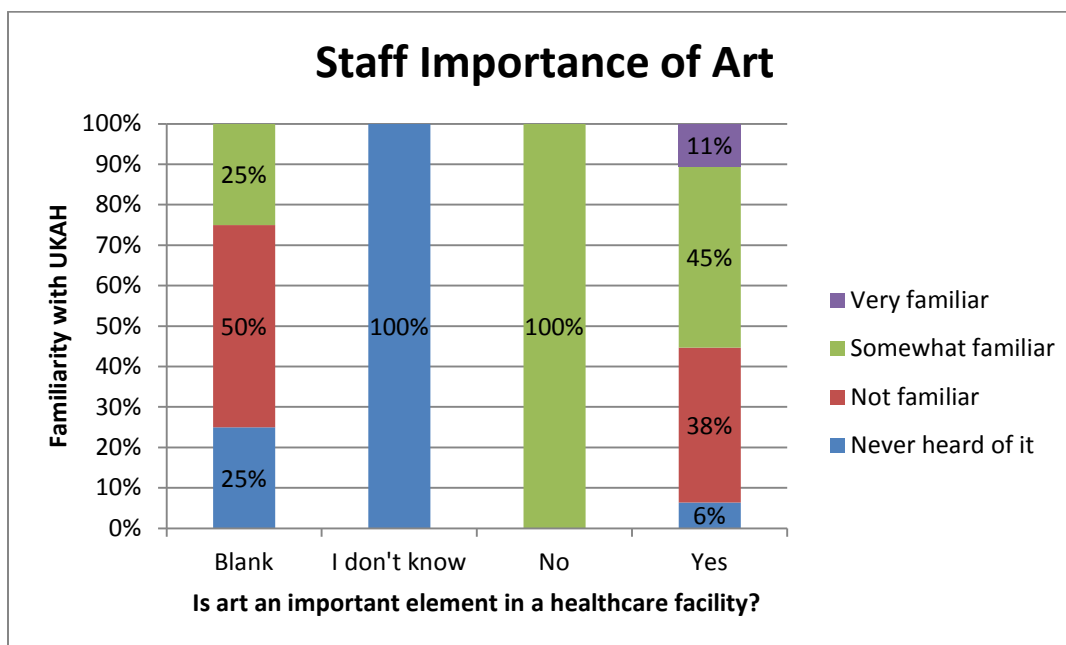


Figure 10. Represents the percentage of staff familiarity with UK Arts in HealthCare compared to their assessment of art as an important element in a healthcare facility. This graph also appears in Appendix 2 as Figure 10.

In Figure 10, we compare the percentage of individuals familiar or unfamiliar with the program with their assessment of the value of art in a healthcare facility. Forty-four percent of those who responded “yes” to the importance of art in healthcare (twenty-one total) expressed unfamiliarity with the UK Arts in HealthCare program; fifty-six percent (twenty-six total) were either somewhat or very familiar with the program. If these results reflect the staff population as a whole, appreciation for the presence of art in the hospital space does not correspond with familiarity with the UK Arts in HealthCare initiative.

One of the most critical metrics for determining whether the program meets its goals is the effect the art collection has had on the moods of patients, visitors, and staff. I first asked each group to indicate either “yes” or “no” in response to “has seeing art in the hospital affected your mood?” (Appendix 2, Figure 11) Fourteen percent of patients/visitors said “no,” eighty percent of patients/visitors said “yes,” and six percent left the question blank. Eleven percent of staff members said “no,” eighty-one percent said “yes,” and eight percent did not respond. In both instances, the overwhelming conclusion to be drawn is that the art has indeed affected the moods of people who experience it.

Following this question, I asked respondents to explain how their mood has been affected. As mentioned earlier, I sorted these responses into five separate categories: calming, distracting, positive, stimulating, and uplifting. The top two responses for staff were “positive,” at twenty-five percent, and “calming,” at twenty-two percent. The top response for patients and visitors was “uplifting,” at twenty-six percent, followed by “calming,” at twenty percent.

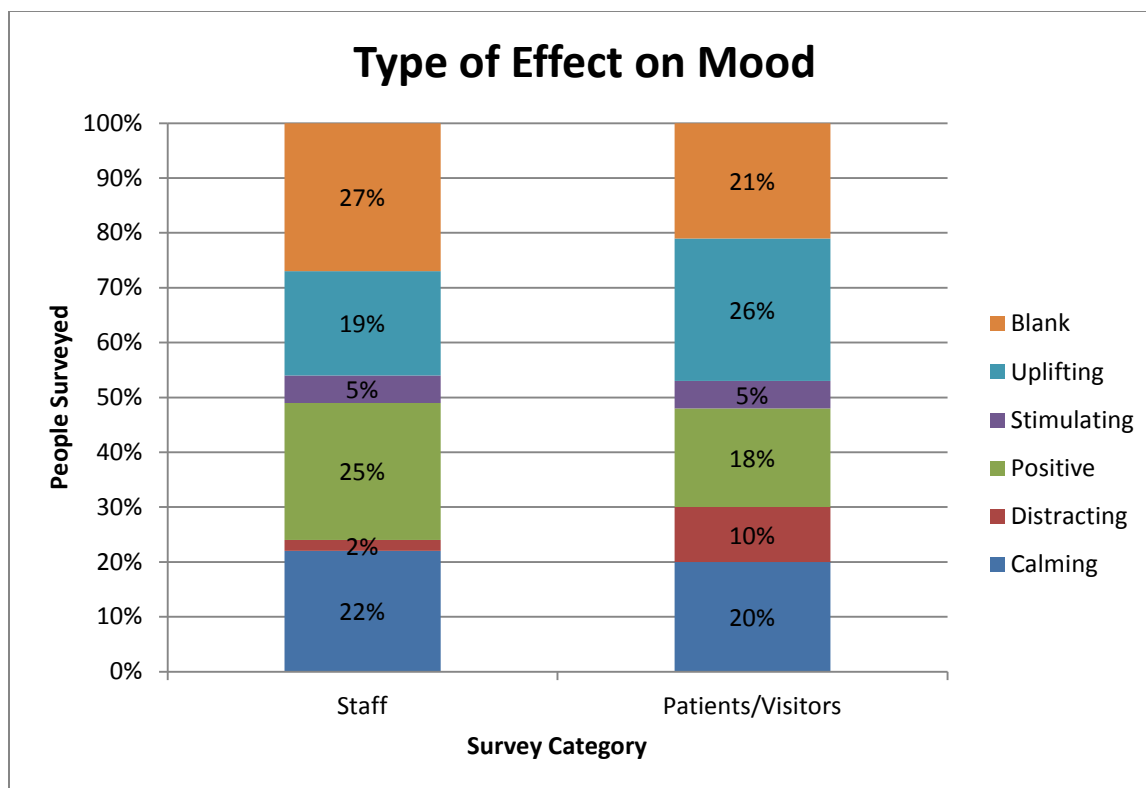


Figure 12. Represents percentages of patients/visitors and staff in terms of the type of effect the art had on their mood. For example, twenty-two percent of staff and twenty percent of patients/visitors found the art collection to be “calming.” This graph also appears in Appendix 2 as Figure 12.

A far greater percentage of patients and visitors found the art to be distracting, i.e. drawing their attention away from medical and other concerns. One visitor stated “it seems to just help get your mind off some things,” and another claimed “it can be a distraction from the worries that are associated with having a family member in the hospital.” In general, the high percentage of positive comments from patients, visitors, and staff—seventy-nine percent from patients/visitors and seventy-three percent from staff—indicates that the Arts in HealthCare program has indeed focused “on the spiritual and emotional well-being of [its] constituents.”

Breaking down the responses regarding effects on mood by gender yielded some interesting comparisons. (Appendix 2, Figures 13 and 14) For female patients and visitors, the

top two responses were “uplifting” and “calming,” while for male patients and visitors the top two responses were “uplifting” and “distracting.” Men were more likely to find the art “distracting” than women, who were more likely to see the effect on their mood as “positive.” For female staff, the top two responses were “calming” and “uplifting,” while for male staff the top two responses were “positive” and “calming.” Women staff members were more likely to find the art “distracting;” men were more likely to find it “stimulating.” These responses may allow the program to better understand the emotional needs being met by the art collection, and to tailor new efforts to continue to meet those needs.

Both the patient/visitor and the staff surveys included a series of questions addressing the respondents’ perceptions of the art in the hospital with regard to its impact on comfort and overall experience. (Appendix 1) The five questions were specifically focused on patient comfort, family/visitor comfort, patient recovery time, overall patient experience, and overall family/visitor experience. These five categories were each ranked on a scale from one to seven, with one being “no impact” and seven being “a lot of impact.”

Because both surveys had this identical set of questions, it is possible to compare the staff responses to those of patients and visitors. (Appendix 2, Figures 15-25) For patient comfort, “seven” was the most frequent response among patients, visitors, and staff. (Appendix 2, Figures 15 and 16) With “four” indicating the median level of impact, eighty-eight percent of staff and eighty-five percent of patients and visitors perceived the impact of art on patient comfort as at or above the median. The mean value of staff responses was 5.1, and for patients/visitors it was 5, both well above the median. These responses seem to reflect a

consensus among both groups that the art collection has at least a moderate impact on patient comfort.

In terms of family/visitor comfort, “seven” was the most frequent response for patients, visitors, and staff. (Appendix 2, Figures 17 and 18) Ninety-five percent of staff and ninety percent of patients and visitors saw the impact of the hospital art collection on family/visitor comfort as at or above the median. The mean value of staff responses was 5.7, and for patients/visitors it was 5.5, both significantly higher than the median. While these responses are overwhelmingly positive, it is interesting to note that staff members, on average, perceived the impact on family and visitor comfort to be higher than did the families and visitors themselves. Both survey groups also assessed the value of the art for families and visitors to be higher than for patients.

Patient recovery time received the least-favorable scores among the five categories. (Appendix 2, Figures 19 and 20) “Seven” was still the most frequent response for both surveys, but the results also included a significantly larger proportion of respondents who assessed the value of the program below the median. Only sixty-eight percent of staff members and seventy-seven percent of patients and visitors saw the impact of the art collection on patient recovery as at or above the median. The mean value of staff responses was 4.2 and for patient/visitor responses it was 4.7, both only slightly above the median. This indicates that while there is a strong correlation for respondents in terms of the collection creating a more comfortable environment, those same respondents did not perceive the “healing effect of the arts” emphasized in the program mission statement.

The fourth category for analysis was overall patient experience. (Appendix 2, Figures 21 and 22) “Seven” was again the most frequent response on both surveys. Ninety percent of staff members and eighty-five percent of patients and visitors perceived the impact on overall experience to be greater than or equal to the median value, both results almost identical to those for the first category, patient comfort. The mean value of staff responses was 5.2 and for patient/visitor responses it was 5.1, both well above the median. These results, particularly when paired with the responses concerning patient comfort, demonstrate a consensus among respondents with regard to the positive impact the art collection has on the patient experience.

The final category was overall family/visitor experience. (Appendix 2, Figures 23 and 24) Both surveys once again had “seven” as the most frequent response. Ninety-five percent of staff members and ninety-two percent of patients and visitors indicated an impact on overall experience at or above the median value, results quite similar to those for the second category, family/visitor comfort. The mean value of staff responses was 5.8 and for patient/visitor responses it was 5.6, both significantly greater than the median. This suggests, especially in conjunction with the assessment of family/visitor comfort, that both groups of respondents have observed that the art collection has a significant positive impact on families and visitors.

By isolating just the patient responses to the surveys—seven in total—it is possible to compare patient perceptions of impact to those of the entire pool of patient/visitor respondents.

