# The (Un)Settled Space of Healthcare Musicians

## Hybrid Music Professionalism in the Finnish Healthcare System

TARU-ANNELI KOIVISTO

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Sibelius Academy of the University of the Arts Helsinki
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The (Un)Settled Space of Healthcare Musicians:
Hybrid Music Professionalism in the Finnish Healthcare System

Sairaalamuusikoiden työ avoimena tilana: Musiikillinen hybridiammatillisuus
suomalaisessa terveydenhuoltojärjestelmässä


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# ABSTRACT


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Music professionalism is undergoing a period of turbulent change. Musicians are not only performing in traditional concert audiences, but also increasingly work in unconventional spaces and novel sites for and with different groups of people in a wide array of life situations. Hybrid music professionalism refers to a highly reflexive expanding professional approach. This article-based doctoral dissertation addresses the emergence of this expanding music professionalism by exploring the work of musicians in the Finnish public healthcare system. The guiding research question is: How does healthcare musicians' relational work inform a new understanding of expanding, hybrid music professionalism in a changing society?

The empirical material was generated at one children's hospital and one eldercare hospital, through observations and interviews with musicians, patients, their families, and healthcare personnel, as well as with policymakers and other arts practitioners working in healthcare settings. Through a multiple case study approach, the research builds on four sub-studies in which thematic and reflexive analyses were applied. A qualitative cross-case analysis was then used to synthesize the findings of the sub-studies. The findings have been reported in four international peer-reviewed publications: (1) a qualitative systematic review exploring healthcare musicians' work and professional space in somatic hospital wards; (2) a descriptive case study that analyzes musicians' interprofessional work and musicking with and for families, their relatives, and healthcare personnel in neonatal intensive care units; (3) an instrumental case study theorizing musicians' professional work in eldercare hospitals; and (4) an in-depth case study that reflects and theorizes musicians' emotional work in end-of-life care contexts. Additionally, a policy recommendation aimed at cross-sectoral service providers was produced.

The findings present healthcare musicians as socially responsible practitioners who co-construct their professionalism through reciprocal, relational practices, not only in but *with* the healthcare community, including patients, their families, and healthcare personnel. These relational practices are manifested in healthcare musicians' work; for instance, through creating metaphorical thinking and language, engaging in musico-emotional interaction, and supporting gerotranscendence. Such hybrid professionalism requires interprofessional reflection and collaboration that can guide musicians towards acknowledging the limits and boundaries of their work, their own transforming expertise, and—most importantly—the necessary expertise and knowledge of others. The findings imply that hybrid professionalism, realized through boundary work, incorporates emotionally sensitive, situational ethics that integrate the practice with the everyday life of healthcare communities to support the agency and integrity of potentially vulnerable patients. It is proposed that although music may serve as a clinical intervention, or maintain a performative value as entertainment, its inherent value for the participants should be better and more deeply considered in higher music education. Healthcare musicians' socially engaged work unfolds aesthetic and existential dimensions of the whole spectrum of human interaction, and raises critical questions about what constitutes a good life for patients, their families, healthcare personnel, and the musicians themselves. The study suggests that expanding our understanding of music professionalism in healthcare as a salutogenic orientation to wellbeing can support not only professional self-care and patient safety, but also wider systemic change and a reorganization of professional education and working life. As part of this theoretical and practical development, music professionals may become more legitimized and significant actors in our rapidly changing societies.



## Keywords

Boundary work, healthcare, hybrid professionalism, multiple case study, musicians, reflexivity, salutogenesis, music professionalism

# TIIVISTELMÄ


Koivisto, Taru-Anneli. (2022). *Sairaalamuusikoiden työ avoimena tilana: Musiikillinen hybridiammatillisuus suomalaisessa terveydenhuoltojärjestelmässä.*

Musiikin ammattilaisuudessa tapahtuva muutosprosessi on tällä hetkellä nopea. Muusikot eivät enää esiinny yksinomaan perinteisille konserttiyleisöille, vaan työskentelevät yhä useammin toisentyyppisissä tiloissa ja ympäristöissä. Lisäksi työskentely tapahtuu monenlaisten ryhmien kanssa, joiden jäsenten elämäntilanteet vaihtelevat. Tämä artikkeliväitöskirja käsittelee laajenevaa ammatillisuutta tarkastelemalla muusikoiden työtä suomalaisessa terveydenhuoltojärjestelmässä. Tähän ilmiöön, joka edellyttää äärimmäisen joustavaa työskentelyotetta, viitataan tutkimuksessa uudella käsitteellä hybridiammatillisuus. Keskeinen tutkimuskysymys on: kuinka sairaalamuusikoiden työ edistää musiikin laajentuvan, hybridin ammatillisuuden uudenlaista määrittelyä oman aikamme muuttuvassa yhteiskunnassa?

Tutkimusaineisto kerättiin yhdessä lastensairaalassa ja yhdessä ikääntyneiden sairaalassa, ensin havainnoimalla ja sen jälkeen haastattelemalla muusikoita, potilaita, omaisia, hoitohenkilökuntaa, päättäjiä sekä muita terveydenhuollossa työskenteleviä taiteen ammattilaisia. Väitöskirja on monitapaustutkimus, ja se perustuu neljään osatutkimukseen, joissa sovellettiin temaattista ja refleksiivistä analyysiä. Osatutkimusten löydökset syntetisoitiin tapauksia vertailevalla laadullisella ristikkäisanalyysillä. Tulokset raportoitiin neljässä kansainvälisessä vertaisarvioidussa julkaisussa: (1) laadullisessa, systemaattisessa katsauksessa, joka kartoitti sairaalamuusikoiden työtä sairaaloiden somaattisessa erikoissairaanhoidossa; (2) kuvailevassa tapaustutkimuksessa, jossa analysoitiin muusikoiden moniammatillista työtä ja yhteismusisointia vastasyntyneiden teho-osastolla yhdessä perheiden, omaisten ja terveydenhoitohenkilökunnan kanssa; (3) instrumentaalisessa tapaustutkimuksessa, joka teoretisoi muusikoiden työtä ikäihmisten sairaaloissa; sekä (4) syventävässä tapaustutkimuksessa muusikoiden tunnetyöstä saattohoidossa. Lisäksi tutkimuksen yhteydessä tuotettiin toimenpidesuositus sektorirajat ylittäville palveluntarjoajille.

Tutkimuksen tuloksissa sairaalamuusikot näyttäytyvät vastuullisina moniammatillisina toimijoina, jotka kehittävät ammatillisuuttaan vastavuoroisten ja suhdeperustaisten sosiaalisten käytäntöjen avulla. Lisäksi tulokset osoittavat, että osallistavat musiikilliset työskentelytavat luodaan yhdessä hoitohenkilökunnan, potilaiden ja näiden omaisten kanssa, ja ne näkyvät sairaalamuusikoiden työssä muun muassa vertauskuvallisen ajattelun ja kielen luomisena, musiikillis-emotionaalisena vuorovaikutuksena sekä gerotranssendenssin eli ikääntymisen tuoman elämänkokemuksen ja kypsymisen tukemisena. Hybridiammatillisuus ohjaa muusikoita ymmärtämään oman ammatillisuutensa rajoituksia ja rajoja, omaa muuttuvaa asiantuntijuuttaan sekä ennen kaikkea havaitsemaan *muiden* asiantuntemuksen ja erityisosaamisen tarpeellisuuden terveydenhuollossa. Tulosten mukaan terveydenhuoltojärjestelmän rajapinnoilla toteutettuun hybridiin ammattilaisuuteen sisältyy tunnetasolla herkkää ja tilannesidonnaista etiikkaa, joka hoitoympäristöjen jokapäiväiseen elämään yhdistyessään voi auttaa sairaalamuusikoita tukemaan haavoittuvassa asemassa olevien potilaiden toimintakykyä ja itsemääräämisoikeutta.

Tutkimuksen tulokset viittaavat tarpeeseen uudistaa musiikin korkeakoulutusta. Vaikka musiikkia voi käyttää kliinisenä interventiona terveydenhuollossa ja se voidaan myös ymmärtää virkistävänä elementtinä hoivaympäristöjen arjessa, tutkimuksessa esitetään, että musiikin korkeakoulutuksen tulisi paneutua syvällisemmin musiikin merkityksellisyyteen osallistujien itsessään arvokkaan kokemuksen näkökulmasta. Sairaalamuusikoiden työ avaa esteettisen ja eksistentiaalisen ulottuvuutensa avulla inhimillisen kanssakäymisen tarkasteltavaksi koko laajudessaan. Se nostaa esiin kysymyksen siitä, mikä on potilaiden, näiden omaisten, hoitohenkilökunnan, ja muusikoiden itsensä näkemys hyvästä elämästä. Tutkimuksessa esitetään, että musiikillinen ammatillisuus tulisi terveydenhuollossa ymmärtää yhteisölliseksi ja salutogeeniseksi eli terveys- ja voimavaralähtöiseksi suuntautumiseksi kohti hyvinvointia. Salutogeeninen lähestymistapa ei tue ainoastaan ammatillista kasvua ja potilasturvallisuutta, vaan myös ammatillisen koulutuksen ja työelämän uudelleenjärjestelyä osana laajempaa systeemistä muutosta. Tällä tavoin musiikin ammattilaisten työ voidaan oikeuttaa paremmin ja siitä voi tulla merkittävä osa nopeasti muuttuvaa yhteiskuntaa.



## Asiasanat

Hybridiammatillisuus, monitapaustutkimus, refleksiivisyys, sairaalamuusikot, salutogeneesi, terveydenhuoltojärjestelmä

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*Espoo May 16th, 2022*
Taru Koivisto

## Published works by the author as part of the dissertation

I Koivisto, T.-A., & Tähti, T. (2020). Professional entanglements: A qualitative systematic review of healthcare musicians' work in somatic hospital wards. *Nordic Journal of Music Therapy, 28*(5), 416–426. https://doi.org/10.1080/08098131.2020.1768580

II Koivisto, T.-A. (2021). Making our way through the deep waters of life: Music practitioners' professional work in neonatal intensive care units. In. H. Westerlund & H. Gaunt (Eds.), *Expanding professionalism in music and higher music education – A changing game* (pp. 115–128). London: Routledge. https://doi.org/10.4324/9781003108337-10

III Koivisto, T.-A., & Laes, T. (2022). Music professionalism promoting gerotranscendence: An instrumental case study of healthcare musicians in an eldercare hospital. *International Journal of Music Education*. https://doi.org/10.1177/02557614221087340

IV Koivisto, T.-A. (2022). Healthcare musicians and musico-emotional work: An in-depth case study within the context of end-of-life care. *Approaches: An Interdisciplinary Journal of Music Therapy*. First view.

V Koivisto, T.-A., Lehikoinen, K., Lapio, P., Lilja-Viherlampi, L.-M., & Salanterä, S. (2020). *Culture and the arts in hospitals and other health service organisations.* [Kulttuuri ja taide sairaalassa ja muissa terveyspalveluissa]. ArtsEqual policy brief 1/2020. Helsinki: University of the Arts Helsinki.

The reprinted articles are included in Part II of the dissertation.

## Electronic data sets and published protocols of the dissertation

Koivisto, T.-A. (University of the Arts Helsinki). (2022). Kokemuksia sairaalamusiikkitoiminnasta 2018 [Music practitioners in the Finnish healthcare system 2018], [computer file], version 1.0. Tampere: Finnish Social Science Data Archive (distributor), 2022. http://urn.fi/urn:nbn:fi:fsd:T-FSD3589

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The (un)settled space of healthcare musicians: Developing hybrid professionalism in and through music in the Finnish healthcare system. CERN: Zenodo Data Repository. https:doi.org/10.5281/zenodo.6325201

Koivisto, T.-A., & Tähti, T. (2019). Systematic review protocol. Professional entanglements: A qualitative systematic review of healthcare musicians' work in somatic hospital wards. CERN: Zenodo Data Repository. https:doi.org/10.5281/zenodo.3589993

## Selected published works by the author relevant to the dissertation

Laukkanen, A., Jaakonaho, L., Fast, H., & Koivisto, T.-A. (2021). Negotiating boundaries: Reflection on the ethics of arts-based and artistic research in care contexts. *Arts & Health*. https://doi.org/10.1080/17533015.2021.1999279

Koivisto, T.-A., & Kivijärvi, S. (2020). Pedagogical tact in music education in the paediatric ward: The potential of embodiment for music educators' pedagogical interaction. In L. O. Bonde & K. Johansson (Eds.), *Music in paediatric hospitals: Nordic perspectives* (pp. 27–46). Oslo: NMH-publications. https://hdl.handle.net/11250/2651482

Backer Johnsen, H..... Koivisto, T.-A., & al. (2020). Collaboratively navigating liminality in music education doctoral studies. In T. Laes & L. Hautsalo (Eds.), *Remarks on a visionary 's journey: An anthology celebrating Heidi Westerlund* (pp. 194–220). Helsinki: Sibelius Academy of the University of the Arts Helsinki.

Koivisto, T.-A., & Lilja-Viherlampi, L.-M. (2019). Sairaala- ja hoivamusiikkityön käsitteistöä ja tietoperustaa jäsentämässä. [Constructing knowledge and conceptualisations on music work in health and care settings]. In Lilja-Viherlampi, L.-M. (Ed.), *Musiikkihyvinvointia! Muusikkona sairaala- ja hoivaympäristöissä* (pp. 9–42). [Music and wellbeing! Musicians in healthcare and care contexts]. Turku: Turku University of Applied Sciences. http://urn.fi/URN:NBN:fi-fe2019112544093

## Keynote address relevant to the dissertation

Musicians in healthcare: Exploring expanding professionalism through the work of hospital musicians. MACS Joint Doctoral Research Seminar 2019. University of Jyväskylä, Finland. November 10, 2019.

## Selected academic presentations relevant to the dissertation

Research on musicians in healthcare. Introductory paper presentation with Dr. Krista De Wit. International Symposium of Musicians in Healthcare. University of the Arts Helsinki, Finland (online). December 8, 2021.

Healthcare musicians in the twilight of life: Emotional work within end-of-life interprofessional care. Paper presentation. Music, Mortality, and Ritual: A Death Studies Symposium. University of Durham, UK (online). May 15, 2021.

"But I cannot sing. I have turned 80 years and I am sick." Exploring healthcare musicians' end-of-life work. Paper presentation. The 11th Midterm Conference of the European Sociological Association Network Sociology of the Arts. University of the Arts Helsinki, Finland (online). March 9–12, 2021.

"I try to play it like creating a beautiful morendo": Healthcare musicians' work in eldercare hospitals. Paper presentation. International Society for Music Education Pre-Conference – Music for all, music with all: Equity and diversity in special music education and music therapy. Special Music Education and Music Therapy Commission. University of the Arts Helsinki, Finland (online). August 29–31, 2020.

NICU music therapy in Norway, Sweden, Finland & The Netherlands. Collaborative paper presentation with music therapy researchers. NICU music therapy – Sharing international trends through integrative family-centered music psychotherapy. The Sixth Conference of the International Association for Music and Medicine. Special Interest Group Summer Webinar Series. Boston, US (online). May 4, 2020.