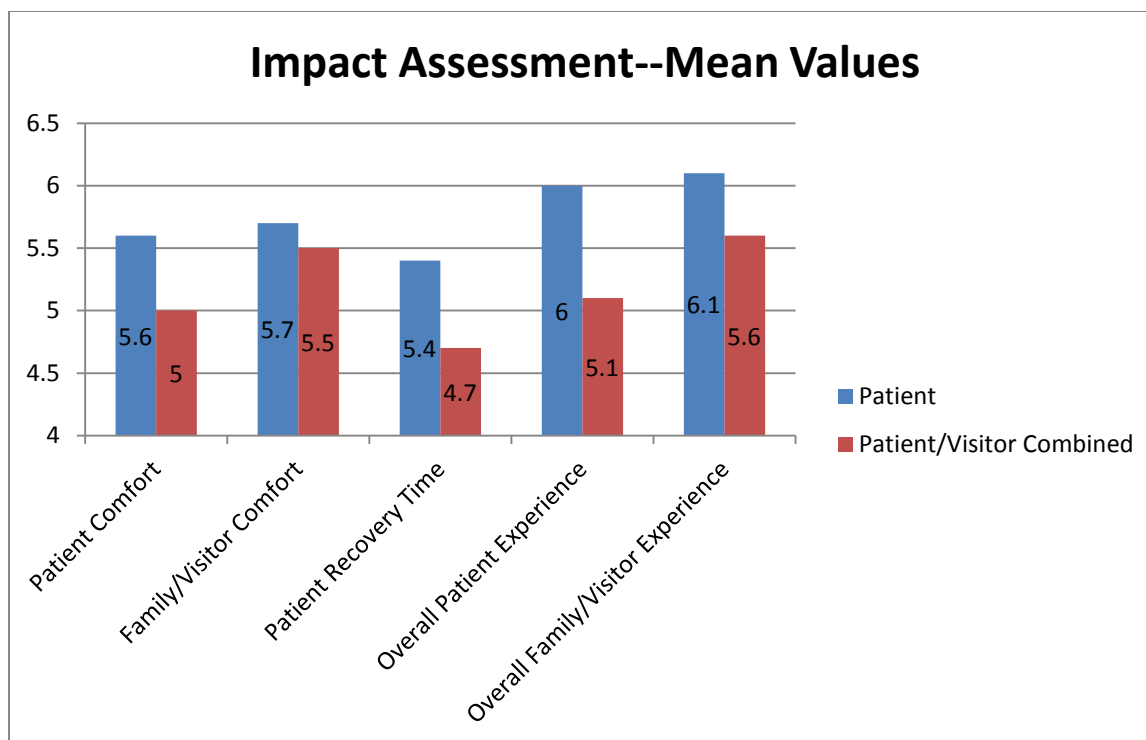


Figure 26. Represents a comparison of the mean values of the impact assessment of the art collection between isolated patient and patient/visitor combined responses. For example, the mean value, on a scale from one to seven, of the assessed impact on patient comfort was 5.6 for isolated patient respondents and 5 for patient/visitor combined respondents. This graph also appears in Appendix 2 as Figure 26.

In all five categories, the mean value of the patient assessment is higher than that of patients and visitors combined. This is especially true for the three patient categories. For patient comfort, the mean value of patient responses was 5.6, compared to the overall patient/visitor value of 5. For patient recovery time, the mean value of patient responses was 5.4, significantly higher than the overall patient/visitor value of 4.7. And for overall patient experience, the mean value of patient responses was 6, well above the overall patient/visitor value of 5.1. A study involving a larger pool of patients could potentially corroborate these findings, but in terms of this survey, the total patient count of eight is too small a sample size from which to draw any significant conclusions.

The only trend that seems apparent and conclusive when comparing the responses to this set of questions is that the impact of the art is perceived to be greater on families and visitors than on patients. All three patient categories had lower mean values than the family/visitor categories, and the patient recovery time received an especially low valuation. Because the goal of UK Arts in HealthCare is to serve all of the individuals who interact with and within the hospital environment, it can be concluded that, from the perspective of those surveyed, the program is currently perceived to be serving patients less effectively than it is serving families and visitors.

Aside from patients, families, and visitors, the art collection is intended to positively impact staff members by “elicit[ing] calming creative resources.” In order to determine how successfully the program is meeting this goal, I asked the staff to indicate whether or not the art collection has impacted their work. Only one-third of the staff members surveyed responded to the question. (Appendix 2, Figure 27) Out of these twenty-one responses, sixty-two percent were negative, indicating that the art had not impacted their work, and thirty-eight percent were positive, implying some impact. Additionally, one hundred percent of the affirmative responses were from female staff members. (Appendix 2, Figure 28) This data would suggest that, in general, the staff does not perceive the art collection to have a significant impact on their work, and, among staff members, men are much less likely to perceive an impact than women.

The follow-up question on the survey asked staff members to explain how the art collection in the hospital impacted their work. Out of thirty-four total responses, twenty-two



explained the positive impact art has had on their work. The other answers ranged from “N/A” to “not really” to “not that I know of.” Among the positive responses, many staff members remarked on how they have observed the art has impacted patients and families, which in turn made their jobs easier. One respondent commented “I feel patients and families are put at ease in such a beautiful room with a nature background. Working with relaxed patients and family is a great help to my work.” Others identified how the art has made a personal impact on them. One staff member said of the art “it reminds me there is a point and goal to medical treatment. It reminds me it is a calling and not a job.” This type of feedback is certainly positive, and it attests to the fact that in some cases the art collection affects staff members’ work. However, the paucity of responses, to both the open response question and the yes/no question regarding work impact, could be interpreted to show that the Arts in HealthCare program is not adequately meeting its goals with regard to caregivers.

### ***Conclusion***

In an essay entitled “Whose Culture?” Gwyneth Lamb stated: “A hospital is not an art gallery. It is the most public of public spaces. Its mixture of patients, staff, volunteers, relatives, carers is about the widest cross section of society you will find anywhere.”<sup>44</sup> This is certainly true of the UK Medical Center. The hospital serves patients and families from the urban environs of Lexington as well as from more distant, rural counties. The students and staff members who walk through the space daily represent a myriad of backgrounds and interests. This constituent diversity challenged the UK Arts in HealthCare program when it developed a

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<sup>44</sup> This essay, written by Gwyneth Lamb, is part of an anthology that contains various perspectives on the arts in healthcare movement. Turner and Senior, eds., *A Powerful Force for Good: Culture, Health, and the Arts—An Anthology* (Manchester Metropolitan University, 2000), 4.

collection of visual art to “focus on the spiritual and emotional well-being” of these disparate people.

One of the major difficulties the program felt that it faced was that the art collection could be poorly received by members of the general public if it was displayed in a way that evokes an elitist tone. According to Lamb, “if our hospitals are filled with works of art to which the majority of people cannot relate, they will get the message that hospitals are designed for other kinds of people who can understand, people with education and critical faculties, but people who are not like them.”<sup>45</sup> This concern led the program to work hard to create a communal identity and sense of ownership within the hospital that would in turn extend to the university, the city, and even the region. By incorporating a variety of visually-accessible pieces created by local artists, the donors and committee members of UK Arts in HealthCare sought to dispel the impression of an elitist fine art collection and replace it with pride in the local art community, through the inclusion of folk art pieces with more traditional paintings and sculpture, and to foster a beautiful, calming hospital environment.

Despite an awareness of this concern, however, in some ways the UK program continued a centuries-long tradition of emphasizing recognition of donors and presenting the audience with inaccessible artwork. Van der Weyden’s *The Last Judgment* (Figure 2) included portraits of the couple who commissioned the work for the hospital, honoring their contribution while also presenting them as a model for exemplary behavior. While her portrait is not present within the space, Myra Leigh Tobin’s name across the face of the UK hospital chapel (Figure 7) functions in a similar fashion; by donating money to adorn the space, she has

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<sup>45</sup> Ibid, 5.

visually associated herself with the chapel and the art. Paintings such as Bolotowsky's *Abstraction* (Figure 5) began to be incorporated into hospital art programs in the twentieth century without consideration for their inaccessibility to a general audience. Although most of the art in the UK collection is representational, there are several pieces, including the *Ginkgo* (Figure 6), that fall on the abstract end of the artistic spectrum. These works, while they may resonate with much of their audience, tend also to seem elitist and, therefore, excluding, to patients, visitors, and staff in the hospital.

The survey results seem to indicate that generally the UK Arts in HealthCare program has not been as inclusive as its mission statement and its constituency demands. Very few staff members consider themselves involved in the program, despite the fact that many were included in the art selection process. Sixty-eight percent of patients and visitors and forty-nine percent of the staff members surveyed were unfamiliar with the program by name. (Appendix 2, Figures 4 and 5) Open-response queries regarding favorite artworks and the expansion of the collection also proved underwhelming in terms of total responses, further reinforcing a sense of disengagement with the art among patients, visitors, and staff.

Although the survey results were largely less than favorable, there was some positive feedback received in terms of ownership and collective interest in the visual art program. For instance, fifty-five percent of the staff members who claimed to be unfamiliar with the UK Arts in HealthCare program nonetheless selected a favorite artwork from the collection, compared to fifty-six percent of those who stated familiarity with the program. This suggests that staff members connect with and appreciate the artwork even without being aware of the UK Arts in

HealthCare initiative. Additionally, only one specific request made with regard to subject matter for new artworks is not currently represented in the collection. Although less than fifty percent of respondents provided suggestions for an expanded collection, the survey results seem to indicate that the current artwork, in terms of subject, style, and medium, reflects the interests of the patients, visitors, and staff in the hospital.

While few studies with published results are available for comparison, the two evaluations from which I derived several questions for my own surveys do provide an opportunity for some comparisons, the Creative Center in terms of ownership and the Exeter Health Care Arts Project evaluation, discussed later, in terms of program efficacy. In the case of issues of ownership, the Creative Center study asked respondents (in this instance staff members) to indicate their familiarity with the program. Of the Creative Center staff members surveyed, sixty-two percent indicated that they were very familiar with the program, twenty-three percent were somewhat familiar, four percent were unsure, and eleven percent were not familiar with the program.<sup>46</sup> The Creative Center results are much more favorable than those of the UK staff in my survey. Only eight percent of UK staff claimed to be very familiar with the program, while forty-eight percent were either not familiar with it or had never heard of it. While the Creative Center's program is rooted in art therapy rather than a visual art collection, UK Arts in HealthCare nonetheless compares unfavorably in terms of engaging staff members.

The second major topic I sought to address in this evaluation was if and how UK Arts in HealthCare is meeting its stated objectives. Inspired by the work of Florence Nightingale, contemporary hospital art programs have begun to value the impact art can have on patients

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<sup>46</sup> KCI Research and Evaluation, "Satisfaction and Outcomes Assessment," 13.

and the care giving experience. The UK mission statement explicitly states that it “will enhance [the] environment by recognizing the spiritual and healing effect of the arts.” While this study was not designed to measure or evaluate the possible medical and psychological effects of the artwork on patients and their families, it did ask patients, visitors, and staff to share their perceptions of this potential impact.

Because this art collection is intended to address the specific needs of the UK community, it was important to establish a level of interest in the arts within this community. Fortunately, patients, visitors, and staff overwhelmingly responded that they were somewhat or very interested in creative arts—just six percent of patients, visitors, and staff were not at all interested. (Appendix 2, Figures 6-9) Another source of positive feedback came from questions about the effect of the artwork on the moods of patients, visitors, and staff. A large majority (eighty-one percent of staff and eighty percent of patients/visitors) believe that the art did impact their mood. (Appendix 2, Figure 11) The types of effects, including uplifting, stimulating, and calming, were generally positive as well. (Appendix 2, Figures 12-14) Additionally, three-quarters of the staff who responded to the survey felt that art is an important element within a healthcare facility.

The series of questions that asked respondents to rate various outcomes on a scale from one to seven, seven being the highest or most impact, also yielded a generally positive assessment of how the program meets its goals with regard to patient and visitor comfort, patient recovery time, and overall experience for patients, visitors, and families. (Appendix 2, Figures 15-26) In all five categories, the impact assessed was above the mean value for on both

surveys. Patient recovery time received the lowest scores, while family/visitor comfort and overall experience received the highest scores. The comparatively lower scores in all three patient categories are not reflected when patient responses are isolated from the patient/visitor combined totals. Unfortunately, the small sample size of patients makes those results purely speculative; a second study with a much larger group of patients would be necessary to confirm the results of the assessment.

In general, these results demonstrate that the groups benefitting most from the presence of art in the hospital are visitors and families. Because the goal of UK Arts in HealthCare is to serve all of the individuals who interact with and within the hospital environment, it can be concluded that, from the perspective of those surveyed, the program is currently failing to serve everyone equally effectively. Analysis of the staff survey responses with regard to work impact could be considered disappointing if the program realistically expected the art collection to positively affect their work. (Appendix 2, Figure 27)

Three comparisons can be made between the results from the evaluation of UK Arts in HealthCare and the Exeter Health Care Arts Project evaluation, another study used as a model for several questions in these surveys. According to a report on the Exeter results, “90.4% of users [patients and visitors] agreed that arts in health care settings make a positive difference to their experience of health care and/or of visiting hospital, and 64% of clinical staff confirmed that arts made a positive difference to the experience of working in health care.”<sup>47</sup> The set of questions dealing with the UK program’s impact on patients and on visitors and families yielded similarly favorable results. However, the UK staff assessment of work impact produced a much

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<sup>47</sup> Scher and Senior, “Exeter Health Care Arts Project,” 73.

lower percentage of staff members who perceive the art collection to have a positive impact on their work experience. On the Exeter survey, patients and visitors asked to evaluate the effect of art on the healing process yielded thirty-three percent positive and fifty-one percent negative. Staff responded with seventy percent positive and twenty-five percent negative. The Exeter results can be compared specifically to the question regarding patient recovery time on the UK surveys. Ninety-seven percent of staff and ninety-two percent of patients/visitors assessed the impact at or above the median. This suggests a favorable comparison between UK Arts in HealthCare and other hospital arts programs in terms of perceived effectiveness of the program.

Based upon the outcome of these evaluations, I have identified several areas for improvement for future evaluations. First, a few questions or sets of questions did not yield significant or useful results. One of these types of questions, regarding specific artworks in the hospital, could be improved to better assess the contents of the art collection. Respondents were asked if they had seen certain specific pieces or categories of art in the hospital space, such as the Kentucky Wall and folk art. Rather than simply asking whether or not they had seen these artworks, it would be more beneficial to have respondents evaluate certain pieces that they have seen.<sup>48</sup> The survey could ask them to indicate if they like the specific artwork, which among a select group is their favorite piece, or an open-response seeking feedback on how they felt upon viewing the artwork. This level of specificity with regard to the art collection might provide stronger feedback on how to expand or tailor the collection to better meet the needs of the audience.

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<sup>48</sup> This style of evaluation was utilized in the Exeter surveys.

Another question that could be improved for the future is the staff evaluation of work impact. The current question, or series of questions, is too general. It would be more useful to ask staff members how UK Arts in HealthCare has impacted their ability to provide patient care.<sup>49</sup> This line of questioning would provide an opportunity to better assess if the program is meeting its goal to “elicit calming creative resources from patients, families and care givers.”

Additional suggestions for improvement include repeating the survey several more times over a longer period, allowing for a broader base of responses; gaining more access to patients in order to collect their feedback and impressions of the collection; and working to further edit and clarify those questions and/or sections of the surveys that seemed to prove confusing for patients, visitors, and staff.

The UK Arts in HealthCare program has become a fixture of UK Chandler Medical Center. The art collection has permeated every space throughout the hospital, and it is available for viewing by thousands of patients, visitors, and staff members on a daily basis. This initial evaluation of the program seems to indicate that the hospital constituency feels somewhat disconnected from the program, although more focused questions might serve to identify whether respondents feel disconnected from the art collection itself or, rather, from the UK Arts in HealthCare program. Initial feedback also indicates that visitors may be benefitting the most from the collection, and that in order to fulfill the goals set forth in the program’s mission statement, more attention needs to be focused on the well-being of patients and staff. For the most part, however, these evaluations confirm that the time when “the effect in sickness of beautiful objects, of variety of objects, and especially of brilliancy of colour is hardly at all

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<sup>49</sup> This new question format is modeled off of the Creative Center evaluations.



appreciated,” as described by Florence Nightingale, is long past.<sup>50</sup> The individuals who encounter the vast collection of artwork displayed throughout the hospital space seem, in large part, to appreciate the impact this art can have as a mechanism by which to humanize the environment. As the program continues to grow and evolve, it will hopefully remain concerned with how best to relate to and serve the patients, visitors, and staff at UK as part of the hospital’s commitment to holistic care and overall well-being.

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<sup>50</sup> Nightingale, *Notes on Nursing*, 58.

## **Appendix 1—Patient/Visitor Survey**

The UK Arts in HealthCare program began in 2007 with a mission to “create an environment of care and to focus on the spiritual and emotional well-being of our patients, families, caregivers, and staff.” The creation of a visual art collection became an early focus of the program. The hallways, galleries, lobbies, and waiting rooms now feature a diverse selection of art. The collection is intended to appeal to the wide array of individuals who encounter it daily. With that in mind, we would like to assess the strengths and weaknesses of the program in order to better fulfill our mission and improve our ability to serve patients, visitors, and staff. We would appreciate your honest feedback. **Please feel free to skip any question(s). All responses will remain confidential.**

1. In general, how interested are you in creative arts like dance, theater, visual arts, etc.?

- Very interested
- Somewhat interested
- Not interested at all

2. For each of the following, please circle how often you attend an arts event or participate in the creative arts?

Dance:            0 times per month    1-2 times per month    3 or more times a month

Theater:           0 times per month    1-2 times per month    3 or more times a month

Music:             0 times per month    1-2 times per month    3 or more times a month

Visual art:        0 times per month    1-2 times per month    3 or more times a month

Film:               0 times per month    1-2 times per month    3 or more times a month

3. How familiar are you with the UK Arts in HealthCare program?

- Very familiar
- Somewhat familiar
- Not familiar
- Never heard of it

4. What kinds of art have you seen in the hospital? (check all that apply)

- Paintings
- Theater
- Music
- The Ginkgo sculpture

- Folk art
- The Kentucky Wall
- Other (please specify): \_\_\_\_\_
- I have not seen any art in the hospital → **SKIP TO QUESTION 8**

5. Did seeing art in the hospital affect your mood?

- Yes
- No

6. Please explain how your mood was affected.

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7. How much impact do you think the hospital art has had on the patients, families, and visitors? For each of the following, please indicate on a scale from 1 to 7, with 1 being “No impact” and 7 being “A lot of impact”.

	No Impact						A lot of Impact
Patient comfort:	1	2	3	4	5	6	7
Family/visitor comfort:	1	2	3	4	5	6	7
Patient recovery time:	1	2	3	4	5	6	7
The overall patient experience:	1	2	3	4	5	6	7
The overall family/visitor experience:	1	2	3	4	5	6	7

8. If UK were to expand the visual art collection, what would you want to see incorporated?

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So we can better understand your answers, please answer the following questions (all responses are confidential).

9. What is your reason for visiting the hospital today?

- I'm a patient
- I'm visiting a patient
- I'm visiting an employee
- Other (please specify): \_\_\_\_\_

10. How many times have you been to UK Hospital in the past 5 years, either as a patient or visitor?

- This is my first time
- 1 to 2 times
- 2 to 5 times
- 5 to 10 times
- More than 10 times

11. What is your gender?

- Male
- Female

12. What is your age? \_\_\_\_\_

13. In what county do you live? \_\_\_\_\_

14. Please share any suggestions you have on how UK HealthCare can improve its Arts in HealthCare program.

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Thank you for your participation. Your feedback will help us better serve the patients and staff of UK Albert B. Chandler Hospital through the UK Arts in HealthCare initiative.

## Appendix 1—Staff Survey

The UK Arts in HealthCare program began in 2007 with a mission to “create an environment of care and to focus on the spiritual and emotional well-being of our patients, families, caregivers, and staff.” The creation of a visual art collection became an early focus of the program. The hallways, galleries, lobbies, and waiting rooms now feature a diverse selection of art. The collection is intended to appeal to the wide array of individuals who encounter it daily. With that in mind, we would like to assess the strengths and weaknesses of the program in order to better fulfill our mission and improve our ability to serve patients, visitors, and staff. We would appreciate your honest feedback. **Please feel free to skip any question(s). All responses will remain confidential.**

15. In general, how interested are you in creative arts like dance, theater, visual arts, etc.?

- Very interested
- Somewhat interested
- Not interested at all

16. For each of the following, please circle how often you attend an arts event or participate in the creative arts?

Dance:	0 times per month	1-2 times per month	3 or more times a month
Theater:	0 times per month	1-2 times per month	3 or more times a month
Music:	0 times per month	1-2 times per month	3 or more times a month
Visual art:	0 times per month	1-2 times per month	3 or more times a month
Film:	0 times per month	1-2 times per month	3 or more times a month

17. How familiar are you with the UK Arts in HealthCare program?

- Very familiar
- Somewhat familiar
- Not familiar
- Never heard of it

18. How involved are you with the UK Arts in HealthCare program?

- Very involved
- Somewhat involved
- Not involved

If involved, please describe:

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19. What kinds of art have you seen in the hospital? (check all that apply)

- Paintings
- Theater
- Music
- The Ginkgo sculpture
- Folk art
- The Kentucky Wall
- Other (please specify): \_\_\_\_\_
- I have not seen any art in the hospital

Do you have a favorite piece of art in the collection? If so, please identify/describe it.

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20. Do you feel that art is an important element in a healthcare facility? Why or why not?

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21. Did seeing art in the hospital affect your mood?

- Yes
- No

22. Please explain how your mood was affected.

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23. Has the art collection in the hospital impacted your work? Please elaborate.

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24. How much impact do you think the hospital art has had on the patients, families, and visitors? For each of the following, please indicate on a scale from 1 to 7, with 1 being "No impact" and 7 being "A lot of impact".

	No Impact						A lot of Impact
Patient comfort:	1	2	3	4	5	6	7
Family/visitor comfort:	1	2	3	4	5	6	7
Patient recovery time:	1	2	3	4	5	6	7
The overall patient experience:	1	2	3	4	5	6	7
The overall family/visitor experience:	1	2	3	4	5	6	7

25. If you have been employed in another healthcare facility: Does the art collection change your overall work experience in a hospital environment? How does this environment/experience compare to past work environments/experiences?

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26. If UK were to expand the visual art collection, what would you want to see incorporated?

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So we can better understand your answers, please answer the following questions (all responses are confidential).

27. What is your gender?

Male

Female

28. What is your age? \_\_\_\_\_

29. What is your role in the hospital? \_\_\_\_\_

30. Please share any suggestions you have on how UK HealthCare can improve its Arts in HealthCare program.

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Thank you for your participation. Your feedback will help us better serve the patients and staff of UK Albert B. Chandler Hospital through the UK Arts in HealthCare initiative.



## Appendix 2—Survey Data

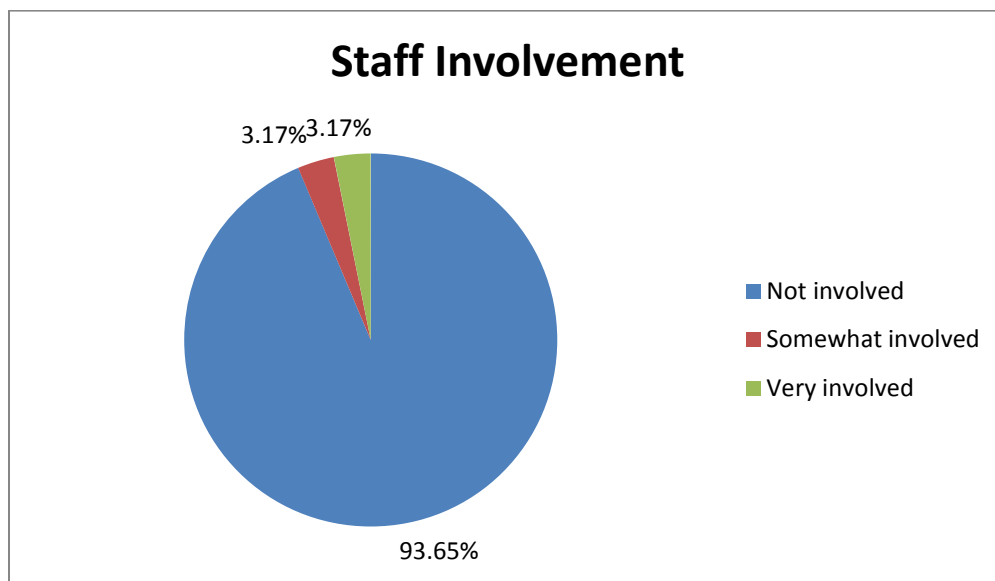


Figure 1. Represents staff involvement in UK Arts in HealthCare by percentage of total responses to the question.