Practices of music therapists and other health musicians: Competition or productive co-existence? Symposium with Professor Brynjulf Stige and doctoral researcher

Katarina Lindblad. 11th European Music Therapy Conference – Fields of Resonance. University of Aalborg, Denmark. June 26–30, 2019.

Cultural wellbeing as a boundary object. Panel presentation with Professor Norma Daykin, Dr. Kai Lehikoinen, Dr. Anu Laukkanen, doctoral researcher Heidi Fast, and doctoral researcher Liisa Jaakonaho. Nordic Arts and Health Research Network meeting. Malmö, Sweden. May 22, 2019.

The (un)settled space of music practitioners in the Finnish healthcare system. Paper presentation. The 9th Nordic Music Therapy Congress – Come together: Body and mind, heart and soul. Stockholm, Sweden. August 8–12, 2018.

Beyond music and musicians? Conceptualizing music education in the Finnish healthcare system. Paper presentation. GRS Summer Course 2018 – Practitioner knowledge: Musicology, music performance, education and therapy. University of Stavanger, Norway. June 18–20, 2018.

Rethinking music educators' professionalism within the paediatric ward. Potentials of embodiment for the social model of health. Paper presentation with doctoral researcher Sanna Kivijärvi. Music in Paediatric Hospitals Symposium. Centre for Research in Music and Health. Norwegian Academy of Music. Oslo, Norway. February 16, 2018.

Is there a space or place for music in healthcare settings? Paper presentation. The 10th International Symposium on the Sociology of Music Education. London, UK. June 11–15, 2017.

Health promotion, music, power – Reproducing or diminishing the patterns of equality and diversity? Paper presentation. Cultural Diversity in Music Education Conference. Kathmandu, Nepal. March 29–April 1, 2017.

## Statement of contribution to the co-authored articles

In **Article I**, my co-author was doctoral researcher Taru Tähti, who collaboratively worked through with me a systematic review methodology and thematic analysis processes, as well as took accountability on the ethical accuracy and integrity of the research process. As the first author, I created the study design of the systematic search procedure, and led the collaborative, but at the same time also independent research process, to increase the reliability of the publication. The division of contributorship is estimated as follows: doctoral researcher Tähti 30%, doctoral researcher Koivisto 70%.

In **Article II**, I was the sole author, responsible for all parts of the work.

In **Article III**, my co-author was Dr. Tuulikki Laes, who also served as my supervisor. I was responsible for the empirical part and design of the article, and Dr. Laes contributed with the theoretical implementation and analysis parts. The research process was an open and collaborative endeavor, wherein both writers contributed to analyzing and writing the research report from the beginning to the end. Beyond generating the empirical material, we were equally accountable for the integrity and accuracy of the research process. The division of contributorship is estimated as follows: Dr. Laes 20%, doctoral researcher Koivisto 80%.

In **Article IV**, I was the sole author, responsible for all parts of the work.

In **Article V, ArtsEqual policy recommendation**, I was the leader of the collaborative group, which co-authored the policy recommendation document. The division of contributorship is estimated as follows: Dr. Lehikoinen 25%, Ms. Lapio 15%, Dr. Lilja-Viherlampi 15%, Dr. Salanterä 10%, and doctoral researcher Koivisto 35%.

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## List of tables and figures

# PART I

*Dissertation summary*

# 1
# INTRODUCTION

Professional musicians' work is undergoing a period of turbulent change, as the spaces and conditions for their work are becoming more diversified and it is more openly acknowledged that they require societal attention (Ansdell & Stige, 2018; Daykin, 2019; López-Íñiguez & Bennett, 2020). As a consequence, increasing opportunities in novel sectors of society are setting new frames for the practice, research, and education of music professionals. Musicians are not only performing for traditional concert audiences, but also increasingly working in unconventional spaces and novel sites for and *with* different groups of people in a wide array of life situations (Gaunt & Westerlund, 2021). One of the emerging fields where traditional forms of musicianship and music-related work are being challenged is music practitioners' work in the health and wellbeing contexts, such as healthcare services.

The purpose of this doctoral study is to investigate musicians' professional work in relation to their professionalism in hospitals, within the context of the Finnish healthcare system. A healthcare musician—who may be referred to, for instance, as a health musician (Bonde, 2011; Ruud, 2012), hospital musician (Preti, 2009, 2013b), or in care environments as a care musician (Hoover, 2021; Lilja-Viherlampi, 2013)—is a professional music practitioner who may have diverse backgrounds, such as artistic, music education, or ethnomusicology (Koivisto & Tähti, 2020; see also De Wit, 2020). In this study, healthcare musicians are considered to hold a professional degree in music, and some of them have participated in in-service training in music and healthcare settings. They mostly work in hospitals in collaboration with patients, their families, and healthcare personnel, such as nurses, doctors, or arts therapists.

As a rapidly evolving and multi-layered phenomenon, musicians' work in healthcare is an example of how music professionalism expands in relation to emerging, new contexts and spaces. This study applies a dynamic approach to professionalism (Evetts, 2009, 2013; Sugrue & Dyrdal Solbrekke, 2014; see Abbott, 1988), combined with more recent perspectives on expanding professionalism in music (Gaunt & Westerlund, 2021, p. 14) as a continual and proactive approach in our modern, rapidly changing societies. Explored within a wide research area called sociology and/or the theory of professions (Abbott; 1988; Cribb & Gewirtz, 2015; see Pekkola et al., 2018), *professionalism* is viewed through the capabilities and specialized professional attitude of a person, as qualities that are acknowledged as something that are not taken for granted and may be developed throughout the duration of one's (working) life (see Cribb & Gewirtz, 2015, pp. 48–49, 155–156; Dent et al., 2016, pp. 25–27). Existing in a close relation to the processing and sharing of knowledge (Jensen et al., 2022), professionalism in this study is seen as socially constructed through working in-between boundaries of different systems (Akkerman & Bakker, 2011; Gieryn, 1983; Star & Griesemer, 1989). The study draws from the idea of professional activity as possessing a deeply hybrid, dialogical, and negotiated nature (Edwards, 2010, p. 10; Noordegraaf, 2016; see Faulconbridge & Muzio, 2012). Although professionalism is related to professional autonomy and emphasizes being mindful towards institutions (Edwards, 2010, p. 3), it should be separated from the notion of *a profession*, which may hold great institutional power and is oftentimes highlighted through professional boundaries, status, and agency (Gaunt & Westerlund, 2021, pp. 18–20; Jensen et al., 2022; Saks, 2016).

This study was conducted at the somatic hospital wards of one children's hospital and one eldercare hospital, where specialized medical care is provided. The wards serve as nurturing care environments, where the diagnostic work, medical procedures, and curing of diseases is naturally underlined. Exploring musicians' work as part of public healthcare services implies that all of the patients of the healthcare system are understood as potential participants of the reciprocal music making. The Finnish healthcare system is characterized by laws and restrictions that state that everyone residing in the country has equal rights to receive adequate social, health, and medical services. The objectives of the healthcare services include a premise that everyone is treated fairly, that social inclusion and participation are encouraged, and that everyone's health and functional capacity are supported (Ministry of Social Affairs and Health, 2021).

Just as the Finnish education system seeks to provide high quality education for all (Sahlberg, 2015, pp. 116–117), the public healthcare system aims to provide health and wellbeing services equally for all citizens (Ministry of Social Affairs and Health, 2021). Despite the egalitarian welfare society in Finland, public music services are not necessarily equally available to everyone (Ilmola-Sheppard et al., 2021; Väkevä et al., 2017). The Non-discrimination Act of Finland (1325/2014; Ministry of Justice, 2022) and the Universal Declaration of Human Rights (United Nations [UN], 1948) emphasize that discrimination based on any personal characteristics, such as gender, age, origin, sexual orientation, or family relationships, is prohibited. This legislation touches on values characteristic of the professional work of music practitioners, which include concerns for accessibility, inclusiveness, and the overall equality of public services (Kivijärvi, 2021; Laes, 2017). However, public services need to be affirmed not just through rights-based thinking, but also through the equal recognition of different needs within a society (Fraser, 2014, pp. 11–12). Considering music and arts professionalism as an integral part of the Finnish healthcare system engenders

a demand to analyze how individual life experiences, participation, and activity can change one's life or way of thinking in relation to their cultural wellbeing (see Lilja-Viherlampi & Rosenlöf, 2019; Laukkanen et al., 2021). Highlighting solidarity in relation to public services therefore stems from wider calls in developing societal sectors, such as healthcare services, for a more patient-centered direction (Huber et al., 2008; Wahlbeck et al., 2008). In other words, it should be possible to experience everyday *life* within healthcare through its uniqueness, and as "worth living" for everyone, despite the pathological approach—focusing on the effective cure of diseases—that inevitably dominates in medical environments.

## 1.1 Emerging music practices in healthcare

The music therapy scholar Even Ruud has affirmed that, despite many "different agents with distinct qualifications, educational training, and professional identities", many socially engaged music professionals' practices seem to be "much the same" (Ruud, 2012, p. 94). It could be further argued that a prosperous "creative arts in health and wellbeing" grounding in research and practice (e.g., Clift & Camic, 2016; Staricoff & Clift, 2011; in music MacDonald et al., 2012) has created a dynamic framework wherein it has been possible for many kinds of stakeholders, organizations, and practitioners to develop diversified research methods, empirical settings, and practices in safeguarded ways. On the other hand, the agency of arts practitioners within this frame has overlapped in a manner that may be confusing to individually distinguish not only for the practitioners themselves, but also for healthcare personnel and policy makers.

There have been some earlier initiatives to define the agency and professional boundaries of music-related practitioners in healthcare, such as music psychology and music education researcher Raymond MacDonald's review in 2013, presenting qualitative research in the wide area of music, health, and wellbeing, and aiming to increase "multidisciplinary dialogue across the multitude of professions that are involved in researching the relationship between musical participation and wider health parameters" (p. 1). Furthermore, music and health scholar Lars Ole Bonde (2019) has created a taxonomy of five different kinds of agencies in the field of music and health promotion: 1) music therapy; 2) music medicine; 3) health musicians; 4) music as health promotion; and 5) music as a diversion and/or entertainment. This taxonomy is adopted in this study, not just to differentiate individual music practitioners' agency and music practices from each other, but also to recognize the shared professional efforts and educational background of different kinds of music practitioners.





In order to focus on the previously unarticulated special features of hospital musicians' work, the following contexts and/or conceptualizations have been purposefully excluded from the empirical part of this study: music for self-care, voluntary uses of music, music medicine, music therapy, and trans-professional learning in medicine through music. As part of this pragmatic focus, the study concentrates on the socio-emotional elements of music work in somatic inpatient healthcare services that lay beyond the biological, physical, and clinical aspects of arts experiences, although all these aspects are seen as intertwined in healthcare services. These interpretations may have narrowed substantial interdisciplinary knowledge that has been produced within identical healthcare contexts, for example by music therapy research, but that also aligns with the study's endeavors to develop artistic and educational knowledge in the blurred arts-in-health field more systematically (e.g., Hoover, 2021, pp. 2–3; Laitinen et al., 2020).

Under these premises, musicians' work has been explored in manifold healthcare contexts, including eldercare (Creech et al., 2013; Moss, 2014; Richardson et al., 2015), dementia care (Daykin et al., 2018; Schmid et al., 2018), pediatrics (Guillermo & García, 2016; Hawley, 2018; Issaka & Hopkins, 2017), general hospital wards (Hallam et al, 2016; Zhang et al., 2018), and the wellbeing of hospital staff (De Wit, 2020; Preti & Welch, 2012). The professional space, musical skills and competences, other skills and competence beyond music making, specific skills needed in healthcare settings, burdensome aspects of the work, and educational requirements have been reflected and/or described in various studies (e.g., Daykin et al., 2018; Moss & O´Neill, 2009; Preti & Welch, 2013a, 2013b; Richardson et al., 2015). With reference to professional education, there are some established international in-service education programs and networks for healthcare musicians, such as "Music in Healthcare Settings" in France (Musique et Santé, 2022). Moreover, curriculum support and ethical codes for arts-in-health professionals, aiming at further professionalization, have been provided for example by the National Organization for Arts and Health in the United States (The NOAH Professionalization Committee, 2018; see also Fancourt, 2017, p. 259).

Furthermore, previous work has been conducted in research and practice on the diversified contexts and working approaches of musicians in healthcare:

- *Music in healthcare* is explored solely through cultural venues and advocacy work implemented by musicians, which create communication and participation opportunities for patients and their families (Bouteloup, 2016; Musique et Santé, 2022).

- *Hospital music* is explored as emerging through musicians' performative and artistic aspects within musicianship and emphasizes the aesthetic and social nature of the music work (Preti, 2009; Preti & Welch, 2012).
- *Health musicking* opens up a variety of contexts, practices, and conceptual work of many kinds of music-related music practitioners who work to promote the health of individuals and communities, and may also operate on the systemic levels of the society (e.g., Ruud, 2010, 2012; Stige, 2012; Wagner, 2016).
- *Care music, or music as care* explores the therapeutic uses of music in care facilities and environments (e.g., Dons, 2019; Foster, 2014; Hoover, 2021; Lilja-Viherlampi, 2013).
- *Participatory and creative practices*, which may be facilitated by musicians, is explored as part of holistic, high-quality care, and as supporting healthcare communities (e.g., De Wit, 2020; Hallam et al, 2016; Huhtinen-Hildén, 2014; Preti & Welch, 2012).
- *Music in hospital schools* is presented from the viewpoint of music education and pedagogical activity that is practiced in the hospital wards, or in separate institutionalized hospital schools (Guillermo & Garcìa, 2016; Issaka & Hopkins, 2017; Ruiz & Álvarez, 2016).

Despite this rich explorative work on healthcare musicians' practices, the analysis of theoretical aspects is not widely developed (however, see e.g., Bonde, 2011; Ekholm & Bonde, 2018). Nevertheless, three music education dissertations exploring musicians' work in care and healthcare settings have been published. Costanza Preti's doctoral research in 2009 explored the working processes of eight hospital musicians—and the impact of their work—in an Italian pediatric hospital. The study, based on the grounded theory approach, discussed the potential of live music performance in hospital environments through the perspective of musicians and participants, including children, their relatives, and hospital personnel. Preti's (2009) study claimed that there are many challenges in hospital musicians' work, such as their status, identity development, the stressful nature of the work, lack of monitoring and support, and the complexity of defining and selecting suitable musical repertoire. Classical musicians' co-creative musicking in eldercare contexts was researched in Karolien Don's dissertation ten years later, in 2019. Don's (2019) ethnographic study, which took place in the Netherlands and the United Kingdom, analyzed the understandings of the dialogical interaction between musicians and their audience in eldercare. It stated that there are particular challenges in power dynamics in-between musicians and participants, and that emerging reflective ethical perspectives are the grounding elements of musicianship in eldercare contexts. Participatory music practices within eldercare contexts that supports the learning and occupational wellbeing of hospital nurses and nursing home caregivers was the topic of Krista De Wit's (2020) recent dissertation. The study, carried out in the Netherlands, investigated live music in nurses' workplaces through an ethnographic approach from the perspective of philosophical pragmatism, and a broad conceptual framework of theories relating to wellbeing. The research suggests that participatory music practices may support person-centered care, healthcare professionals' participation, and the understanding of compassionate care beyond their professional performance (De Wit, 2020). Together these doctoral studies point towards developing the understanding of music as an artistic and/or pedagogical practice, integral to the medical and care environments.