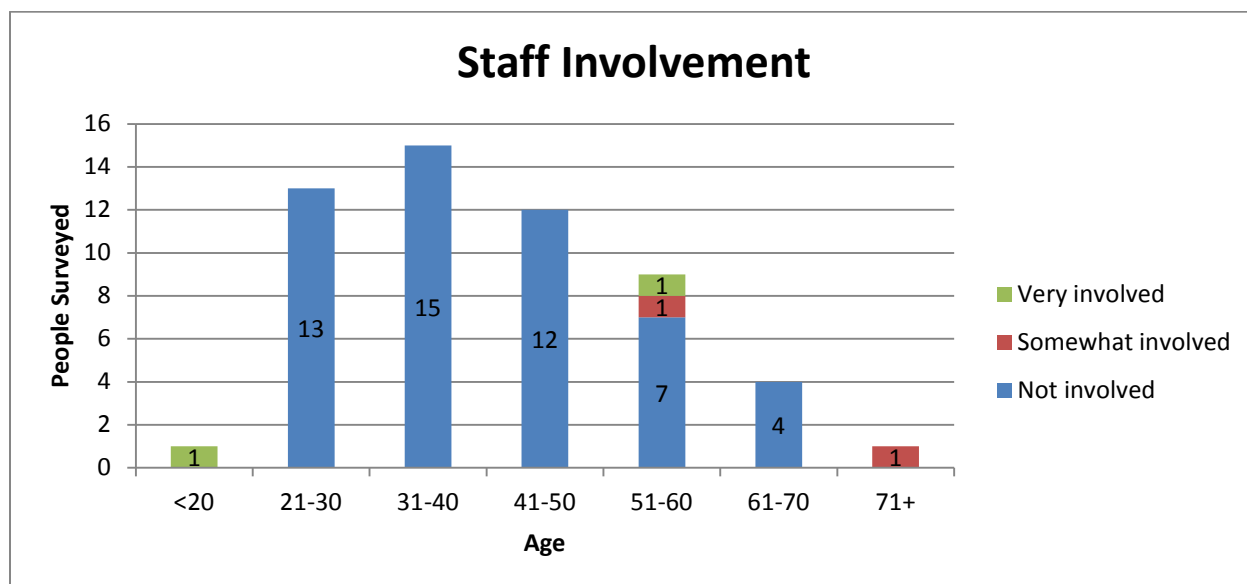


Figure 2. Represents staff involvement in UK Arts in HealthCare by number of total responses to the question divided into categories by age of respondent. For instance, for staff age 51-60, seven respondents were “not involved,” one was “somewhat involved,” and one was “very involved.”

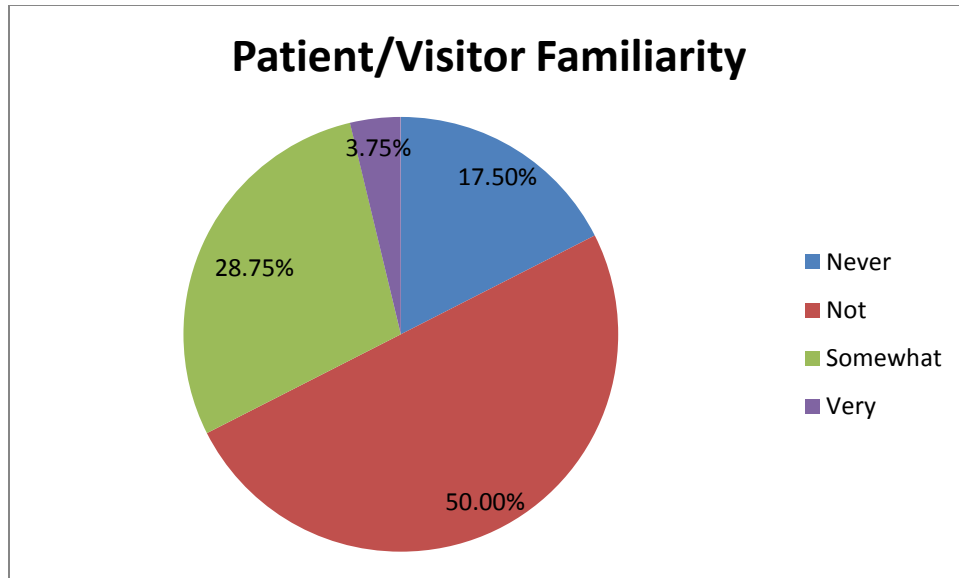


Figure 3. Represents patient/visitor familiarity with UK Arts in HealthCare by percentage of total responses. The response options were “never heard of it,” “not familiar,” “somewhat familiar,” or “very familiar.”

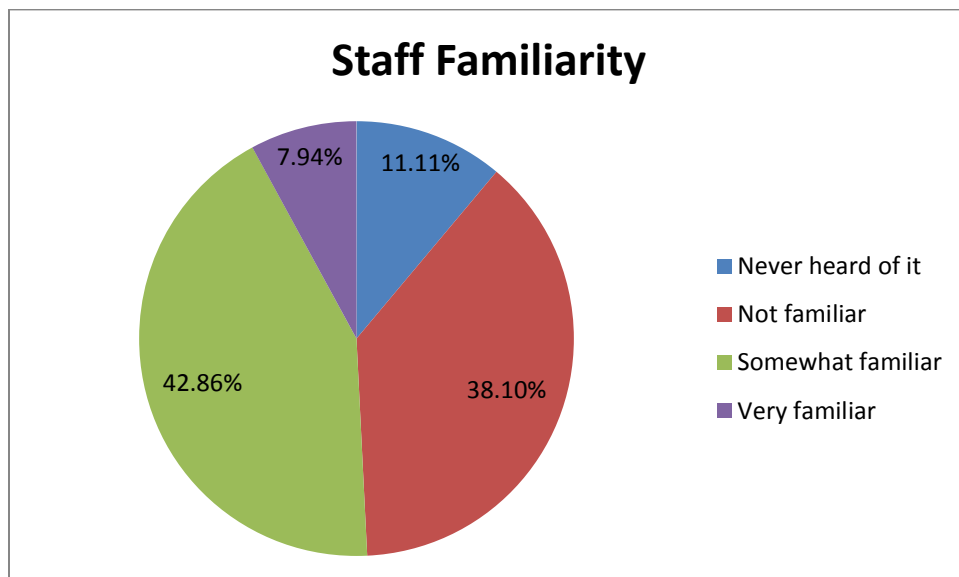


Figure 4. Represents staff familiarity with UK Arts in HealthCare by percentage of total responses. The response options were “never heard of it,” “not familiar,” “somewhat familiar,” or “very familiar.”

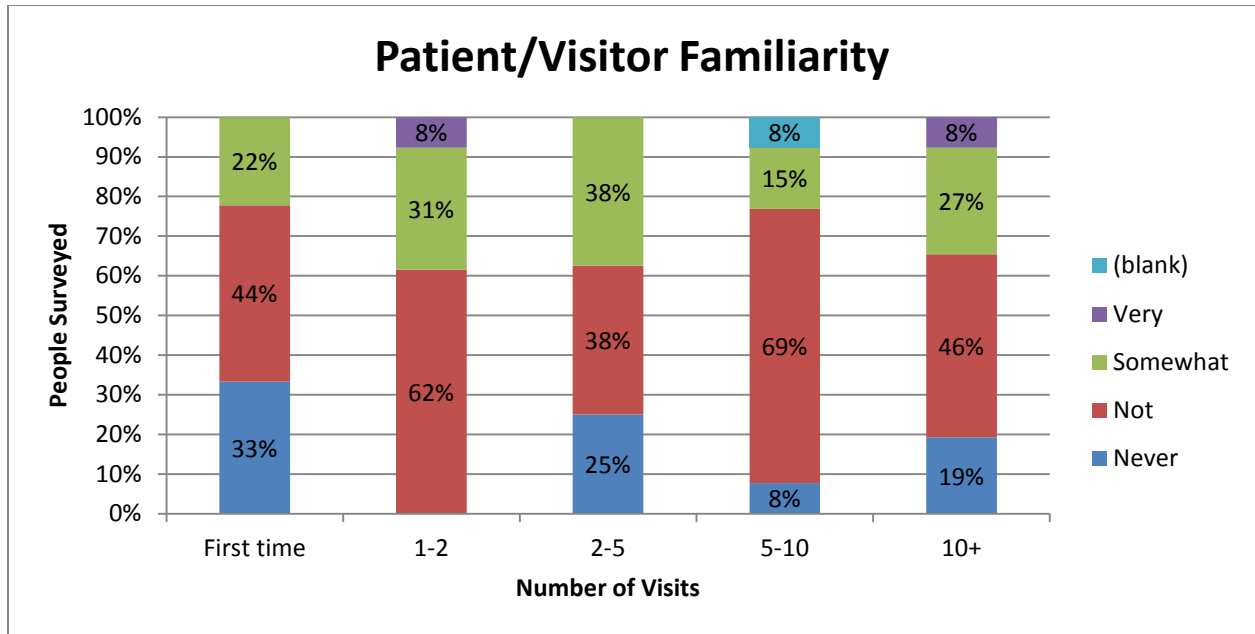


Figure 5. Represents patient/visitor familiarity with UK Arts in HealthCare as a percentage of total responses grouped by number of visits. For example, among first time patients and visitors, thirty-three percent had “never heard of it,” forty-four percent were “not familiar,” and twenty-two percent were “somewhat familiar.”

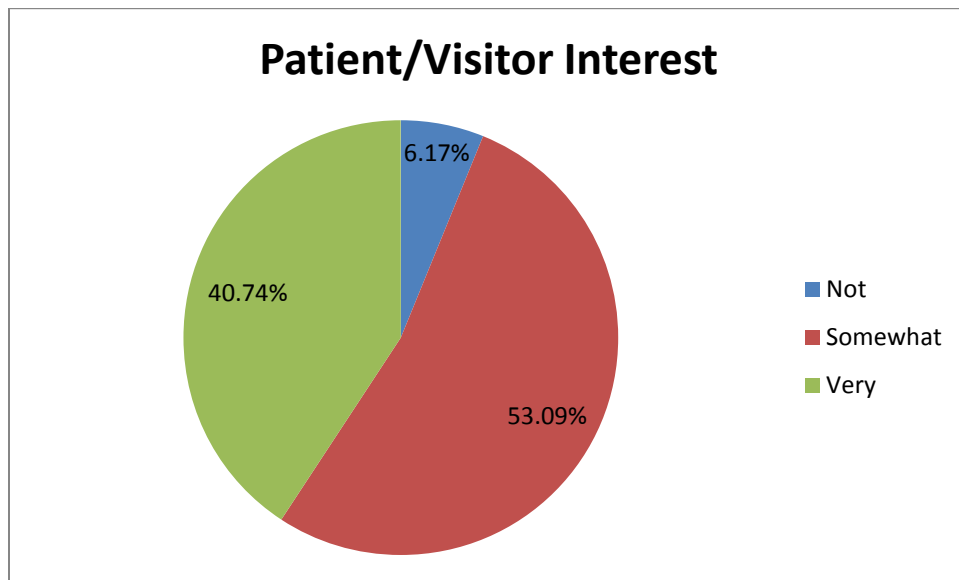


Figure 6. Represents patient/visitor interest in the creative arts as a percentage of total responses.

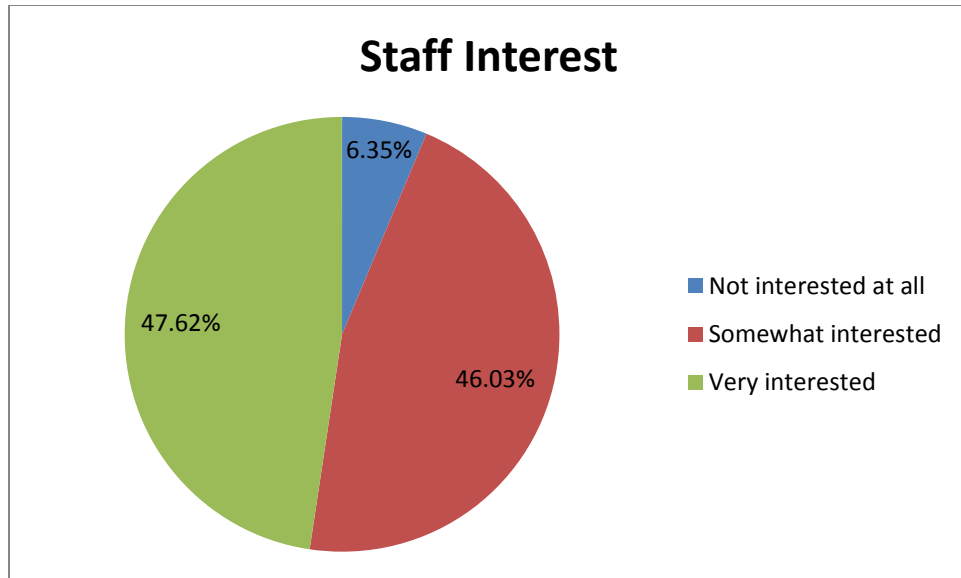


Figure 7. Represents staff interest in the creative arts as a percentage of total responses.

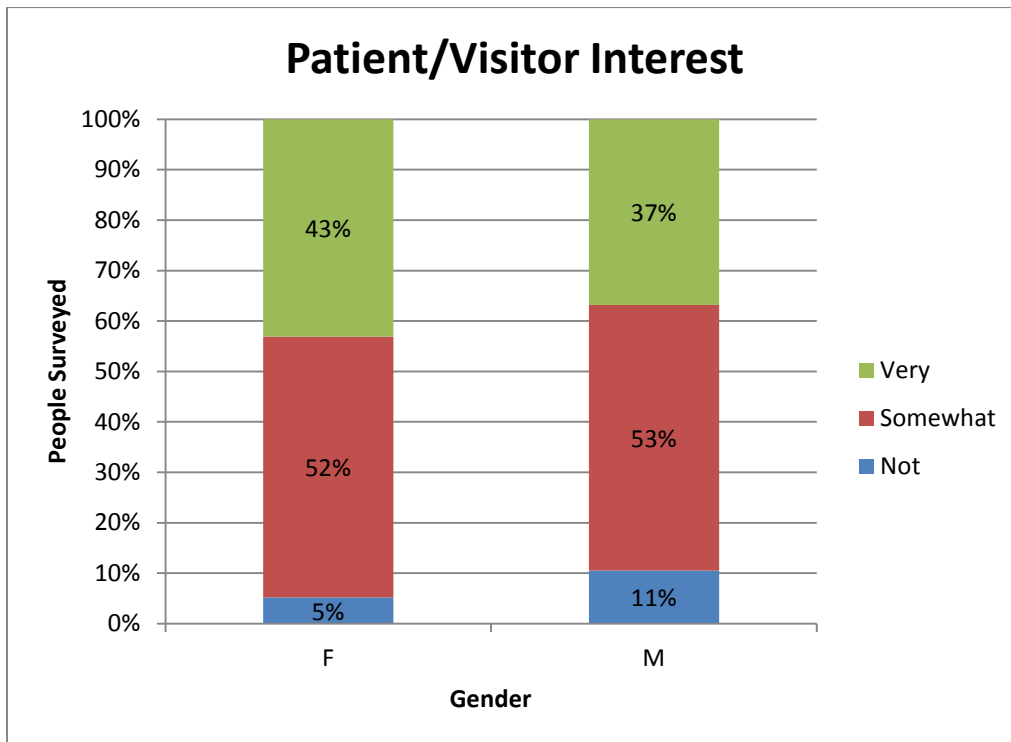


Figure 8. Represents patient/visitor interest in the creative arts as a percentage of total responses, divided into categories by gender. For example, forty-three percent of women indicated that they are “very interested” in creative arts as compared to thirty-seven percent of men.

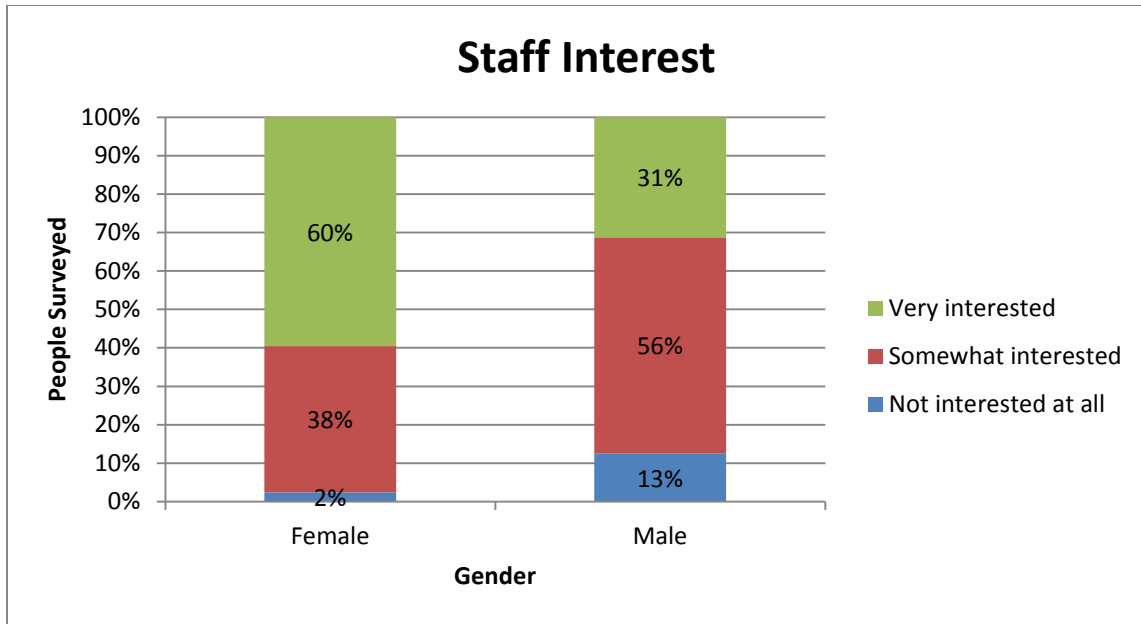


Figure 9. Represents staff interest in the creative arts as a percentage of total responses, divided into categories by gender. For example, sixty percent of women indicated that they are “very interested” in creative arts as compared to thirty-one percent of men.

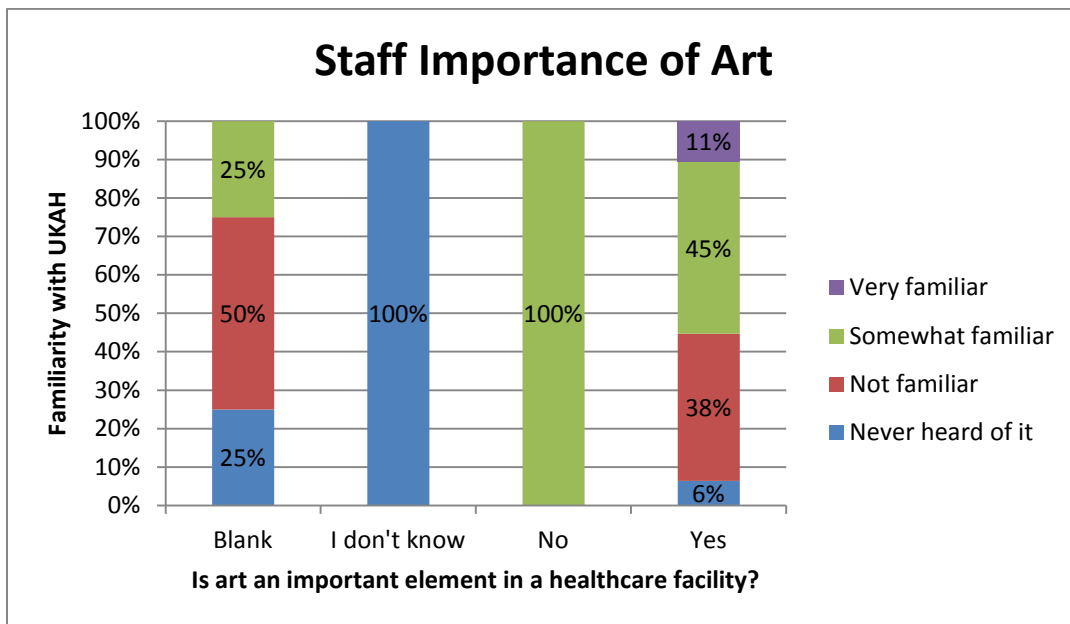


Figure 10. Represents the percentage of staff familiarity with UK Arts in HealthCare compared to their assessment of art as an important element in a healthcare facility. For example, one hundred percent of respondents (three total) who do not think art is an important element in a healthcare facility are “somewhat familiar” with UKAH.

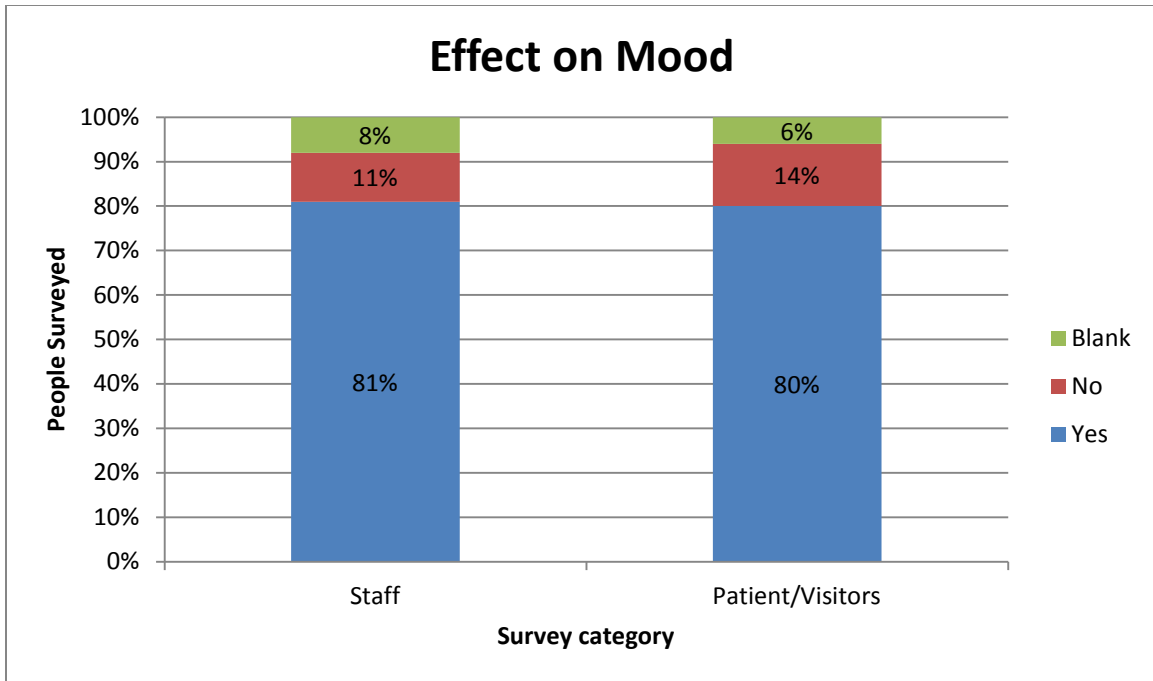


Figure 11. Represents percentages of patients/visitors and staff who responded “yes” or “no” to “has seeing art in the hospital affected your mood?”