## 1.2 Shared interests at the nexus of music performance, music education, and music therapy

During recent decades healthcare professionals and policy makers, as well as entire healthcare systems, have placed an increasing emphasis on arts as an integral part of publicly funded healthcare (All-Party Parliamentary Group on Arts, Health and Wellbeing, 2017; Laitinen et al., 2020; Liikanen, 2010; Stickley & Clift, 2017). This affluent sector, which is often called "arts, health, and wellbeing", could be characterized as innovative in nature (Clift & Camic, 2016; in music see MacDonald et al., 2012). Frequently, interdisciplinary research and practice in this area is defined through an understanding that arts and engagement in the arts and culture have the potential to impact the health and wellbeing of individuals and communities (Fancourt, 2017, p. 23). These expectations are based on the growing body of evidence provided by measuring the impacts of the arts in relation to health and/or wellbeing, which has been very successful in music-related research as well, such as neuroscience and music (Särkämö et al., 2008; Thaut & Hoemberg, 2014), the psychology of music (Hallam, 2010), and a wide range of music practices within health promotion and public health (Bonde & Theorell, 2018).

Although practical and political collaboration has been promising, unsustainability on many levels—funding, practices, research, intersectoral collaboration, and theory development—is hindering the development of arts-in-healthcare (Stickley & Clift, 2017, pp. 1–4; see also Clift et al., 2021). As a distinctive phenomenon in many countries, the associated practices, and especially research in the context of arts-in-health, have consisted so far of a rather fragmented sets

of projects rather than a coherent developmental process (Belfiore & Bennett, 2010; Fancourt & Finn, 2019, pp. 51–53; Stickley & Clift, 2017). Overall, throughout the years many scholars have advised researchers and practitioners to carefully reflect on their work when conducting and reporting arts-based activities and research (e.g., Belfiore & Bennett, 2010; Clift et al., 2021). Therefore, in this study, this complexity is approached through a critical view of healthcare musicians' work as a "healing practice", or as a social practice that aims to "help" or somehow set free marginalized groups.

Discussion of music professionals in healthcare has usually concerned music therapists, who work as people-centered clinicians in hospitals and other healthcare settings (Ansdell & DeNora, 2016; J. Edwards, 2016). Many grounding arguments on the societal and health benefits of arts-based work stem from the clinical and academic work conducted by music therapists (e.g., Bonde & Theorell, 2018, p. 1; Fancourt & Finn, 2019; MacDonald et al., 2012, p. 20). Music therapy research, drawing from interdisciplinary knowledge and the discipline called music therapy, has established a body of evidence for practice in medical and other settings globally (J. Edwards, 2016; Wheeler, 2015; Wigram et al., 2002). To focus on music professionalism that does not consider music therapy, or the therapeutic uses of music was an explicit decision made in the beginning of this research process, seeking to explore the arts and arts education as a public service. Furthermore, this study aims to explore healthcare musicians' work as artistic and music educational practice and a bio-psycho-social phenomenon, extending beyond the solely biomedical body of evidence (Ruud, 2017, p. 670).

The broader connections of music and the arts in relation to healthcare have generated discussions over recent decades but are not yet widely recognized by higher music education institutions. In recent years, developmental efforts on socially engaged arts-based work have been focused on new agendas that can inform future views on the field (Daykin, 2021). For example, cross-sectoral policy level work is grounded by an increasing awareness of basic cultural rights safeguarded by the Universal Declaration of Human rights (UN, 1948). Various national and international human rights conventions have required policy makers, institutions, organizations, and individual professionals to consider cultural needs as basic needs (UN, 1948; in Finland see Koivisto et al., 2020; Lehikoinen & Rautiainen, 2016). Many music education scholars in Finland have introduced expanding music professionalism as part of a wider development in professional work, drawing from social justice and social change theoretization (e.g., Kivijärvi, 2021, pp. 29, 36; Laes & Westerlund, 2018; Timonen, 2020, pp. 17, 34) as well as the expansion of novel spaces for professionals (Westerlund & Gaunt, 2021; Westerlund et al., 2021).



Acknowledging the relationship between wellbeing and culture, a concept of *cultural wellbeing* has shaped recent arts-in-health discussions in Finland. Through cultural wellbeing, the interchange of arts, culture, health, and wellbeing is seen as an important facilitator of the participation and wellbeing of citizens, and has been recognized at practical, organizational, and societal levels (Laitinen et al., 2020; Ministry of Education and Culture, 2018). This significant refinement of the role of arts practices in healthcare has been developed through effective cross-sectoral policy management (Stickley & Clift, pp. 33–34) and rapid professionalization. Therefore, the cultural wellbeing definitions used at any one place and time may at the moment depend on the ways that different practitioners, stakeholders, or institutions define them (Laitinen et al., 2020). Following cultural wellbeing researcher Liisa-Maria Lilja-Viherlampi and arts-in-health specialist Anna-Mari Rosenlöf, Finnish arts-based and artistic researchers, including the author of this dissertation, define cultural wellbeing "as a phenomenon in which people *experience* culture and the arts as increasing their well-being and as a field of multidisciplinary and multi-professional activity, development, education, and research, as well as a field of service" (Laukkanen et al., 2021, p. 2, italics added; see Lilja-Viherlampi & Rosenlöf, 2019). As this emerging ecosystem of cultural wellbeing calls for further theoretical and academic elaboration, such as engaging with community-oriented views on wellbeing, and acknowledging the agency of all people who are participating in culture and the arts (Ilmola-Sheppard et al., 2021, p. 24; see Huhtinen-Hildén & Isola, 2019), it will also be developed further throughout this dissertation.

## 1.3 The researcher's multilayered sphere

This research has contributed to The Arts as Public Service: Strategic Steps Towards Equality (ArtsEqual) consortium project carried out in 2015–2021 and funded by the Strategic Research Council (SRC, 2021) of the Academy of Finland. This study specifically added to ArtsEqual's interdisciplinary aim to explore arts practice and art education as a form of public service, to support social justice and improve the social determinants of health and well-being of the citizens (Ilmola-Sheppard et al., 2021). During my doctoral research I was affiliated with one of ArtsEqual's research sub-groups, *Arts in Health, Welfare, and Care*, which examined accessibility to arts-based services in care contexts and explored how participation in arts and culture can increase individuals' cultural and social capital and improve their capability to make choices that foster wellbeing and contribute to the common good (Lehikoinen, 2019; Laukkanen et al., 2021).

One of the main demands of the SRC-funded interdisciplinary consortia is to produce an extensive amount of research knowledge for Finnish society, which is then passed on to, or co-constructed with, stakeholders and policymakers to communicate effectively, promote the social impact of the research, and prepare legislation (SRC, 2021). As a response to this demand, I, as the leading researcher of this study, initiated a policy recommendation (a policy brief) to support science communication and offer research-based knowledge to reinforce decision-making.

As a musician, music educator, music therapist, and researcher, I have been part of ever-changing and intermingling discourses, where my place has differed depending on who or what circumstances were defining it. I have experienced that professional boundaries and power dynamics can play a crucial role in research. Instead of representing my positionality, a *researcher's sphere* better describes my research journey in-between complex systems and research fields (Holmes, 2020; Subramani, 2019; see Laes, 2017, p. 14). Throughout the dissertation journey, I have had three important paths to follow: *writing as knowing; identifying and developing a sphere of my own; and becoming a reflexive research practitioner*. As the emphasis throughout the study has been on a reflective and curious attitude, and sharing the journey together with other people, these paths have been ever-changing and evolving.

I have prepared this dissertation from within a music education doctoral community (see Laes & Hautsalo, 2020) that follows a community of practice (Wenger, 1999), where I was able to be freer and more creative in my professional thinking than before, and still identify myself as a highly ethical and responsible music practitioner. From the beginning until the end of this research process, *writing as knowing* (Richardson, 2003) was for me an ongoing process, including writing many kinds of texts: professional articles, reports, individual blog posts and series, peer-reviewed articles, and so forth. Taking a publicly engaged scholar stance was not easy in the beginning. Writing as knowing, in that sense, included all literal activity relating knowledge-building in a very holistic way, such as the processual nature of attending academic conferences and immersing in the actual stages of the research process in and through the presentations.

The second researcher path, *identifying and developing a sphere of my own*, was created through the music education research seminar in which I participated for altogether five and a half years, first as a doctoral candidate, and then as a doctoral associate. Collaborative discussions on musical and societal phenomena have had a transformative effect on my reflections regarding this study. As with many other doctoral candidates, at first I felt rather isolated when starting the research project. At times I felt uncomfortable, as the hybrid professional approach applied in this research resulted in some questions being posed by my colleagues. Little by little I became more familiar with my interdisciplinary topic, which fortunately became more centered in the political and educational discussions as the doctoral process progressed. This process stemmed from my work in the early 2000s, when I, along with other experimental music practitioners, worked in collaboration with various health promoting associations within socially diverse working contexts. At that time, socially engaged music work in Finland was often navigated rather intuitively towards ethically right and just work, because the field was not necessarily recognized as arts-based work. My research area, and socially engaged work overall, became more topical within the arts and cultural policy later in the 2010s (Liikanen, 2010; Ministry of Education and Culture, 2018; see Clift & Camic, 2016; MacDonald et al., 2012). It was satisfying to understand that the interdisciplinary field had started to integrate into broader societal frames.

To be-in-the-world, and to experience the world with others, has been the key academic instrument in my doctoral journey, and facilitated me in *becoming a reflexive research practitioner.* For me, "reflexivity as practice" (Subramani, 2019, p. 2)—seeking to adopt reflexivity within the researcher's everyday practices—signified adopting a novel approach towards time and space. Sometimes the time went by very quickly, and making decisions relating to the research was easy. Other times, lingering in the moments and reflecting on professional and personal experiences proceeded at a very slow pace. For me, the research process was neither an act of translation within a certain context or culture, nor the interpretation of an observer, but an interplay between these two aspects. This "insider-outsider dialectic" (Holmes, 2020, p. 5) represented a considerable part of my reflective path, since I was thoroughly intertwined with the practitioner's grass-roots approach as a researcher.

As I have aimed to develop a sphere that serves as my personal research approach, I believe that open acknowledgement of one's professional situation and experience is one key to the betterment of research in interdisciplinary fields. Although I expect, as a white privileged woman, never to be able to understand the life of a truly marginalized person(s) or communities, I feel that it is time to start seeking for a better understanding of how all music professionals could provide more equally driven music practices (e.g., Baines, 2013). In this way we could prevent phenomena where the self-promotion activity of music professionals goes too far and is in danger of developing even ethically suspicious managerialism practices (e.g., Byers, 2020; in organizational studies see Noordegraaf, 2015, 2016). Furthermore, I have consistently aimed to reflect my ethnocentricity, but find it important to emphasize that reflexivity indicates that my relational interpretations are "perspectival" as such (Alvesson & Sköldberg, 2018, p. 4).

## 1.4
## Structure of the dissertation

This dissertation consists of four sub-studies, which were reported in four articles in international peer-reviewed journals (see Part II, Articles I–IV). The first published article is a theoretical pre-study, supporting the design and implementation of the multiple case study. The next three articles are individual case studies drawn from the theoretical starting points and the empirical material of the study. Each of the sub-studies contribute to the overarching task, explore the research questions, and aim to fulfill the objectives of the study. The findings of each study are synthesized further in this dissertation summary through a cross-case analysis. A policy recommendation that originated from the findings was produced collaboratively by an interdisciplinary working group and serves as one of the contributions of the dissertation, as well as a starting point for further theoretical elaboration within the discussion section (see Part II, Article V).

The dissertation summary is divided into two parts: In part I, the grounding of the study is described, and followed by a discussion of the researcher's sphere (chapter 1). After this introduction, the theoretical starting points are outlined, and the research task presented (chapter 2). Next, a description of the research process, methodological choices, and ethical considerations are provided (chapter 3). Then, the findings of each sub-study, the key contributions of the policy recommendation, and a summary of the findings are presented (chapter 4), and synthesized in the discussion section (chapter 5). Finally, the conclusions, limitations, and future potential of the study are discussed (chapter 6). Part II includes the reprinted scientific articles (referred to as articles I–IV), a policy recommendation (article V), and material relevant to the successful implementation of the research process (referred to as appendices 1–3).

# 2
# THEORETICAL STARTING POINTS AND RESEARCH QUESTIONS

In this study, music professionalism is approached by investigating how musicians develop and maintain their professional practices and space from very grassroots levels to the community level in hospitals. As indicated in the Introduction, musicians' work in healthcare settings is part of an emerging *expanding professionalism*, explored by music and music education scholars Heidi Westerlund and Helena Gaunt (2021), theorizing and describing the potential of music practitioners' work in socially diverse contexts and as shaped by these contexts. Furthermore, musicians' work is understood as involving a dynamic social practice, namely *boundary work* (Gieryn, 1983, see also Akkerman & Bakker, 2011), which is manifested in and through exploratory interprofessional aspects, and professional and organizational boundaries in healthcare.

The theoretical starting points of this study engage with understanding artistic work as extremely hybrid in nature, as sociologist Pascal Gielen has described (2009, 2015, see Lehikoinen et al., 2021). In healthcare musicians' work, hybridity is understood not just as reflective, unsettled, and creative interdisciplinary action that intertwines with music practices in healthcare contexts, but also as socially engaged professional practices that challenge conventional musical expertise by reaching beyond the musical qualities of the work. More specifically, the musicians' work is explored through the concept of *hybrid professionalism*, which has been examined in organizational studies, for example, by Mirko Noordegraaf (2015, 2016; see Faulconbridge & Muzio, 2008). Hybrid professionalism requires boundary work, and reveals professionalism as something that is in constant motion and highly relational in nature, recognizing the relationality to depend on and transform within the context, space, and time wherein the professionals work. Hence, hybrid professionalism in this study incorporates the idea of *relational work*, which refers to the practical, philosophical, and ethical choices and activities at work as relational (Edwards, 2010, pp. 1, 37; see also Frelin, 2013; Noordegraaf, 2015). In relational work, all social activity, such as arts and music, is transactional and reciprocal in nature, and in relation to the context and space wherein the activity—or being—takes place. Furthermore, *relational expertise* and *relational agency*, as investigated by cultural-historical and educational scholar Ann Edwards, includes the ability to connect with the changing expertise and agency of the practitioners themselves, but also of others (Edwards, 2010, pp. 13–15, 61–63; see Tsoukas, 2009). The theoretical starting points of this study are presented in Figure 1.