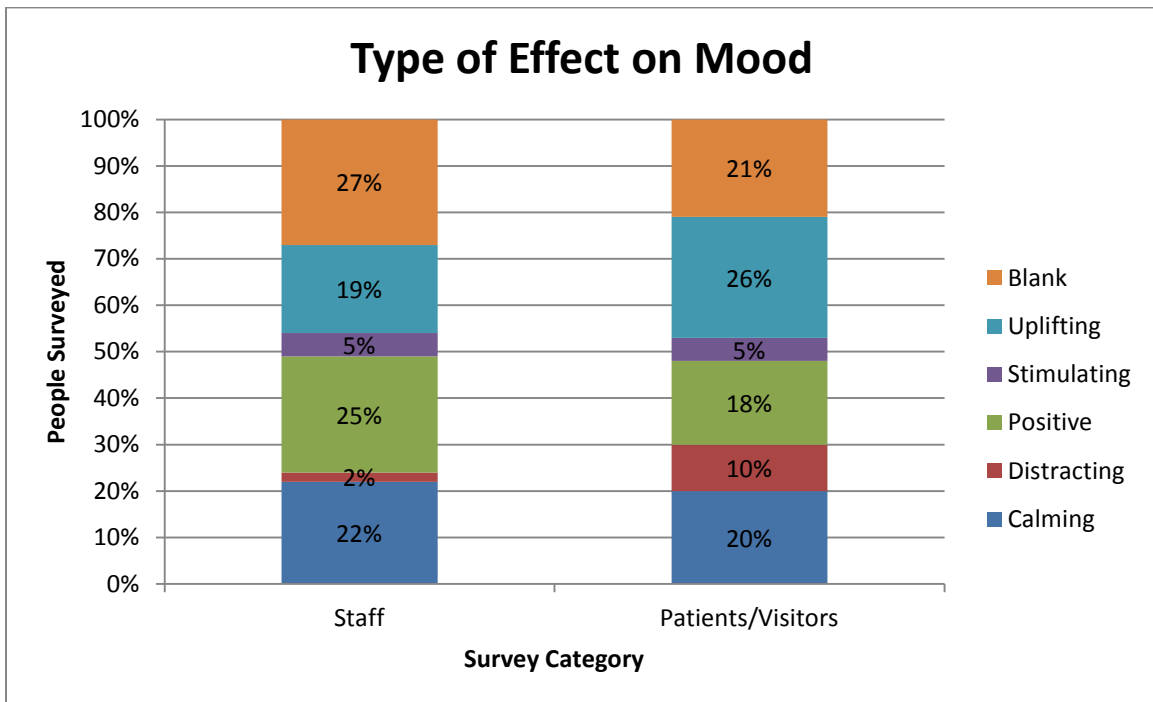


Figure 12. Represents percentages of patients/visitors and staff in terms of the type of effect the art had on their mood. For example, twenty-two percent of staff and twenty percent of patients/visitors found the art collection to be “calming.”

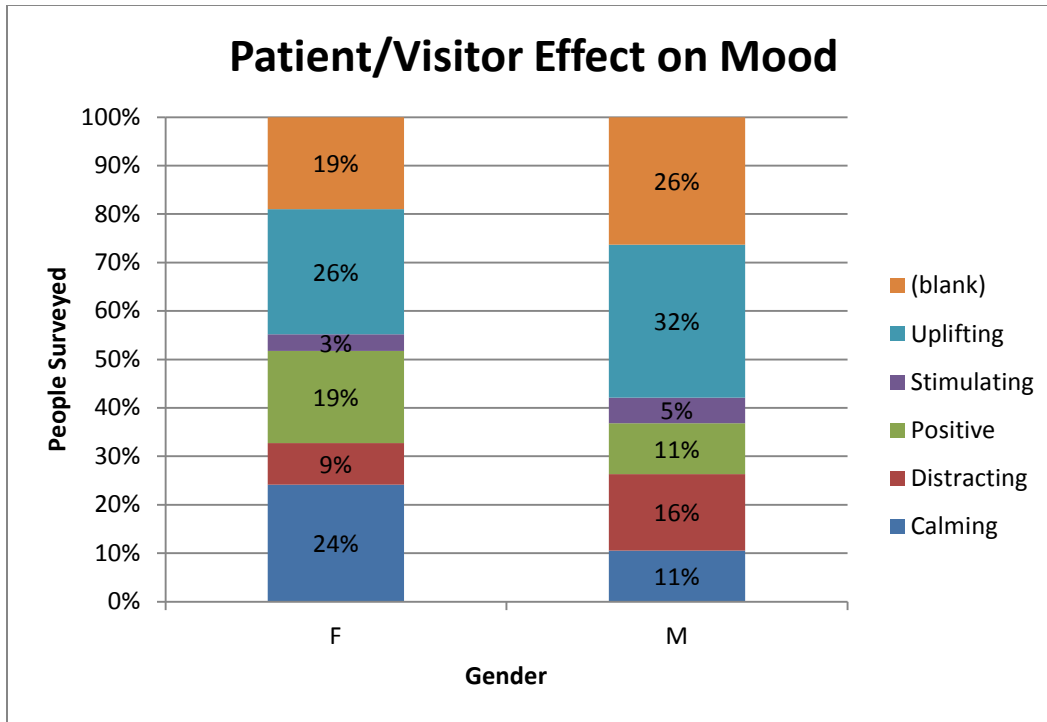


Figure 13. Represents the effect the art had on the mood of patients/visitors as a percentage of the total surveyed, divided by gender.

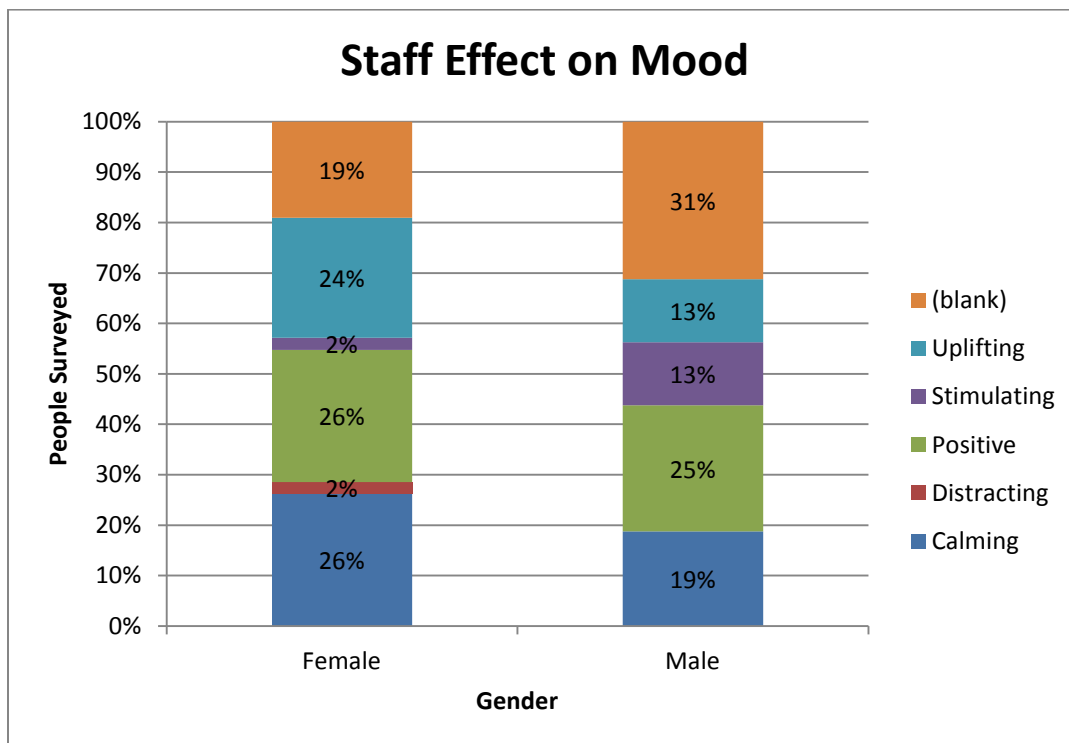


Figure 14. Represents the effect the art had on the mood of staff members as a percentage of the total surveyed, divided by gender.

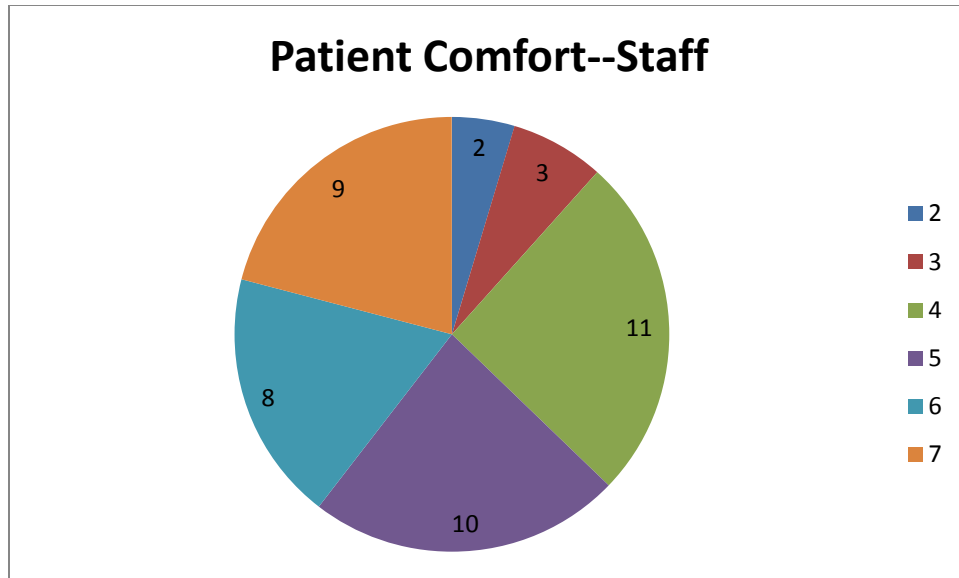


Figure 15. Represents the total count of staff responses regarding the impact of the art collection, divided into categories by a ranking system of one through seven. For example, nine staff respondents identified the impact of art on patient comfort as “seven,” or, “a lot of impact.”

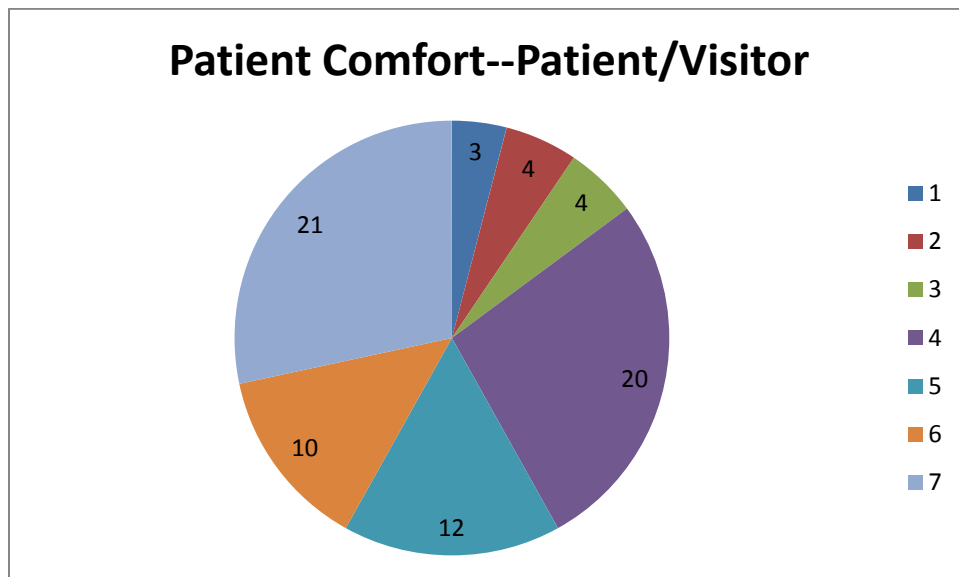


Figure 16. Represents the total count of patient/visitor responses regarding the impact of the art collection, divided into categories by a ranking system of one through seven. For example, twenty-one patient/visitor respondents identified the impact of art on patient comfort as “seven,” or, “a lot of impact.”



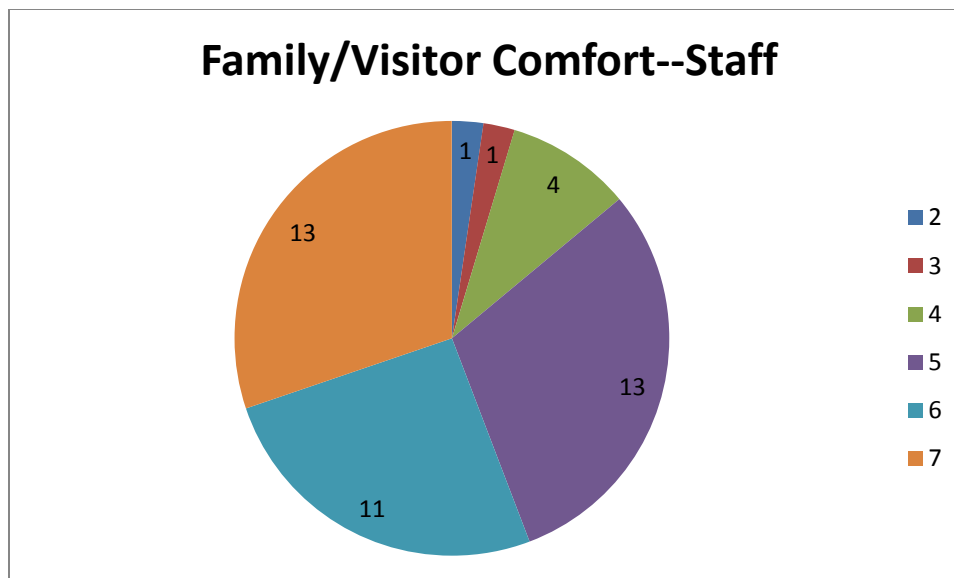


Figure 17. Represents the total count of staff responses regarding the impact of the art collection, divided into categories by a ranking system of one through seven. For example, thirteen staff respondents identified the impact of art on family/visitor comfort as “seven,” or, “a lot of impact.”