***Figure 1. Theoretical starting points for expanding music professionalism in healthcare contexts.***

## 2.1
## Boundary work in healthcare

Healthcare is understood in this study as a service system that includes healthcare musicians, whose work intersects with other systems such as cultural organizations systems, policy systems, performing arts systems, and higher music education systems. Healthcare thus offers an interesting context to explore boundary work in-between multiple systems. Boundary work, deriving from boundary studies, is an academic field consisting of applied research practices, constructing a multidisciplinary alternative towards a centrist focus on academic disciplines (Wansink & Ittersum, 2016; see Gieryn, 1983), where one discipline dominates. On a paradigm level, boundary studies appraise diversity (Finlay, 2008; Star & Griesemer, 1989) and help to bring decentralized issues into public discussion (Akkerman & Bakker, 2011). By exploring systems as social, interrelated, and interactive entities, this study engages with "a shift of mind" (Senge, 2010, p. 22);

namely, instead of investigating music practice as a separate or isolated activity, systems thinking reveals a deep interconnectivity with the changing world, in this case the spaces in-between the systems where healthcare musicians' boundary work takes place. Furthermore, systems—possessing diversified philosophical, organizational, and institutional logics—are here understood as multi-voiced in nature, involving multiple voices and interpretations (Akkerman & Bakker, 2011; Thornton et al., 2015). As such, the systems view, including boundary work as a dynamic social practice, addresses a necessary aim to gradually advance innovative and systemic thinking, as well as future professionalism, through the agency of *all* the people involved within the systems (Aungst et al., 2012; Star & Griesemer, 1989; in music see Westerlund et al., 2019).

Having access to different systems disentangles the possibilities for analyzing boundary work in relation to societal interaction. Crossing boundaries through boundary work helps practitioners to enter a new professional space, where they to some degrees are newcomers and professional learners (Star & Griesemer, 1989; in the arts see Laukkanen et al., 2021). Moving in-between systems, here mainly healthcare institutions and cultural or arts institutions, provides access to the other systems' resources, which may be unfamiliar to the boundary workers. These kinds of resources, explored through the "otherness" and systemic logics (Thornton et al., 2015; Weiner-Levy & Queder, 2012) of another system, may be for example rules, protocols, procedures, professional practices, or professional relationships (Engeström, 2001; Finlay, 2008). By providing collaborative opportunities, these resources unfold a possibility for a transformative reconceptualization of the time, space, and focus of practices.

Boundary work does not always have an established knowledge or theoretical basis, and often includes a peripheral quality, which can be confronted with great resistance (see Akkerman & Bakker, 2011; Star & Griesemer, 1989). In that sense, boundary work may even be understood as a practice that can be implemented with a precarious nature, threatening the best patient care and hierarchy of the healthcare system (Aungst et al., 2012; Christiansen et al., 2017). Undoubtedly, blurring boundaries and working in-between those boundaries involves both uncertainties and possibilities. Concurrently managing and understanding boundary spaces forms a strong rationale for boundary work within arts-related professions. In line with the systems approach, music professionalism is this study is understood as a deeply interrelated and socially constructed activity and practice. Accordingly, working at the boundaries of professions, disciplines, and organizations has an integrative nature, and therefore carries a great value in supporting the vulnerabilities of our societal systems, which have lately been exposed, for example, through the global pandemic (Ahrendt et al., 2020; Zhongming et al., 2020).





## 2.2 Hybrid and relational views on professionalism

This study explores healthcare musicians' hybrid professional work as a thoroughly social and connective practice (Noordegraaf, 2016, p. 802), adding a further interconnected layer onto the existing hybrid theoretization, which explores professionalism as a merely organizational or managerial professional property (see Faulconbridge & Muzio, 2012; Noordegraaf, 2015). As Noordegraaf has advised, beyond their skills-based focus, future professionals should be able to "connect to other professionals, other disciplines, and outside worlds" (Noordegraaf, 2016, p. 802). In line with wellbeing-oriented hybrid theories (e.g., Woodard, 2015), hybrid professionalism may include contradictions, which do not necessarily need to be solved, but merely recognized and reflected on in an ethically relevant manner, leading to a better understanding of the hybridity. In the arts, this hybridity may include interesting contradictions between liberalistic agendas and the so-called intrinsic nature of the arts. Following the ideas of liberalism and economic consumerism (Noordegraaf, 2015; see Carvalho, 2014), music professionals in healthcare would maintain a position of business owners and/or managers, pursuing the principles of managerialism by selling their professional products, which are presented as cheap and effective interventions in healthcare. In contrast, their work may simultaneously be seen as part of holistic care, or as part of cultural efforts extending beyond health services, establishing the intrinsic nature and aesthetic values of arts and culture in societies (Belfiore & Bennett, 2010; Moss, 2014; Napier et al., 2014). Instead of making this dichotomous distinction between instrumental and intrinsic values and uses of music, the diversified nature of musicians' work and the multitude of subjective and contextual values within everyday music making practices comes under scrutiny in this study (see also Siljamäki, 2021, pp. 221–223).

Some of the theoretical underpinnings of professional work in healthcare may be presented as part of a broader frame of expanding professionalism. Starting firstly with the practice of the artists themselves, expanding professionalism may serve as a catalyst of social change (see Daykin, 2019; Dunphy, 2018). Hence, participation and shared music-making may be understood as a social change mechanism itself (Dunphy, 2018), wherein the objective of the artistic work in healthcare is not necessarily to intentionally *change* anything by themselves, but instead to adopt a curious and open attitude, which as a proactive approach may support engagement in collaborative work, thus enhancing societal transformation. The setting is especially fruitful when working within the boundaries of professions, disciplines, and organizations (Evetts, 2009; Gieryn, 1983; Pekkola et al., 2018).

Beyond the effects of individuals who experience personal transformations, social change requires some reorganization within respective systems if change is desired as a final goal of the activity (Dunphy, 2018). In relational work, the *unfolding* of things and activity is essential, referring to a process where something becomes revealed through time, space, and explicit meaning-making between people. As Edwards argues: "Relational work calls for an enhanced form of professionalism, which includes the capacity to identify organizational goals, to question organizational purposes and practices as well as to contribute to and recognize the distributed expertise available to support actions on complex problems" (Edwards, 2010, p. 37). Professionalism then becomes reconceptualized in a relational sense, as professionals preferably engage in problem-solving with each other rather than protecting their professional boundaries. In addition, professional work is reshaped with an understanding that (net)working in systemic and relational ways often requires engagement beyond projects, time limits, fixed spaces, or professional boundaries (Järvensivu & Möller, 2009; Senge, 2010, p. 8).

Central to relational work (Edwards, 2010) is interprofessionality. Interprofessional work refers here to a phenomenon where two or more professions work in cross-settings and learn together respectfully during all or part of their work (Cribb & Gewirtz, 2015, p. 150; World Health Organization [WHO], 2010). Sometimes interprofessional work is related to an activity where professionals work in the same environment or context, but do not necessarily interact or collaborate. In the context of interprofessional work in healthcare (see Barr et al., 2016; WHO, 2010), the music and healthcare professionals are expected to collaborate, at least to some extent, and share all or some of the objectives of the work together. One of the shared objectives of interprofessional work in somatic healthcare is to support the potentially fragile and vulnerable patients and their families during the hospitalization process (e.g., Dons, 2019; WHO, 2010). Simultaneously, it is important to acknowledge patients' integrity and agency in healthcare, which may be related to their experienced wellbeing (Caspari et al., 2006; see Ruud, 2017). As presented earlier, developing these abilities and a *will* to relate and share agency with the participants within *socially responsible work* (Sugrue & Dyrdal Solbrekke, 2014, pp. 11–12) requires the capacity for relational agency (Edwards, 2010; Edwards & Mackenzie, 2008). Relational agency, as part of a larger relational turn in professional work, provides "an alternative to the idea of professionals as heroic individuals who are given status through their ability to work autonomously" (Edwards, 2010, p. 61). This agency with dependency, in a relational sense and more generally as an altruistic human capacity, is embedded within the social situations, and may bridge change and development (Daykin, 2019; Dunphy, 2018; see Emirbayer, 1997). Furthermore, relational expertise brings forth an alternative form of expertise, which allows collaborative work that acknowledges and deepens not just the expertise of an individual professional, but also other professionals (Edwards, 2010, p. 13), and in healthcare the expertise of the patients and their families in relation to their life situations at hand. This kind of expanding professionalism thus encourages arts professionals to take a proactive and responsible approach to social change, aiming to facilitate both the professionals' abilities to support the agency and expertise themselves and that of all people involved in the artistic practices, and their understanding of the rapidly evolving societal and contextual issues.

## 2.3 Artistic and musical expertise in healthcare

In this study, a healthcare musician is considered to be an expert of musical work in healthcare. Expertise, as a highly specialized knowledge, skills, and competence in and through music, has been traditionally emphasized in musicians' performative work and their education (e.g., López-Íñiguez & Bennett, 2020; Mishra, 2019). As Westerlund et al. (2019) describe, although "sustaining the expert tradition is important… the social practices that fuel this process need to be constantly scrutinized against the emerging needs of a late modern society" (p. 27). In healthcare contexts, this means that the expertise and agency of not just music professionals, but also the other participating professionals, patients, and their families, should be considered and respected (De Wit, 2020; Dons, 2019; Ruud, 2017). Relational expertise is not then defined by the social position or other pre-set parameters of a practitioner, but is negotiated within the everyday working environments through collaborative problem-solving (Edwards, 2010, pp. 1–2). Thus, healthcare musicians' work may be grounded on musical skills and expertise, but also needs to reach beyond their musical competences.

An enduring lack of aesthetic environments (Moss, 2014, p. 6; Moss & O´Neill, 2009), impacting the whole healthcare community—patients, their relatives, nurses, and healthcare personnel—is an issue that musicians as musical experts usually face in their work in healthcare. Beyond the concept of aesthetic deprivation, there are several historical arguments drawing from the philosophy of aesthetics that may mirror the issues of music making in healthcare. Music therapy researcher Hilary Moss has explored these theoretical underpinnings and classical philosophical arguments in her 2014 dissertation studying aesthetic deprivation and the role of the arts for older people in hospitals. Following the argumentation of Moss, Stige (2002), and Barrett (2002), I have categorized these themes, which as implicit pre-understandings often create additional complexity within artistic

work in healthcare: 1) arts and artists may be seen as divinely inspired; 2) arts as cathartic action may help emotional and ethical articulation, and help us to escape from everyday life; 3) arts possess a beautifulness which pleases the soul; 4) in addition to their instrumental uses, arts also have an important intrinsic nature, and should be valued as a craft; 5) arts create a rationale for our being in the world, and are something we make sense with (Moss, 2014, pp. 6–10; Stige, 2002, pp. 61–62, see Barrett, 2002). It can be argued that all of these presented aesthetic views are held in relation to later societal development, which principally enabled arts—mainly the so-called higher arts as an elitist entity—to be established as autonomous institutions in society (Stige, 2002, p. 61). However, contemporary arts professionals are increasingly facing situations where these traditional aesthetic principles are challenged, reconstructed, and transformed in a significant manner (Gielen, 2009; Gielen & De Bruyne, 2012; Revelli & Florander, 2018).

In addition to facing issues related to artistic aesthetics, the professional identities of musicians may be challenged in healthcare environments (see MacDonald et al., 2017; in music therapy see Ruud, 2010, chapter 3). A professional identity refers here to fundamentally social ways of *being* and *doing*, identity work that is in constant flux through continuous negotiations that take place in the contexts where musicians work (Hargreaves et al., 2017, pp. 3–5, p. 8). Hence, identity may include thoroughly musical aspects, but as Hargreaves et al. (2017) argue, musicianship "is by no means restricted to individuals who have high levels of conventional instrumental performance ability" (p. 5). As sociologist Tia DeNora (2017) has noted, relational musical identities involve hybridization (p. 60), which is manifested through their interchangeability and flexibility. However, in this study the professional identities of musicians are not considered utterly hybrid—as mixed and/or somehow disintegrated—but merely enriched through the social and musical negotiations that entail relational music practices in healthcare. Nevertheless, identity work pertains not just to the identities of the professionals, but also to those of the patients and their families, which may be perceived as liminal or threshold identities (pp. 59–60) that are under ongoing flow. This approach highlights the understanding of both professional and patient identities as relational and taking shape relationally.

## 2.4 Overarching research task and research questions

The overarching research task of this study is to investigate musicians' professional work in relation to their expanding, hybrid professionalism in the Finnish healthcare system. To fulfill the overarching task of the research, the objectives are:

1. to map the interprofessional possibilities and challenges within the healthcare environments;
2. to explore the professional music making practices that musicians implement in somatic healthcare services; and
3. to develop a better understanding of hybrid professionalism through arts in health policies, stakeholder collaboration, and education related to arts organizations and healthcare systems.

The grounding research question covering the overarching task of the study is:

> *How does healthcare musicians' relational work inform a new understanding of expanding, hybrid music professionalism in a changing society?*

To cover the overarching research task, the main findings of the study are presented through four peer-reviewed studies addressing research questions formulated within each research context. Based on the studies—a systematic literature review and three case studies—and the collaborative work of interdisciplinary scholars and practitioners, a policy recommendation was created that also serves the research task. The sub-questions were formulated as follows:

- *Sub-study I: A literature review.* According to the literature, how is the hybrid professional work and space developed by the healthcare musicians in somatic hospital wards?
- *Sub-study II:* How is professionalism expanded through healthcare musicians' relational and hybrid professional work and interprofessional reflections in neonatal intensive care units?
- *Sub-study III:* How could the understanding of healthcare musicians' expanding professionalism contribute to eldercare hospital work and the development of music professionalism in higher music education?
- *Sub-study IV:* How might the emotional and expanding work of healthcare musicians in end-of-life contexts support families in hospital wards?

As part of a reflexively designed and conducted multiple case study, these sub-questions guided the inquiry throughout the research process.

# 3
# RESEARCH APPROACH AND EMPIRICAL MATERIAL

## 3.1.
## Multiple case study

This inquiry employs a multiple case study design—known also as collective case design—where several cases are selected to develop in-depth understanding beyond a single case (Stake, 1995, 2006, p. 22). Building on reflexive research (Alvesson & Sköldberg, 2018), I refer to this inquiry as a *multiple case study approach*, serving as both a methodological framework and a research strategy (Stake, 1995, 2006; Yin, 2018). The research questions and theoretical starting points guiding the research process were emphasized through reflexivity where generic sampling for cases, or utilizing rigorous methodology, was not realistic, or even relevant. Instead, to demonstrate a common structure and consistency (Brereton et al., 2008), the crafting and shaping of methodological instruments (such as cross-case analysis) and protocols was selected as a strategic tool. Although case studies work well for constructing theoretical views (Yin, 2018, p. 58), theory development is known to be complex and requires a large amount of effort within the case framework. Consequently, it is recommended to establish some theoretical underpinnings before the empirical explorations (Yin, 2018, p. 77). In practice, the process "alternates between (previous) theory and empirical facts (or clues) whereby both are successively reinterpreted in the light of each other" (Alvesson & Sköldberg, 2018, p. 5). According to Yin (2018, p. 66), it is crucial to avoid a situation in which the research findings do not address the research questions, and there is more to research design than just a working plan.

The research plan of the project, grounding the design of this research process, was updated regularly, and allowed space for an abductive approach: moving in-between inductive and deductive cycles in the research process, where the theoretical and empirical levels could interact and intertwine, as the study progressed (Alvesson & Sköldberg, 2018, p. 5). Towards the end of the process, there emerged a need for a more rigid and multilevel planning, and a case study protocol called "Healthcare musicians 2016–2022" was created (see Koivisto, 2022b). The case study protocol was constructed subsequently after the generation of the empirical material, in order to: 1) analyze, synthesize, and strengthen in a systematic way the multiple case study at hand; 2) better bridge knowledge in-between disciplines, organizations, and practitioners (i.e., the micro-, meso-, and macro-levels of the inquiry); 3) and to facilitate the research at hand, as well as future educational and artistic research projects that include multiple sources of data in healthcare.

The case study protocol follows the reporting items in Yin (2018, pp. 66, 87), Brereton et al. (2008), and Pucihar et al. (2015), when applicable to the qualitative methodology of the inquiry at hand. The best practices of the PRISMA-P reporting methodology (Preferred Reporting Items for Systematic Review and Meta-Analysis Protocols; Moher et al., 2015) were also applied. The document contains information and instructions for carrying out and reporting the multiple case research approach, single case studies, and cross-case analysis. As such, it served as a strategically valuable tool for conducting a non-medical, non-registered qualitative multiple case study in healthcare environments. The public protocol documents include a systematic review protocol (Koivisto & Tähti, 2019) for the preliminary literature review, a data management plan created by a data management planning tool (DMPTuuli; Koivisto, 2019a), and a General Data Protection Registration privacy statement (GDPR compliant document; European Commission [EU] 2016/679; Koivisto, 2019b). An anonymization plan (Anonymisointisuunnitelma; see Koivisto, 2022a) was created in February 2021 to open the interview raw data. The anonymization plan included an assessment of the possibility for identifying research participants through the data after anonymization, and the need for residual risk assessment in the future. In addition, the interview data of the multiple case study, and the documentary background information on the generation of the empirical material (such as documents informing the empirical part of the study and informed consent forms; see Appendix 2: Information letter and informed consent form for the empirical part of the study), were stored in the Finnish Social Science Data Archive (Koivisto, 2022a).

As presented earlier, by employing a reflexive multiple case study approach this study sought to meet the research project objectives and the overarching research task on multiple interrelated levels: contextual, practical, and theoretical. The design allowed the sub-studies to adopt a diversified nature: the first study being a descriptive case, the second study an instrumental case, and the third study an in-depth case. Rather than seeking direct replication, the cases represent three of the multiple working contexts of healthcare musicians (NICU, eldercare hospital, and end-of-life care). Beyond contextual diversity, the methodological validity was strengthened by utilizing replication logic in the thematic analysis of the cases (Yin, 2018, p. 87). This helped to form a stronger theoretical basis—connected to the epistemological and methodological reflexivity—to explore research phenomena (Alvesson & Sköldberg, 2018, p. 13).

In practice, the research approach was developed through four phases: 1) planning, defining, and designing the research; 2) generating the empirical material;

3) analyzing, reporting, and publishing the cases; and 4) conducting a cross-case analysis and writing this synthesizing text, called the *kappa* (see Table 1. Research approach: Multiple case study).

MULTIPLE CASE STUDY

| 1. DEFINE AND DESIGN | 2. PREPARE AND GENERATE | 3. ANALYZE AND CONDUCT |
|---|---|---|
| Review literature | Conduct ethical reviews | Write and publish individual case reports |
| Develop theory | Conduct empirical research<br>Hospital 1 (Eldercare hospital)<br>Hospital 2 (Children's hospital) | Case 1: Descriptive / NICU |
| Select cases | | Case 2: Instrumental / Eldercare |
| Design research approach | Establish a case study database<br>• Participant observations<br>• Participant interviews<br>• Professional narratives<br>• Other interviews | Case 3: In-depth / End-of-life care |
| Implement pilot study | | |

| 4. ANALYZE AND SYNTHESIZE |
|---|
| Draw cross-case conclusions |
| Modify theory |
| Develop policy implications |
| Write cross-case report / Synthesizing kappa |

***Table 1. Research approach: Multiple case study.***



In a case study design, beyond the consideration of specific data items, there may be many more interesting variables to research, such as theoretical elaboration and developing an analysis approach (Yin, 2018, p. 50). All these variables guide the design of the study and the generation of the empirical material, which should preferably include multiple sources of evidence, and therefore it is usually recommended to establish a case study database. The database of this study was formed through both non-empirical and empirical material. The non-empirical material included the data of the systematic review, other relevant manually searched literature (such as gray literature, international recommendations, and reports), and the documentation provided by hospitals and musicians (such as leaflets, grant applications, information packages for the patients and healthcare personnel, etc.). The empirical material consisted of interviews and participant observations. The musician participants of the study also wrote professional narratives, and I kept a researcher's diary, although the diary did not become a decisive data set in the research process.

Creating multiple sources of data followed Yin's (2018) four principles of data collection in case studies: 1) use multiple sources of evidence; 2) create a case study database; 3) maintain a chain of evidence; and 4) exercise care when using data from social media sources (p. 176). Although Yin (2018, p. 178) recommends six sources of evidence to strengthen the cases, four sources (interviews, participant observations, written professional narratives, and a researcher's diary) were considered as sufficient for a clear and strong case presentation, linking to the emerging theoretical underpinnings of the study (Stake, 1995). Utilizing a chain of evidence is an influential principle to follow in case study research (Stake, 1995; Yin, 2018), which increases the reliability of the study. A chain of evidence, as the valid storyline of the case, should be rigid and yet open enough, allowing the reader to follow the investigator on the case (Yin, 2018 p. 206). Although a narrative approach is not employed as such in this case design, the chain of evidence is built on presenting the cases through a narrative technique, which step-by-step strengthens the theoretical perspectives and case study evidence (Alvesson & Sköldberg, 2018, pp. 158–159; Butler-Kisber, 2018, p. 87).

## Systematic literature review

Serving as a preliminary study before starting the generation of the empirical material, the qualitative systematic review launched the whole research process. In addition to exploring literature on healthcare musicians' work, the review helped to develop theoretical starting points for the study before beginning the actual research in the field. As a conceptually informative study, the review facilitated

the selection of the actual cases of the study. I collaborated with the University of the Arts Helsinki library's research unit and decided to utilize the PRISMA method (2018; Moher et al., 2015), which would make the study more systematic in nature. A systematic review protocol was created and served as a route map in the review process; it is publicly available in the Zenodo open data repository (Koivisto & Tähti, 2019). To strengthen the credibility and validity of the study, ethnomusicologist Taru Tähti, a doctoral researcher investigating arts-based agencies in care, conducted the study with me. We had several meetings over a span of six months, planning and conducting different phases of the study, and writing the actual research article collaboratively. We used the PICO(T) tool (Riva et al., 2012) to shape the aim and research questions of the study. In the data search and management phase I was the guarantor, while Tähti contributed to the development of the selection criteria of the articles, the risk of bias assessment strategy, and data extraction. The process ended with so few eligible articles (16) of the total 288 screened articles that we did not perform a quantitative analysis. We still decided to apply the ROBIS tool to assess the bias of the study, although it has served mainly as a quantitative tool (ROBIS, 2018; Whiting et al., 2016). The data was analyzed descriptively and thematically, and the Critical Appraisal Skills Programme tool for systematic reviews (CASP, 2018) was used to assess the quality of the included studies. As the studies were very heterogeneous in nature and theoretical articles were also included in the review, conducting the CASP evaluation turned out to be rather challenging, for example within the categories evaluating the "value" of the studies overall, or reflecting on ethical issues. Differing from many systematic literature reviews, we presented an extensive qualitative and theoretical review, including contextual premises. This approach allowed a discussion section, where music therapists' and musicians' work was explored in a parallel fashion.

## 3.2 Generation of the empirical material

The multiple case study process started in 2016–2017 by identifying the collaborating healthcare musicians and hospitals. When searching for suitable research hospital contexts, the eligibility criteria were: 1) hospitals or hospital wards with the necessary resources and will to collaborate with an external non-medical researcher; 2) hospitals that already had collaborated with healthcare musicians (i.e., the music work was not provided solely within a project or was not temporary in nature); 3) the music work was arranged in somatic hospital wards on a weekly basis; 4) the generation of the empirical material could take place in the time frame of 2018–2019; and 5) the research permit processes before the field work were likely to be conducted within the scope of one year. I had discussions with many stakeholders and ended up starting the collaboration with a children's hospital, administered by a hospital district, and an art-promoting eldercare hospital, administered by a city.

It was agreed that the generation of the empirical material in an eldercare hospital would take place in orthopedic and infection wards, but it was unpredictable where the research in the children's hospital could take place. Therefore, the research permits were prepared to include people of all ages; babies, minor children, youth, adults, and ageing people. It was not likely that the children's hospital sub-study would be conducted in the neonatal intensive care unit (NICU), which is usually considered the utmost restricted and protected space in a hospital. However, the growing confidence between ward personnel and healthcare musician(s) led to a situation that made it possible to generate empirical material in the NICU.

In addition to the case studies in the NICU and eldercare wards, I had planned a third case with a healthcare musician and the hospice care ward personnel of another hospital. In 2018, the healthcare personnel in Finland had been for many years under high stress, because there is a general lack of (specialized) nurses and the biggest health and social services reform since the Primary Health Care Act (see Ministry of Social Affairs and Health, 2022; Finlex 66/1972) had been under development by the policy makers for over a decade. Due to these issues, the collaborating hospice ward stated that they would not presumably have time for the collaborative developmental work they assumed would take place within the scope of this study. For these kinds of reasons, I decided to use interview material as the empirical evidence in the third case study, exploring musicians' work in end-of-life care contexts.

The research design originally included focus group workshops, which included interviews, but it soon became clear that the schedules of both the musicians and the healthcare personnel could not be coordinated to organize the workshops. It was also a matter of prioritization; the hospitals were not eager to provide their personnel the necessary time resources, and the study did not have funding for the salaries of the healthcare personnel. The empirical part had a rather short time window in the hospitals, as well. I found myself thinking that I as a researcher cannot disturb the everyday life of the wards, since this was not an ethnographic case study, although some details of this study aligned with an ethnographic approach. The scarce resources available throughout the study—whether material or immaterial—and synthesizing the findings of the sub-studies led to reflecting on, through salutogenic theorization (see Laverack,

2014; Mittelmark et al., 2017) in the discussion section of the dissertation summary, how to construct future music professionalism in healthcare on a more sustainable basis.

As reported earlier, multiple sources of empirical material were generated. I considered taking video data, but audio-visual methods were finally excluded, because I could not come up with a solution for how to protect the participants' right to anonymity and confidentiality in health-related issues and follow my own obligation to the duty of secrecy in the hospital organizations. I, as the principal researcher, have managed the ownership of data, copyright, and intellectual property copyrights (IPR) of the study, and during the research process only I had access to the raw data. The ownership of the data was agreed on when the research plan, participant consent form, and data management plan for the study was created, prior to the start of actual research. I signed a professional secrecy and confidentiality form regarding the health status of the patients and the participants of the research in the hospital wards. The research project is not medical in nature, and any information considering the health, diseases, or diagnoses of the participants is not included in the data. Overall, the transparency of the collecting, generating, analyzing, and storing of the data and open access publication processes were emphasized throughout the research process to ensure the quality of the research process.

After these reflections, four practical elements were identified that framed the generation of the empirical material: 1) participant observations in two research hospitals; 2) interviews of the musicians, healthcare personnel, patients, and their families in the research hospitals; 3) interviews of other musicians, arts practitioners, and policy makers relating to the research context; and 4) the written professional narratives of the hospital musicians. Next, I will present the recruitment of the participants, and each of these four data elements.

## Pilot study

In health-related research, the responsible researcher is commonly employed by a healthcare organization, and/or the institution is contacted first to recruit the research participants. The recruiting of the healthcare personnel and patients followed this protocol in the hospitals. I did not work in the hospital, and it would have been quite difficult for me to reach out to music professionals working in such a fragmented and non-systematic field. Since the focus of this study was solely on musicians' work, an ethically complex decision was made to identify and recruit the musicians for the study through top-down recruitment, in other words, the musicians were contacted before the institutions. An important underpinning of this decision was to recognize the musicians as collaborators and co-developers in the study rather than participants. Accordingly, the musicians of the study (altogether six musicians: A, B, C, D, E, and F) were identified purposefully through information-oriented snowball sampling (see Creswell, 2014, p. 189). I engaged with national arts in health networks, policy makers, and practitioners, and through this network technique (Ishak & Abu Bakar, 2014; see Yin, 2018) identified musicians specialized in music work in healthcare. The eligibility criteria were: 1) a professional degree in music or music-related areas; 2) in-service training in the field of the arts in health; and 3) several years of experience in practicing music in healthcare and/or care settings.

I first started to collaborate with three of the musicians (musicians A, C, and D in the study), who formed a supportive professional group and musical ensemble together. As the study progressed, the musicians did not work so closely with each other as in the beginning, and I continued to collaborate with each one of them individually. Before starting the empirical part of the research, we went through a collaborative process, constituting a pilot study within the research process. Prior to applying for the research permits, I visited the musicians at their working contexts, which were different from the actual research hospitals. I received permission to attend the music making with the musicians and patients, and briefly discussed the successful implementation of the research approach with personnel on the premises. During the pilot study we applied for permission to produce a public video, because we had received feedback that it was difficult for many stakeholders, and other people interested in the topic, to imagine the actual nature of the healthcare musicians' work in hospital wards. The video served as an audio-visual material in lectures, workshops, seminars, and conference presentations held by the researcher and the musicians. We also did some advocative work together; applied for a collaborative working grant, communicated with collaborative hospitals, and created trust between us—the researcher and musicians. We had one follow-up meeting in Spring 2021 with all the six collaborating musicians, which led to organizing an International Symposium of Musicians in Healthcare at the University of the Arts Helsinki in December 2021, symbolically ending the research process, along with the ArtsEqual research initiative final ceremonies. Both the seminar and the symposium were found to be supportive, because during that time the pandemic situation had transformed musicians' work and working possibilities in society in a significant manner (see Table 2. Pilot study in an eldercare hospital and children's hospital).

| TIME FRAME AND DEPARTMENT | DATA GENERATION |
|---|---|
| 01-05/2017: Hospice ward / Eldercare hospital*<br>01-05/2017: NICU / Children's hospital<br>01-05/2017: Pediatric ward / Children's hospital* | Pilot observations. No data collection. Observing the work of healthcare musicians A, C and D. Producing public video material. |
| 01/2016-12/2017 | Piloting interviews. No data collection. Piloting collaboration, conversations, and interviews with healthcare musicians A, C and D. |

*Other hospital or department than final research contexts.