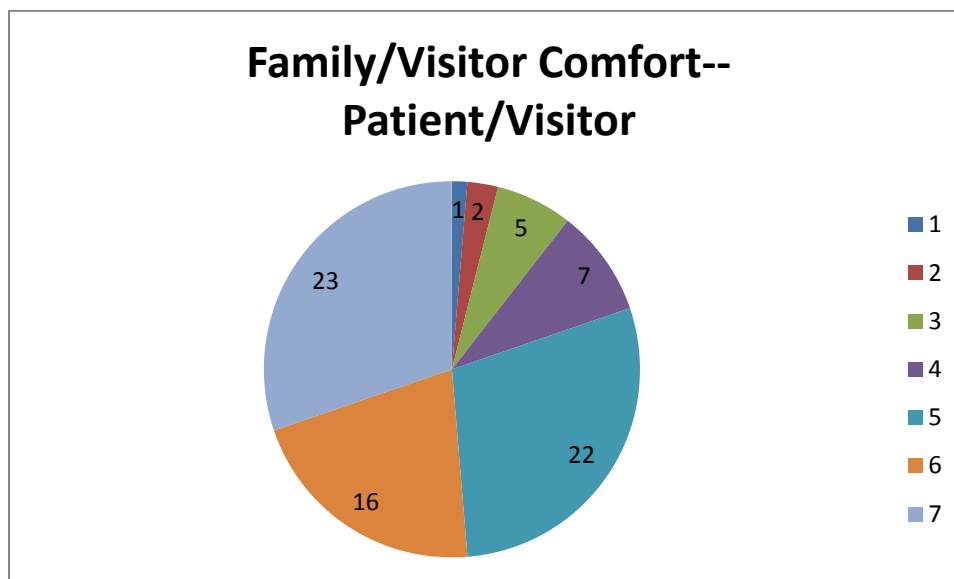


Figure 18. Represents the total count of patient/visitor responses regarding the impact of the art collection, divided into categories by a ranking system of one through seven. For example, twenty-three patient/visitor respondents identified the impact of art on family/visitor comfort as “seven,” or, “a lot of impact.”

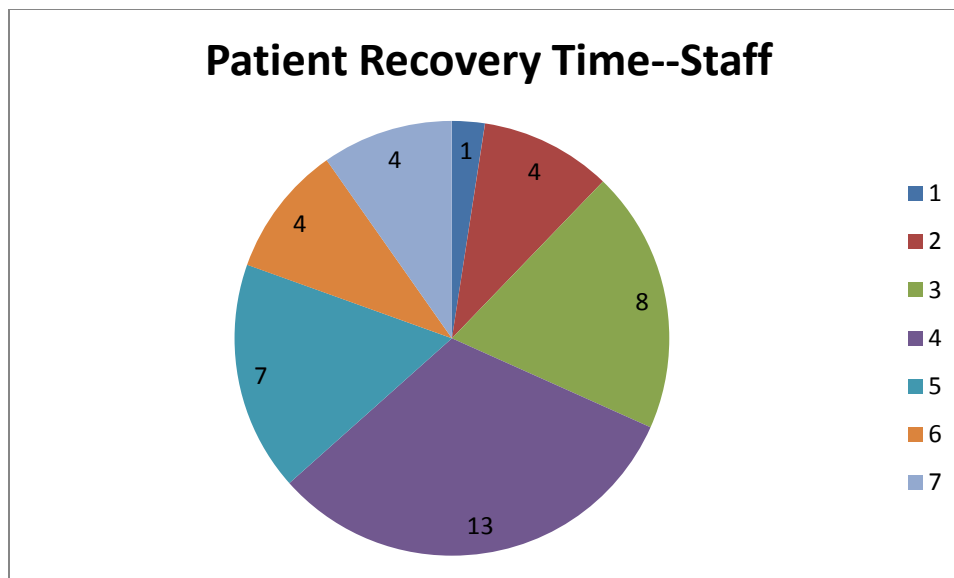


Figure 19. Represents the total count of staff responses regarding the impact of the art collection, divided into categories by a ranking system of one through seven. For example, four staff respondents identified the impact of art on patient recovery time as “seven,” or, “a lot of impact.”

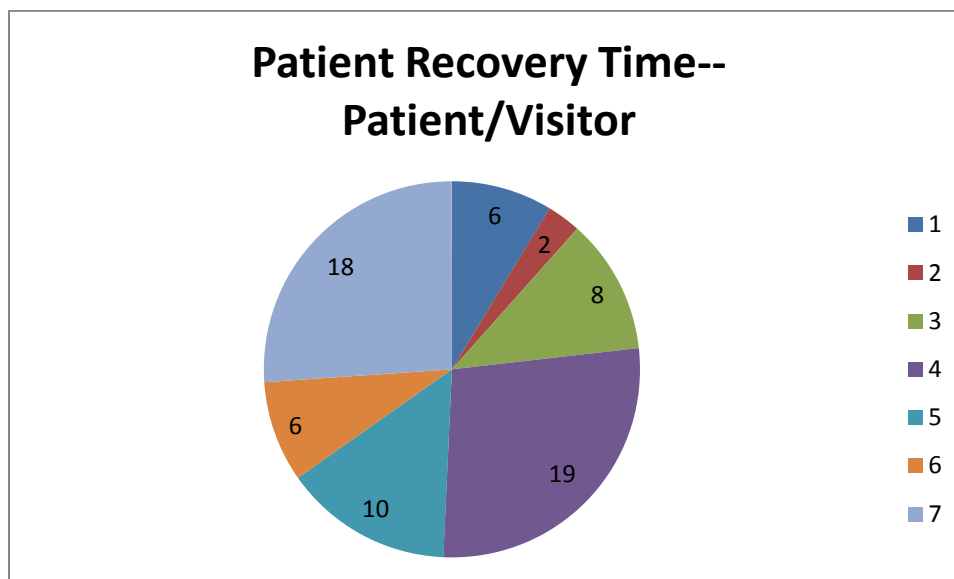


Figure 20. Represents the total count of patient/visitor responses regarding the impact of the art collection, divided into categories by a ranking system of one through seven. For example, eighteen patient/visitor respondents identified the impact of art on patient recovery time as “seven,” or, “a lot of impact.”

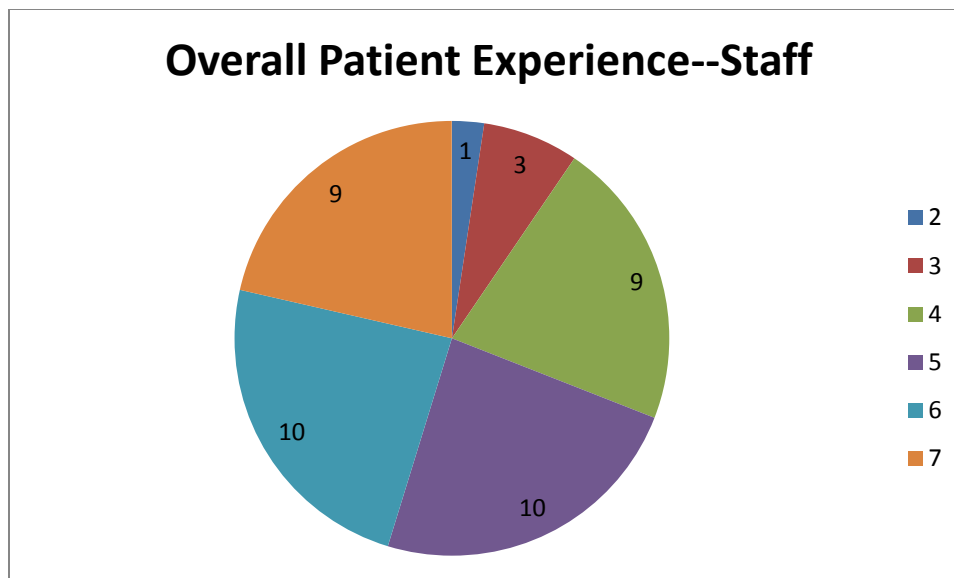


Figure 21. Represents the total count of staff responses regarding the impact of the art collection, divided into categories by a ranking system of one through seven. For example, nine staff respondents identified the impact of art on overall patient experience as “seven,” or, “a lot of impact.”

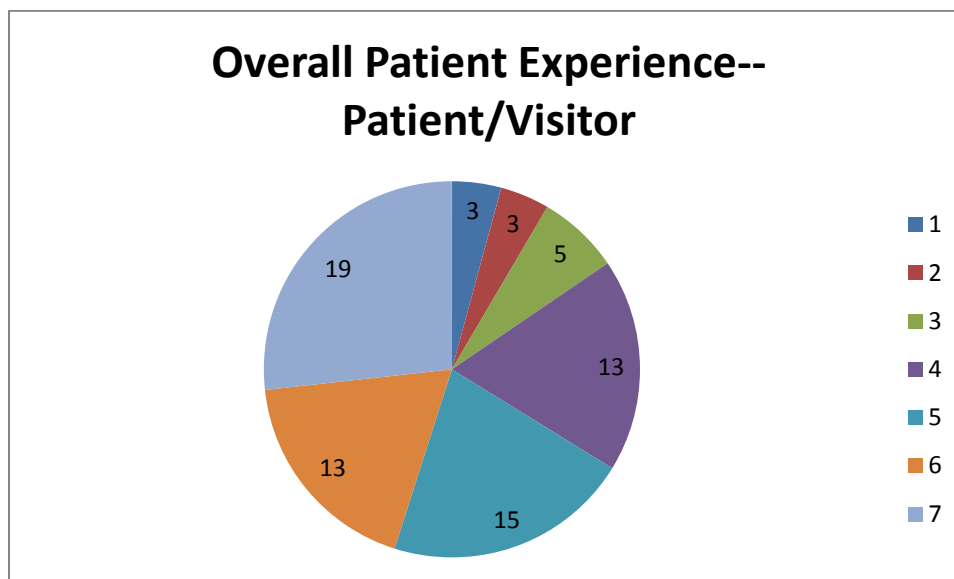


Figure 22. Represents the total count of patient/visitor responses regarding the impact of the art collection, divided into categories by a ranking system of one through seven. For example, nineteen patient/visitor respondents identified the impact of art on overall patient experience as “seven,” or, “a lot of impact.”

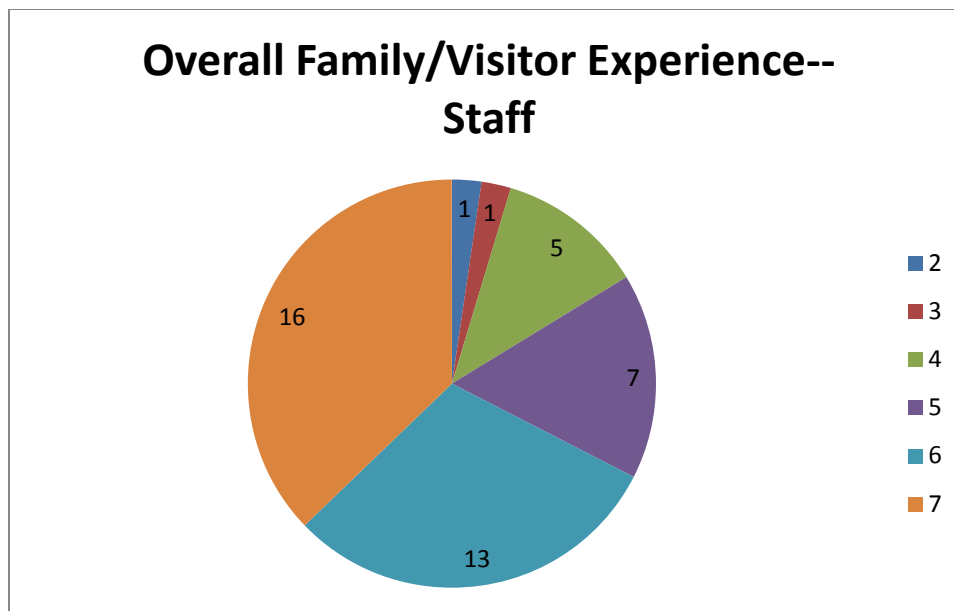


Figure 23. Represents the total count of staff responses regarding the impact of the art collection, divided into categories by a ranking system of one through seven. For example, sixteen staff respondents identified the impact of art on overall family/visitor experience as “seven,” or, “a lot of impact.”