***Table 2. Pilot study in an eldercare hospital and children's hospital.***

## Participants

Two leading music therapists and leading nurses in the wards, who served as gatekeepers in the hospitals, were the key persons for successful participant recruitment. They had worked with the musicians before, and their comprehension of the purpose and objectives of the musical work in hospitals supported the generation of the empirical material. Following the hospital protocols, the patient participants, and their families, were first contacted by the healthcare personnel with an information sheet on the ongoing research (see Appendix 3). All the participants in the research—musicians, healthcare personnel, patients, and their families (including the guardians of the babies) and other interviewed participants outside the research hospitals—were offered a document on informed consent (see Appendices 2 and 3), explaining the purpose of the study and the rights of the participant. I discussed the research process with the participants and presented the informed consent to them in detail, to make sure they understood the content of the documents, and to inform them of their ability to withdraw from the research whenever they chose, without having to provide an explanation (see Table 3. Classification of musician participants and their interviews).





| MUSICIAN | SEX*, AGE | EDUCATION | PROFESSIONAL POSITION | INTERVIEWS |
|---|---|---|---|---|
| A | F, 45-50 | M.Mus (Music Education)<br>Healthcare musician** | Lecturer of Music | Sep 20, 2018: 33 mins<br>Oct 11, 2018: 14 mins<br>Oct 9, 2018: 28 mins |
| B | M, 50-55 | M.Mus (Artistic)<br>Healthcare musician** | Orchestra musician<br>Healthcare musician | Sep 18, 2018: 50 mins<br>Sep 19, 2018: 30 mins |
| C | F, 40-45 | M.Mus (Folk Music)<br>Healthcare musician** | Vocal musician<br>Pedagogue, freelancer | Oct 25, 2018: 41 mins |
| D | F, 50-55 | M.Mus (Church Music)<br>Healthcare musician** | Healthcare musician, freelancer | Oct 1, 2018: 38 mins |
| E | F, 35-40 | M.Mus (Music Education)<br>Care musician** | Music teacher | Oct 24, 2018: 43 mins |
| F | F, 40-45 | M.Mus (Church Music)<br>Community musician** | Parish community musician | Dec 3, 2019: 45 mins |

*Female, Male, Other

**In-service training and/or degree in healthcare music, care music, or community music.

***Table 3. Classification of musician participants and their interviews.***

After generating the empirical material in the hospitals, I started to complement the database with other interviews by following the same snowball sampling and network technique I utilized when identifying the musician participants. Altogether, seven (7) people were interviewed outside the research hospital contexts—administrative persons A, B, C, and D; a healthcare/hospital clown (a professional performer); arts in health policy makers A and B, a community musician, and music therapist A—to better achieve the research objectives (see Table 4. Classification of interviewees in hospitals and other interview participants).

| PARTICIPANT(S) | CONTEXT | F/M/O*, AGE | INTERVIEW |
|---|---|---|---|
| Nurse A | Children's hospital | F, 35-40 | Oct 9, 2018: 38 mins |
| Nurse B<br>Musician A (*parallel interview*) | Children's hospital | F, 40-45<br>F, 40-45 | Oct 8, 2018: 34 mins |
| Mother of a baby patient | Children's hospital | F, 25-30 | Oct 8, 2018: 6 mins |
| Administrative person A<br>Administrative person B (Healthcare clowns' association, *parallel interview*) | Children's hospital | M, 40-45<br>M, 30-35 | Sep 25, 2018: 45 mins |
| Healthcare/hospital clown | Children's hospital | F, 35-40 | Oct 12, 2018: 45 mins |
| Physiotherapist B<br>Nurse C (*parallel interview*) | Eldercare hospital | F, 30-35<br>F, 45-50 | Oct 11, 2018: 25 mins |
| Eldercare patient A | Eldercare hospital | F, 70-75 | Oct 17, 2018: 10 mins |
| Eldercare patient B | Eldercare hospital | M, 70-75 | Oct 11, 2018: 7 mins |
| Administrative person C<br>Administrative person D (Symphony orchestra, *parallel interview*) | Eldercare hospital | M, 45-50<br>F, 30-35 | Oct 29, 2018: 42 mins |
| Arts in health policy maker A | Healthcare music generally | F, 40-45 | Oct 30, 2018: 46 mins |
| Arts in health policy maker B | Healthcare music generally | F, 35-40 | Nov 2, 2018: 48 mins |
| Community musician / Arts in health specialist | Healthcare music generally | F, 35-40 | Oct 30, 2018: 39 mins |
| Music therapist A / Healthcare music specialist | Healthcare music generally | F, 50-55 | March 8, 2019: 30 mins |

*Female, Male, Other

***Table 4. Classification of interviewees in hospitals and other interview participants.***





## Interviews

The interviews of the professional participants (musicians, nurses, and other professionals) were semi-structured and thematic (Creswell, 2014), covering the overarching research task and objectives of the study. To avoid the risk of broadening the discussion with the interviewees so that it strayed too far away from any arts or culture topics, I wanted to delimit the research interviews' space and time. To set up this focus, I sent the themes of the interviews, the research project information, and consent forms beforehand via email for the professional participants, although I also reviewed and verbally discussed the consent and other study protocols with each participant.

The themes of the professional participants' interviews were:

- professional spaces and professional tasks of musicians in hospitals and healthcare;
- objectives, aims, and meanings of the music work in the hospital wards and healthcare generally;
- implementation of interprofessional and/or intersectional collaboration;
- possibilities and challenges of music work in healthcare environments; and
- imagined future of music work in healthcare.

The interviews of the professionals took approximately 30–45 minutes each. Some interviews were recorded immediately after observing musicians' work in the hospital wards, and they were freer in nature, reflecting the observed music making situations. Those interviews did not necessarily last so long. After the interview data of the professional participants of the study was transcribed (see Appendix 3: Excerpts from interview transcriptions), it was returned to the interviewees for a member check, and in the reporting process of the sub-studies the interview material was finally anonymized.

The interviews of the patients and their family members included more structured themes, in the form of the following questions:

- What is the meaning of music or musical situations at hospital for you (or your patient relative)?

- During your inpatient care in the hospital, you have participated in a musical situation with a musician. Would you like to tell me about this musical situation? What feelings and/or thoughts did the shared moment arouse in you? How did you experience the atmosphere?
- Was there something in the shared musical situation that you felt was especially rewarding or meaningful for you? Do you wish something would have been organized differently?
- In your opinion or experience, what meanings or objectives does the work of a musician in healthcare entail?
- Is there something you would like to emphasize or make visible, which did not already come up during this interview? Do you have some further questions regarding this research project?

The participation of the patient interviewees was monitored in collaboration with the healthcare personnel, and in some cases also with a guardian-relative, such as a spouse, or a grown-up child of an eldercare patient. None of the interviewed patients had a legal representative from whom a consent should have been sought, but the patients were able to give their consent independently. Due to their overall condition, all of the interviews with the patients were very short. The patients' interview material was not validated through member checks, but served as a supportive data in the case study database.

All of the interviews were recorded, and most of the interviews were transcribed by a professional transcription service with an obligation of confidentiality. I transcribed a small number of the interviews myself. After the data analysis and member check, the data were anonymized, and the credentials, including the identifications in the classification of the research material, and the informed consent forms, were destroyed. The musician participants were informed before the interviews of the possibility that the data relating to them may contain some residual risks, because they work in such a professionally expert area, and in such a small country on the global scale (Data management plan, Koivisto, 2019a). All of the data related to the patients in hospitals were exclusively anonymized. The anonymized interview material (raw data) is available in Finnish and is opened according to the data management guidelines of the Finnish Social Science Data Archive (2021) and Consortium of European Social Science Data Archives (CESSDA, 2021; Koivisto, 2022a).



## Observations

The observation material of the research was generated in the form of an observational diary. The observations took place over two months in Fall 2018, in line with the other generation of the empirical material. Participant observations took place in both research hospitals, the children's hospital, and the eldercare hospital. Observations were carried out over a short time, altogether three days in a NICU ward of a children's hospital, and five days in the orthopedic and infection wards of an eldercare hospital. The observations included observation material on the musical situations, social interaction, and relational work that took place beyond the shared music-making. The medical context and research permits did not allow any audio or video recordings during the generation of the empirical material. To create relevant understanding of the case (Stake, 1995, pp. 60–62), the observational diary was organized in a temporal order of the interactions under the following categories, which emerged very naturally in the observation situations: 1) musical interactions between healthcare musicians and participants; 2) verbal and embodied communications; 3) selected musical instruments, tools, and approaches; and 4) interprofessional and collaborative ways of working in the ward (see Table 5. Observations in hospitals). To protect the anonymity of the patients, this sensitive data has not been opened for further exploration.

*Hospital 1: Children's hospital**

| TIMEFRAME AND DEPARTMENT | NATURE OF OBSERVATIONS |
|---|---|
| Oct 8, 2018: NICU / Healthcare musician A | 3 participant observations in single rooms |
| Oct 9, 2018: NICU / Healthcare musician A | 4 participant observations in single rooms |
| Oct 28, 2018: NICU / Healthcare musician A | 3 participant observations in single rooms |

*Hospital 2: Eldercare hospital**

| TIMEFRAME AND DEPARTMENT | | NATURE OF OBSERVATIONS |
|---|---|---|
| Sep 18, 2018: | Orthopaedic ward / Healthcare musician B | 3 group music making observations |
| Sep 19, 2018: | Infection ward / Healthcare musician B | 2 group music making observations |
| Sep 20, 2018: | Orthopaedic ward / Healthcare musician A | 1 group music making observation<br>3 participant observations in single rooms |
| Sep 20, 2018: | Infection ward / Healthcare musician A | 2 participant observations in single rooms |
| Oct 11, 2018: | Orthopaedic ward / Healthcare musician A | 1 group music making observations<br>2 participant observations in single rooms |
| Oct 12, 2018: | Infection ward / Healthcare musician A | 1 group music making observations<br>3 participant observations in single rooms |

*All observation days included observations in halls and lounges

***Table 5. Observations in hospitals.***

## Written professional narratives

After the observations and interviews in the hospital wards, it became apparent that it would be necessary to generate some further empirical material on the musicians' own thoughts regarding their professional work and professionalism. The professional narratives, understood as a way to develop professionally fluent thinking, rather than applied through a narrative technique, helped the musicians to reflect on their self-authorship, transforming competence, and expertise regarding their work in hospital wards. The written professional narratives provided me a source with which to explore the professional background of the musicians, and strengthened the chain of evidence and the case study methodology overall. After the interviews, I asked if the musicians would like to provide this study with their written narratives, and they agreed. To confirm the request, and to make clear the objective of the task, I sent each of them written instructions via email. I provided the musicians with six questions, which they could either answer or address the themes through their own personal writing style. The questions considered themes on music practices in the hospital wards; organizational or professional issues that have to be solved outside the hospital wards; the themes musicians considered meaningful and important in their work; their decisions to begin to work in healthcare; and the imagined future of their work in healthcare. These questions and themes resulted in 2–5 pages of written text from altogether four musicians. One musician did not write a separate narrative, but provided a thesis that was written to finalize their in-service training as a healthcare musician. In addition, a music therapist (B) and a musician (A) provided the study database with their professional and collaborative reflections on their work in an eldercare research hospital. To protect the anonymity of the participants, these sensitive materials have not been opened, and excerpts are not provided for further exploration (see Table 6. Written professional narratives).

| PARTICIPANT | FORM OF EMPIRICAL DATA | COLLECTED |
|---|---|---|
| Healthcare musician A | Professional narrative | March 3, 2019 |
| Healthcare musician B | Professional narrative | Sep 19, 2018 |
| Healthcare musician C | Professional narrative | Jan 1, 2019 |
| Healthcare musician D | Professional narrative | Oct 6, 2018 |
| Healthcare musician A<br>Music therapist B | Professional observations and reflections, assigned for researcher later* | Sep 4, 2019 |

*Eldercare hospital wards, including a hospice ward

***Table 6. Written professional narratives.***

## 3.3
## Approaches for analyses

The analyses and the meta level synthesis followed a reflexive (Alvesson & Sköldberg, 2018; Subramani, 2019) and thematic (Braun & Clarke, 2006; Creswell, 2014, p. 197) approach throughout the research process. To frame and strengthen the data analyses, the reflexive and thematic approaches have been compounded with a multiple case study methodology (Stake, 1995; Yin, 2018; see Brereton et al., 2008). I also explored qualitative meta-analysis reporting methodology (ENTREQ, Tong et al., 2012; and QMARS, Levitt et al., 2018).

My professional sphere as a researcher-practitioner has deepened the reflexive methodology in this inquiry, to be understood as an ever-ongoing reflective action, rather than solely an analytical tool. The reflexive approach facilitated me in developing both critically and ethically sensible reflections (Guillemin & Gillam, 2004), in which research is considered "a multi-layered, flexible structure of interpretation and reflection in which the systematic interplay of reflective areas is central" (Alvesson & Sköldberg, 2018, p. 15). Ethical reflection in this study is approached using transparency as a guide (Levitt et al., 2018)—a will and ability to apply and develop as openly and dialogically as possible, not just interdisciplinary research methodology but also the theoretical premises of the research at hand. A central notion of reflexivity—to acknowledge the complexity of everyday societal life in relation to research—fits into the dialogical frame of this research. Reflexivity goes beyond reflectivity by emphasizing that reflection and methodological interplay may happen through several levels: for instance, the researcher's own reflections on empirical material, theoretical or philosophical underpinnings, or author positioning (Alvesson & Sköldberg, 2018, p. 331). Methodological triangulation may take place on many interpretive levels, multidimensionally; within data triangulation, investigator triangulation, theory triangulation, and methodological triangulation, and may be called *quadri-hermeneutics* (p. 328).

In addition to the reflexivity approach, a thematic analysis approach was chosen to construct the data in all of the sub-studies, considering that "through its theoretical freedom, thematic analysis provides a flexible and useful research tool, which can potentially provide a rich and detailed, yet complex account of data" (Braun & Clarke, 2006, p. 78). In thematic analysis, a *data corpus* is perceived as including all the data in the case database, a *data set* as the data used and coded—*extracted*—for a particular sub-study, and *data items* present the nature of the data, such as interviews (p. 79). Although the emerging themes from the empirical material were present in all sub-studies, the analysis was not conducted with a naive "anything goes" (p. 95) assumption. Instead, the process required a critical reflection on the ways in which the analysis was conducted overall, and whether it followed too uncritically the theoretical starting points of the study. Firstly, the theoretical underpinnings and novel theoretization arising from the analysis was presented in as open a manner as possible. Secondly, the identification and coding of the data sets, and identifying themes that really existed in the material, were approached through "an alternative use of thematic analysis" (p. 83). This alternative approach to analysis allowed the co-authors and I to provide a detailed account of the themes, linking directly to the aim and objectives of the study; to be theoretically and practically informed through the healthcare musicians' professional work and hybrid professionalism. Thirdly, the material was utilized and recorded systematically, following the suggestions of Braun and Clarke (2006) on how to conduct the diverse phase of thematic analysis: 1) familiarizing yourself with your data; 2) generating initial codes; 3) searching for themes; 4) reviewing themes; 4) defining and naming themes; and 5) producing the report (p. 87).

The writing and publishing of each individual case study was perhaps the most reflexive part of the research process. During that process, I gave myself permission to concentrate on reporting one case at the time, and in a way to slightly forget the starting points of the original research plan. A reflexive stance helped me to create some new understandings of the research at hand. The overarching task of the research—to investigate musicians' professional work in the Finnish healthcare system in relation to their professionalism—was the most imperative element, which I repeatedly visited during the reporting of the case studies. The sub-studies took their shape rather individually, and the detailed research questions were formulated through the emerging thematic premises.

### Cross-case analysis

In the beginning of the cross-case analysis, I created a case report form for a single case, and reported the preliminary study (literature review) and all three case studies as follows: a) basic information on the case; b) aim and objectives, data generation methodology; c) theories and concepts used; d) data-analyses; e) information on data (e.1 data set used, e.2 coding, e.3 other tools used); f) validation of findings; g) confidentiality of data and ethics, and h) other information (h.1 main findings, h.2 discussion on findings, h.3 value of findings) (see Pucihar et al., 2015). I also documented the policy recommendation with the case report form to facilitate its presentation as part of the dissertation summary. After the case reports, I read the original articles once more with my colleague, and we individually applied a summary of quality appraisals across studies. Then, we discussed

the quality of each of the sub-studies, which helped me to further develop the cross-case analysis. The collaborative evaluation guided me to acknowledge some limitations in individual studies that could perhaps influence the cross-case analysis and synthesizing of the summary of this dissertation, such as insufficient presentation of the thematic analysis method in the published articles.

The cross-case analysis continued with framework analysis, where the aims and contexts of the studies, concepts and theories, research questions and methodology, empirical processes, methodological and ethical considerations, findings, limitations, main implications, and future recommendations were collected into a comparative table. Next, a more relatively organized analytic level took place. From this perspective, the analysis—employing an abductive and quadri-hermeneutic approach (Alvesson & Sköldberg, 2018)—reminded me of creative problem-solving, being reflexive and systematic at the same time, wandering in-between intuitive and rational levels of thinking, and from bottom-up to top-down analytical frames. After the framework analysis I synthesized the original research findings through a qualitative meta-analysis (Levitt et al., 2018, p. 40), a variety of theory-informed interpretations on the findings of the sub-studies. I still strengthened in rather systematic ways the multiple case study evidence, reflecting concepts and theories critically through a continuum of mind maps and tables. This final stage led to integrating the thematization of this study as part of the theoretization on salutogenesis, as a "good life orientation" in and through music professionalism in healthcare. After the qualitative meta-analysis, I revisited the qualitative reporting standards and checklists (QMARS, Levitt et al., 2018) to identify limitations of the study, as well as future possibilities for research.

## 3.4 The policy recommendation process

The policy recommendation produced as part of this study aims to encourage cross-sectoral service providers to pay attention to the cultural contexts of health and the emerging ecosystem of cultural wellbeing, and to integrate culture and arts into their activities. The recommendation states that health service organizations should use all available resources to promote their patients' recovery, health, and wellbeing in hospitals and other healthcare services. The policy recommendation was a collaborative effort, and in addition to the findings of this study, the shared meaning-making of five interdisciplinary researchers and policy makers, as well as the findings of their research in the arts fields, were applied to produce the policy brief. I started the process, which went on from August 2018 to September 2019, with our ArtsEqual research group leader Kai Lehikoinen by identifying the policy recommendation group through our shared networks, including collaborative universities, NGOs, and other associations. The working group, led by me, worked approximately one working day in every-other month together, and members worked independently in-between every meeting. Dr. Lehikoinen and I facilitated the publishing process and English translation of the recommendation. We worked together to achieve three objectives: 1) to co-author and publish a policy brief; 2) to organize a launching event, where the policy brief would be published; and 3) to facilitate the advocacy process that would root the recommendation(s) in practice. First, we burst into a brainstorming level, and simultaneously familiarized ourselves with the policy brief format that had been developed in the ArtsEqual project. Then, we constructed a theoretical basis for the recommendation, and used a thematic approach to cover the actual recommendations, as well as to develop a better understanding of the ecosystem of cultural wellbeing. During this co-constructive process, we were also asked to produce material for other publications as a group. Due to the COVID-19 pandemic, the launching event for the policy recommendation was canceled, but media releases and interviews took place, helping to disseminate the publication.

## 3.5 Research ethics

The ethical statement for this study was approved by the Ethics Committee of the University of the Arts Helsinki (February 15, 2018). The research permits were granted by the HUS Helsinki and Uusimaa Hospital District, Children and Adolescents (June 18, 2018) and City of Espoo, Department of Social and Health Services (Apr 24, 2018). The ethical statement and research permits were translated into English and are presented in the Appendix 1: Statement of the Research Ethics Committee and research permits. The research followed the RCR guidelines of the Finnish Advisory Board on Research Integrity (TENK, 2019), the ethical guidelines of the University of the Arts (UNIARTS, 2015), and the code of ethics of the European Commission in Research (All European Academies/ALLEA, 2017/2022). In addition, the Finnish Investigators Network for Pediatric Medicines (FINPEDMED, 2021) and Helsinki and Uusimaa Hospital District (HUS, 2021) ethical and procedural instructions were followed, when applicable to non-medical research.

When I was in the middle of the research process, a new privacy and security law, the General Data Protection Regulation, took force in Europe (GDPR 2016/679; Koivisto 2019a, 2019b). At the same time, the University of the

Arts Helsinki research ethics protocols were reconstructed (UNIARTS, 2021). Therefore, the ethical documents were subsequently reviewed with the consulting lawyer and the data production officer of the university. Overall, these documents were continuously revisited and reframed throughout the research process, for example during the opening of parts of the sensitive raw data (Koivisto 2019a, 2022a), a procedure which is not yet common in the arts or educational fields.

Obtaining the research permits from the hospital district (a children's hospital) was a challenging process, because the responsible researcher is usually employed by the hospital and therefore can apply for the research permit as an insider researcher of the organization. The research permit of this study was innovatively facilitated in collaboration with a research secretary of the hospital district. A music therapist of the hospital district's Children and Adolescent services was willing to take responsibility for this research, and served as my contact person, as required by the hospital protocols. Similarly, a leading music therapist from an eldercare research hospital supported and facilitated the respective research permit process. The research project, which was non-medical and non-invasive in nature, received an ethical statement from the University of the Arts Helsinki, and the research hospitals did not require another institutional ethical review. To simplify the research permit protocols for the children's hospital, we reciprocally decided with the hospital that I would apply for a thesis level permit, instead of medical research authorization, because the hospital district did not have a protocol for this kind of inquiry. This made the extremely complicated research permit process less complicated for me as an outsider-researcher, and saved the resources of both collaborating institutions.

The sensitivity of not just formal and structural ethics, but also "informal" and situational ethics, brings the researcher's integrity and values into the discussion when interpreting the empirical material. Beyond the procedural and/or normative ethics of institutions, the study entailed practical ethics, which I here identify as virtue ethics (Laukkanen et al., 2021; VIRT2UE, 2021). Good and responsible scientific practice were often challenged by the fragmented nature of this research process. For example, the institutions' ethical procedures could complicate practical everyday interactions, such as treating patients in a sensitive and respectful way. Hence, the implementation of the empirical part of the study challenged my capacity as a researcher to distinguish the best ways to conduct research in ethically discreet ways. These experiences led me to understand that ethically responsible research requires applying institutional ethics successfully in an interdisciplinary research setting, and calls on researchers to integrate ethical thinking into their everyday research practices. In addition, adequate tools to support this ethical reflection, as well as the responsibilities of researchers, should be provided for everyday life and work within institutions (see Kuntz, 2016; Subramani, 2019; VIRT2UE, 2021).

# 4
# PUBLISHED FINDINGS AND KEY CONTRIBUTIONS

In this chapter, I present the main findings of this multiple case study (sections 4.1, 4.2, 4.3 and 4.4). The findings have been reported in four peer-reviewed publications: a systematic literature review and three case studies (see Part II). I will refer to these sub-studies as I–IV. As part of the research task of this study, the key contributions of a policy recommendation are also presented (section 4.5), as well as a summary of the findings, in the form of thematic statements (section 4.6). The complete texts of the articles and policy recommendation are found in Part II of this dissertation.

## 4.1
## Sub-study I: A systematic review on healthcare musicians' work

The aim of this first, co-authored sub-study (see Part II, Article I) was to explore the research literature addressing healthcare musicians' work and professional space in somatic healthcare wards in hospitals. The purpose was achieved by conducting a systematic review of research literature beyond music therapy and music medicine studies in order to help conceptualize healthcare musicians' emerging professional space in hospitals. In addition, the study laid the groundwork for the multiple case study research approach, where the first stage was to define and design the entire research project, as well as develop the theory, select cases, and design the data generation process. The research questions were: 1) What kind of professional practices and professional space are represented in the reviewed literature concerning healthcare musicians' work in somatic hospital wards? 2) According to the reviewed literature, in what ways can the work and professional space of healthcare musicians be conceptualized? Altogether 208 peer-reviewed research articles were collected for the review; the 16 studies meeting the inclusion criteria were organized, coded, and analyzed. The quality of the studies, as well as the reporting of the methods and analysis, varied greatly. Most of the studies were conducted in pediatric hospitals or pediatric wards of general hospitals. Other identified environments were elderly care wards, acute care wards for people with dementia, adult wards, hospital schools, hospital lobbies, and intensive care units. All of the non-empirical studies (5) considered healthcare settings generally.





The main findings of the study were organized thematically through a dynamic professional framework (Cribb & Gewirtz, 2015; Evetts, 2009, 2013; Pekkola et al., 2018), which included the following themes: Healthcare musicians' musical skills and competences; practitioner knowledge in healthcare settings; conceptualization of music practices and professional spaces; and exploring their professional identities. Through the theoretical lens of hybrid professionalism (Noordegraaf, 2015; see also Gielen, 2009) and conceptualizing the professional space of healthcare musicians, we found that there is an internationally emerging music practice in hospitals, which is artistically and pedagogically oriented, and which should be further explored. As part of the expanding professionalism identified and examined in ArtsEqual (Laes & Westerlund, 2018; Westerlund & Gaunt, 2021; Westerlund et al., 2021), healthcare musicians' work draws from 21st century socially engaged and responsible work (Sugrue & Dyrdal Solbrekke, 2014), social justice approach (ArtsEqual, 2021), and holistic wellbeing discourse (MacDonald et al., 2012). We concluded that by recognizing different kinds of agency in the arts and health, the agency of both professional spaces reflected within this study, that of music therapists and healthcare musicians, could be strengthened.

## 4.2
## Sub-study II: Musicking with and for families in neonatal intensive care units

This second, single-authored sub-study (see Part II, Article II) was the first empirical case study of the research, and was conducted in the neonatal intensive care unit (NICU) of a children's hospital. Published as a book chapter, the descriptive case study design of this study allowed me to take a reflexive approach as a researcher (Alvesson & Sköldberg, 2018). For this particular case study, I constructed data from the multiple case database—the interviews and observations taking place and considering the NICU ward—which had been established for the research project (Stake, 2006; Yin, 2018). The objective of the study, to discuss the work of music practitioners in NICUs when supporting the families and care of newborns, opened a space to reflect musicians' multi-layered work, including supporting families during their challenging times at the hospital.

The research questions for the study were: 1) What kind of musicking as a professional practice emerges when music practitioners work in neonatal intensive care units? 2) What kinds of metaphors were used by the music practitioners, NICU personnel, and families in their reflections on the musicking situations? 3) What kinds of metaphorical thinking and reflections are constructed through

musicking situations, and how could these support music practitioners' professional work in neonatal intensive care units? Through reflexive and thematic analysis of the research participants' reflections, the use of metaphorical thinking and language throughout the musicking situations were explored. The metaphor approach was expanded with the theoretical tool of metaphorical thinking (Lakoff & Johnson, 1980), and engaged with a deeper understanding and analysis of musicians' musicking, as conceptualized by Christopher Small (1987, 1998; see also Odendaal et al., 2014).

The findings of the study identified five kinds of situations where people in the ward were engaging in musicking: 1) solely with and for newborns; 2) during a therapeutic or care procedure; 3) with and for the family; 4) with and for an extended group; and 5) with and for the hospital personnel. Four grounding metaphors regarding musicians' work were identified through the analysis of the interviews and observations: Families' situations were seen as *an earthquake*, which musicians and healthcare professionals sought to balance in interprofessional collaboration. The metaphor of *deep waters* mirrored parents' and families' difficulties in resolving the challenges ahead on their own, and the musical possibilities of supporting the parents in their bonding with their child through music. *Flow of flux* referred to the transforming and flowing time and space in the ward, which was facilitated by musicians through music. Having a preborn baby changes the path and *journey* of the whole family. This metaphor was reflected to present the situation of the family, and as a path where healthcare professionals and musicians are "fellow travelers", seeking to share reciprocally the emotionally weary situations with families.

In the discussion section, I reflected on how music professionals navigate and develop their hybrid work and professionalism, and seek to understand the doxa (Bourdieu 1990, 1991)—rules, practices, and requirements—of the new field. Musicking with and for everyone in the NICU environment therefore crosses the boundaries of customary performance practices, teaching, and playing musical pieces together. Furthermore, experiencing, speaking, and learning through metaphors may be an asset for music practitioners. It may provide ways to bridge music practices with the time and space in the ward, but also to engage professionals with their own expertise and (inter)professional identities. Co-constructing metaphors through musicking makes the ethical and moral challenges in the work more visible and highlights the meaningfulness and relationality of musicking in musicians' work. Finally, the chapter suggests novel directions for the development of higher music education in the future: broader contexts of socially and culturally sensitive and just work should be more widely recognized in practice, research, and education; the fragmented nature of the work should be better supported through reforms in education; and students should be better supported through educational solutions to work in ethically hybrid and unsettled contexts.





## 4.3 Sub-study III: Music professionalism and gerotranscendence in eldercare hospitals

The third sub-study (see Part II, Article III) was co-authored with Dr. Tuulikki Laes, who contributed to the theoretical construction of the study as part of her Academy of Finland research project "The Transformative Politics of Music Education in an Ageing Society". The sub-study sought to explore musicians' collaborative and socially engaged music practices in eldercare hospital wards. As an instrumental case study (Stake, 1995, 2006; see also Crowe et al., 2011), a broader understanding of the phenomenon was facilitated to gain knowledge about the principles of musicians' work and an understanding of eldercare more broadly to better respond to the challenges of an ageing society. The overarching task of the study was to initiate a critical discussion of the meanings of music professionalism in eldercare and healthcare. In addition, we wanted to highlight the holistic wellbeing discourse, which, however, should not be too idealistic, individualistic, or uncritical (ArtsEqual, 2021; Ganesh & McAllum, 2010).