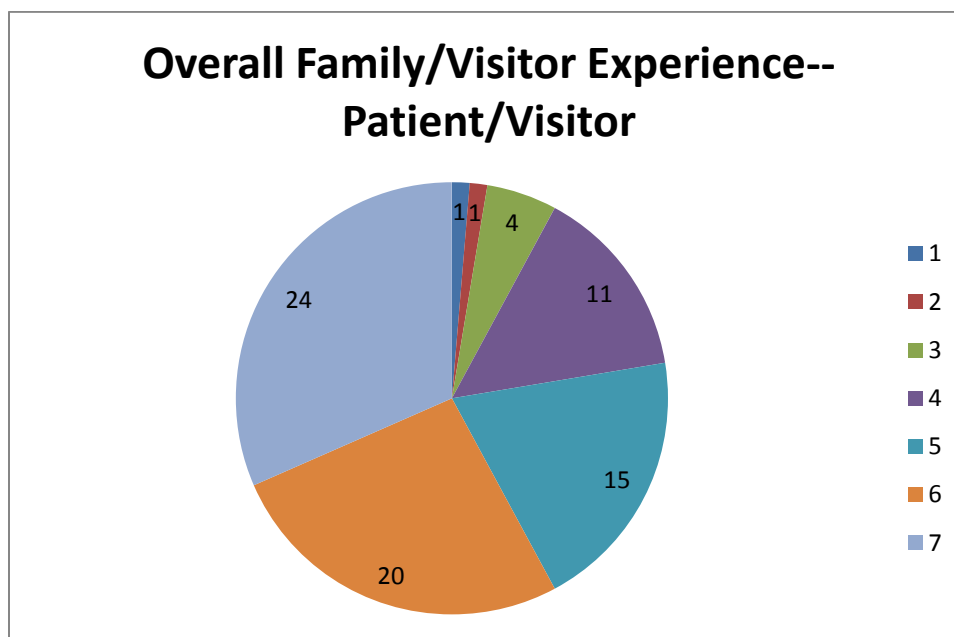


Figure 24. Represents the total count of patient/visitor responses regarding the impact of the art collection, divided into categories by a ranking system of one through seven. For example, twenty-four patient/visitor respondents identified the impact of art on overall family/visitor experience as “seven,” or, “a lot of impact.”

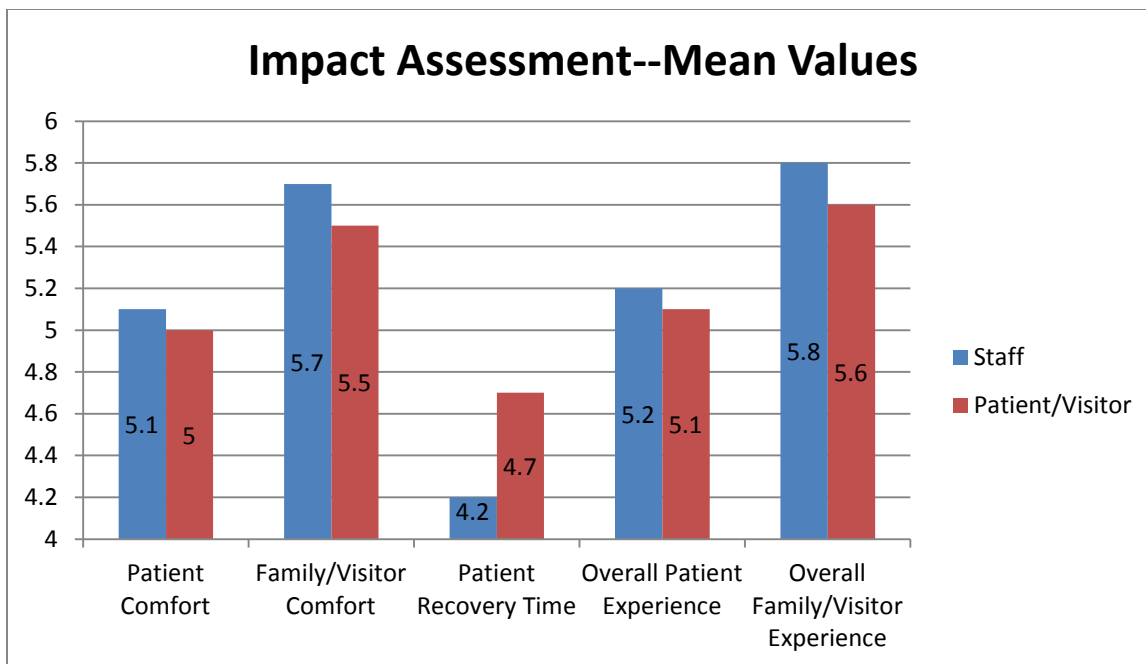


Figure 25. Represents a comparison of the mean values of the impact assessment of the art collection between staff and patient/visitor responses. For example, the mean value, on a scale from one to seven, of the assessed impact on patient comfort was 5.1 for staff and 5 for patients/visitors.

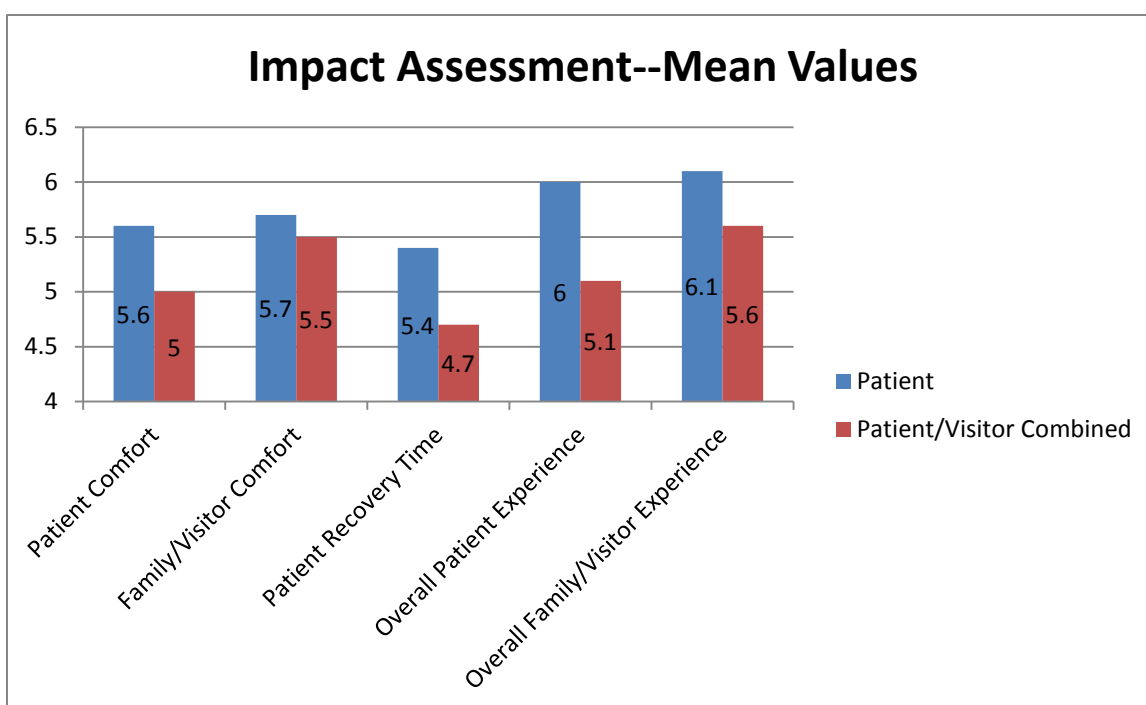


Figure 26. Represents a comparison of the mean values of the impact assessment of the art collection between isolated patient and patient/visitor combined responses. For example, the mean value, on a scale from one to seven, of the assessed impact on patient comfort was 5.6 for isolated patient respondents and 5 for patient/visitor combined respondents.

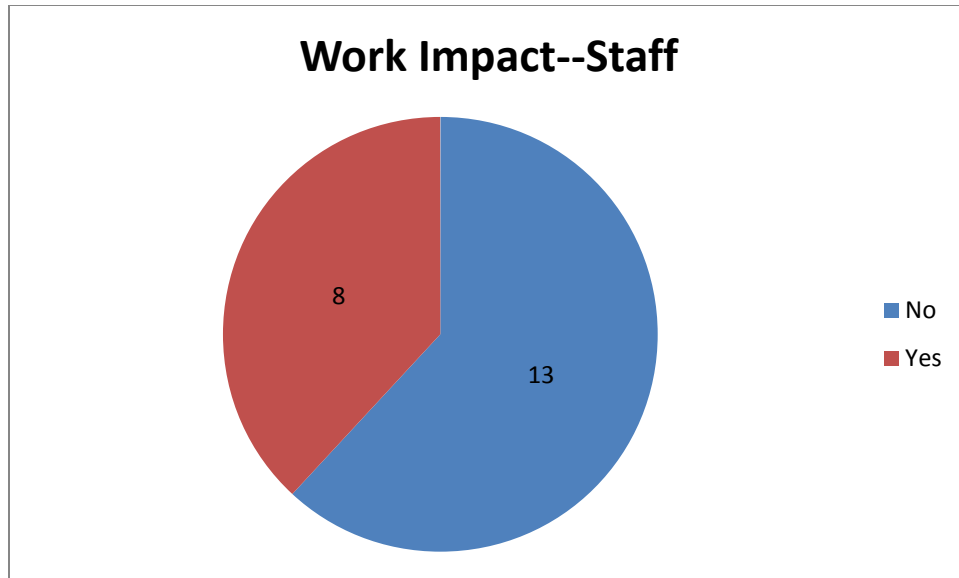


Figure 27. Represents the total count of staff responses regarding whether the art collection impacts their work.

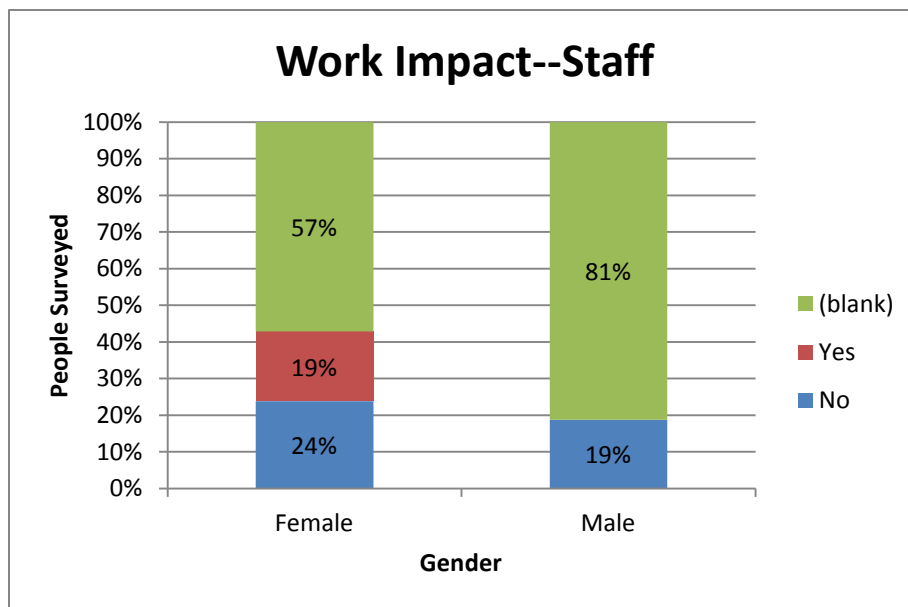


Figure 28. Represents the total count of staff surveys, divided by gender, regarding whether the art collection impacts their work.

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