The study was guided by the following questions: 1) How is the nature of the work in eldercare hospital wards reflected by the efforts of healthcare musicians? 2) How can the understanding of these music professionals' work contribute to the development of expanding professionalism in music and higher music education? In addressing the concerns about the enforced interpretations of what "activation of the elderly" means, we drew from social gerontologist Lars Tornstam's (1994, 2005) meta-theory of ageing, termed *gerotranscendence*. The theory treats ageing as a process of moving beyond physical needs into a sphere of increased satisfaction. As such, the sub-study presents a claim that the prevailing gerontological views in eldercare do not necessarily follow the lived experiences and self-reflections of older people themselves, but focus on the external demands of active and effective lifestyles.

The findings of the study were summarized in five themes on healthcare musicians' work in eldercare hospital wards: 1) considering other people's reactions; 2) appreciating silence and silent participation; 3) tolerating incomplete situations and shapeless processes; 4) celebrating life and acknowledging despair; and 5) taking up the challenge of expanding their professional identity. Gerotranscendence could be one way to broaden the understanding of later life in music education research, by shifting the focus from recreational music activity to

transformative music experiences and the music practitioners' sensitivity to musical interactivity with elderly participants. Music professionals have the potential to invigorate gerotranscendence within care relationships in eldercare contexts, enabling a broader understanding of transformative and developmental ageing for a larger care and healthcare community. We concluded that higher music education institutions should consider how to better support students to expand and understand their work opportunities and novel working contexts, and to increase the broader societal relevance of the profession, including eldercare and healthcare contexts.

## 4.4 Sub-study IV: Healthcare musicians' musico-emotional work in end-of-life care

This fourth, single-authored case study (see Part II, Article IV) portrayed the landscape of healthcare musicians' work in end-of-life care. In many countries, including Finland, end-of-life care in diverse contexts, for example hospice care and palliative care, is developing at a fast pace to support the healthcare systems in providing good quality end-of-life care and bereavement support (MacLeod & Block, 2019; WHO, 2016). In like manner, end-of-life work in the healthcare systems is evolving rapidly, and music therapy research has accumulated extensive knowledge on palliative care and end-of-life care overall over recent decades. Beyond the therapeutic literature, there is some data on musicians working in end-of-life settings, but research on the topic has remained scarce so far.

In this in-depth case study, I interviewed six musicians who had experience of musical end-of-life work in diverse care and healthcare contexts. The research questions presented in this sub-study were: 1) How do healthcare musicians reflect on their end-of-life work with the patients, their families, and healthcare personnel? 2) According to musicians' reflections and experiences, what kind of professional and emotional work is involved in end-of-life care? From a socio-emotional perspective, end-of-life music work requires emotional understanding, emphasizing how to comprehend and seek to understand one's professional work through emotional processes (Denzin, 1984; Humphrey et al., 2015; Swanson, 1989) in socially engaged working situations. From the educational point, emotional burdens, such as emotional stress and workload, are something music professionals in healthcare should not misinterpret or try to push aside (Sonke, 2021, see Meyer, 2009), but seek to learn from. As a free flow of emotional experiences, the emotional process in this study was regarded as an important part of professional reflection, encompassing decision making, personal growth, and learning between patients, their families, and professionals (Jasper et al., 2013).

Based on the musicians' reflections on their end-of-life work, three emerging categories were identified: supporting end-of-life patients in and through music practices; sharing musical and emotional space with patients, families, and healthcare personnel; and engaging as a music professional in holistic emotional processes. To describe the holistic emotional processes of musicians, the concept of musico-emotional work was introduced, drawing from socio-emotional understandings of emotions (Swanson, 1989). Musico-emotional work is an important part of music professionals' work in healthcare, intertwined with the socially and ethically responsible working approach. Musico-emotional work creates other-centered, interprofessional possibilities for reflection and learning for music and healthcare professionals.

Considering the findings of the study, I reflected on how the music education system could better support musicians' musico-emotional work in their expanding working contexts. In music education and higher music education, such action could aim already in the early stages of studies to facilitate students' understanding how professional identity is created through emotional experiences and processes; facilitating students' opportunities to experience culturally and socially diverse working contexts; and organizing mentoring and in-service training programs in such a way that they become integrated with the students' needs. The findings align with the work of music therapists and end-of-life music therapy research (e.g., Clements-Cortés & Klinck, 2016; Hilliard, 2005). Musicians' reflections on the themes embedded in their professional end-of-life work—emotional, comforting, connecting, reflective, musical—are also an essential part of music therapy contexts. Wellbeing, social justice facilitation, and the socio-emotional understanding of music making are emphasized in both music therapists' and musicians' professional frameworks. It was concluded that there is an interprofessional possibility, or even obligation, to recognize and support both professions as providing musical, cultural, health, and care services, or other public services available to the healthcare sector.

## 4.5 Policy recommendation: Culture and the arts in hospitals and healthcare services

The policy recommendation was co-authored with a group of Finnish specialists and researchers in the field of arts in healthcare. The co-authored policy

recommendation (see Part II, Article V) was based on the presented empirical studies of this dissertation, but also built upon the studies of other researchers in the policy recommendation group, and was collaboratively extended to consider arts and culture in the healthcare services. The recommendation states that culture and the arts become particularly important when patients are treated in isolated environments with hardly any access to aesthetic experiences. The broader themes for the recommended action were formulated on the basis of the strategic policies of the Finnish healthcare system (Ministry of Social Affairs and Health, 2021) as follows: 1) strategy planning and the development of health service organizations; 2) monitoring, evaluation, and research; 3) proactive measures and health promotion; 4) treatment, management, and recovery; 5) supporting the personnel and improving occupational health; and 6) operating environments in healthcare. Under these themes, altogether 17 action points were proposed for the policy makers, organizations, and other stakeholders, which they should take into consideration when incorporating cultural wellbeing into healthcare services. Eight practical examples were included regarding the recommendations for how health service organizations can promote cultural wellbeing, such as establishing regular artist-in-residence programs and adopting the principle of extended percent-for-art in health services.

As part of the ArtsEqual impact work, the working group was established in August 2019, and the writing process, with regular meetings and collaborative writing, took place until August 2020, when the policy brief was published. The recommendation was first published in Finnish, and was directed to the Finnish decision-makers, healthcare organizations, and practitioners in the field. The recommendation was later translated into English and adapted to serve international audiences such as healthcare authorities; health service organizations; producers of art, artistic activities, and art-related services; educators and students in the health and social service sector and the cultural sector; and decision-makers in these fields. Within the framework of the recommendation, the understanding of cultural contexts of health (Fietje & Stein, 2017; Napier et. al, 2014) and the perspective on cultural wellbeing in the intersectoral ecosystem of health and wellbeing (HEWE) were emphasized. The policy recommendation concluded that understanding the wider cultural dimensions of health helps the consideration of patients as individuals whose lives, wellbeing, and health are substantially determined by cultural conditions. As an investment in a good life, both wellbeing, inclusive principles, and the alleviation of cultural tensions were emphasized.

As such, the recommendation serves as a contribution to this study by exploring cultural rights and capabilities as part of an engagement within the arts and culture. However, in the discussion section of this dissertation, the individualistic and rights-based approach is elaborated further to address the needs of vulnerable or temporarily-abled persons both within healthcare and more broadly in society.





## 4.6
## Summary of the findings: Musicians' work in healthcare

Next, I will present a summary of the findings in the form of thematic statements, a strategy recommended in health-related qualitative research by Sandelowski and Leeman (2012), enhancing the possibilities to implement the findings of the research.

- Contemporary professional turbulence creates new, innovative agency at the boundaries of healthcare and the arts, in this case music. By adopting a dynamic professional stance and changing the professional game (Bourdieu 1990, 1991), socially engaged work can emphasize and create a need for interprofessional, theoretical, and educational development.
- Healthcare musicians' work can support the emerging wellbeing discourse, which takes account of other/people-centered (care) work and critical notions on how the holistic wellbeing of people may be realistically supported in healthcare.
- Musicians' boundary work includes not simply musical but also ethical and practical boundaries, which should be acknowledged in the professional education of music practitioners. These boundaries include, for instance, hygiene and other safety protocols, understanding the vulnerability of the others and oneself as a practitioner, and the increased risk for ethical stress and job burnout of musicians themselves.
- The limits and boundaries of music work are created through the ethical and practical protocols, rules, and practices in-between the interacting systems, and through navigating them in a sustainable way.
- The socially engaged work of musicians requires an efficient understanding of the adverse impacts of the work and premises of the working context, such as family-centered care, trauma-informed care, or socio-emotionally informed care.
- Metaphorical thinking and language beyond music making and understanding the premises of relational and social music-making—musicking (Small, 1987, 1998)—in healthcare may bridge interprofessional work, support patients and their families, and make ethical and moral challenges in boundary work more explicit and understandable.

- Music professionals have the potential to support patients' developmental challenges and spiritual needs in care facilities, which may improve the care relationships and result in more ethical care work as a whole. In eldercare contexts, healthcare musicians' work and interprofessional collaboration may support existential change, namely the gerotranscendence (Tornstam, 1994, 2005) of the ageing patients.
- Understanding deeply social and emotional processes through musico-emotional work can support the self-reflection of both the musicians and the patients in end-of-life care. This kind of socio-emotional reflective approach may facilitate not just the agency of music professionals, such as music therapists and healthcare musicians, or other professionals in healthcare, but also the agency and integrity of the patients.
- Relational musical expertise and expanding professionalism in different sectors, such as healthcare, requires a reorganization of the professional education of musicians: rethinking some parts of program curricula, and enhancing reciprocal collaboration in-between programs, educational institutions, and societal sectors.
- Educational development does not in all circumstances necessarily require substantial external funding or resources, such as the establishment of new programs or in-service training, but may be achieved through individual, social, and organizational innovations, and resilient organizational thinking that acknowledges the hybrid nature of musicians' work.

# 5
# DISCUSSION

In this study I have investigated musicians' relational boundary work in the Finnish healthcare system. By employing a reflexive research approach (Alvesson & Sköldberg, 2018; Guillemin & Gillam, 2004; Subramani, 2019), I have utilized a multiple case study design to analyze the expanding and hybrid professionalism in music. In chapter 4, a cross-case analysis of the findings of each primary sub-study was conducted, and a summary of the findings was presented. In this chapter, the cross-case analysis is synthesized and interpreted beyond the summary of the sub-studies.

## 5.1
## Relational expertise and agency within musical boundary work

As presented in the introduction of this dissertation (chapter 1), healthcare musicians were approached as music professionals who have a higher music education and specialized expertise in the field of music. Furthermore, musicians were understood as boundary workers (Gieryn, 1983; see Akkerman & Bakker, 2011) whose dynamically constructed and fundamentally social music work can contribute to the research area called the sociology of professions (Abbott, 1998; Cribb & Gewirtz, 2015; Dent et al, 2016; Pekkola et al., 2018). Hence, the aim of this inquiry has not been to construct a new profession, but rather to explore the broader, under-researched frame of music professionalism, and especially the relational perspectives of healthcare musicians' hybrid professional work, including their relational agency and expertise (Edwards & MacKenzie, 2008; Edwards, 2010; Frelin, 2013; Tsoukas, 2009).

Boundary work, as a reciprocal interprofessional activity, sets the scene for music professionalism in healthcare. A characteristic of boundary work is that it may, at first glance, seem to be of secondary relevance and not suited to the time or space at hand. It is in these inconsequential moments, which may even seem worthless in relation to the objectives of the present system(s), that the strength of the work lies, as Wansink and Ittersum (2016) have also argued. These kinds of boundary sites—although they may represent only short moments of reciprocal understanding, or a glimpse of what co-creative work could be—are highly valuable as such (see Dons, 2019, pp. 159–160), as well as for the development of an interprofessional working approach.





Before starting their music work in hospitals, many of the musicians in this study had their own personal transformative experiences they could relate to their work in healthcare; for example, they may have been in a fragile state of health themselves at some point during their lives or had encouraging experiences supporting other people in their vulnerable moments. These *key experiences* intertwined musicians' professional and ethical thinking in such a manner that they decided to start working as healthcare musicians. Hence, they were willing to be newcomers and learners in territories outside of their expertise (Star & Griesemer, 1989), first in the healthcare musicians' in-service training, and afterwards in the healthcare environments that they entered. Based on the findings of this study (sub-studies I and II), it could be stated that all professional music practices that go beyond pure performance, such as giving concerts and occasionally performing for people, require some degree of hybridity—reflective and creative interdisciplinary action in and beyond music practices—as does the boundary work that challenges conventional musical expertise in healthcare settings.

In view of the findings (sub-study II), boundary work provides interprofessional accessibility to the resources, values, and systemic logics of several systems (Akkerman & Bakker, 2011; Finlay, 2008), as musicians blur the boundaries between their own work and healthcare units. Upon entering the healthcare units, the healthcare musicians started to recognize that the changing contexts they work in can affect their music practices in a transformative way. Such awareness of the spatial dimensions beyond one's own practice opens up musicians' understanding of the deep interconnectivity—between people and the systems they work and live in—that is incorporated into relational work (see Edwards, 2010, 2017; Tsoukas, 2009). Although musicians described the interruptions and unpredictability of musical work as part of their work in the healthcare settings, it must be noted that they themselves also interrupted the individual and/or organizational flow in the healthcare units. These interruptions described by the musicians and other research participants in some circumstances led to transformative experiences in the ways that the musicians, healthcare personnel, and patients think and act. This approach, where individual music practitioners engage with social change through supporting the relational agency of individuals, is part of a changing professional ethos in higher music education, as discussed for example by Kivijärvi (2021) and Timonen (2020).

As the findings imply (sub-study I), it can be argued that relational boundary work is becoming increasingly common in music and other artistic fields (see also Daykin, 2019; Laukkanen et al., 2021; Lehikoinen et al., 2021). Indeed, healthcare environments and communities will increasingly face boundary issues, such as reflecting cross-cultural otherness (Weiner-Levy & Queder, 2012) or the need to highlight empathetic care, which encourages further development of professional

concepts, tools, and abilities that help appreciate and develop boundary work. The unfolding of social relations and emotions through relational musical work, sometimes in a very spontaneous way, was central to the musicians' work in hospitals. According to the findings (sub-studies II and IV), collaboration between musicians and healthcare personnel requires the ability to transfer different kinds of knowledge, such as embodied, tacit, or implicit knowledge, into other forms, as the interprofessional work develops further (see also Koivisto & Kivijärvi, 2020). This collaborative meaning making is intertwined with processing and sharing professional knowledge, explored for example by Jensen et al. (2022), and is essential for a professional attitude in which relationships and people-centered approaches are prioritized (De Wit, 2020, pp. 197–198).

As presented in sub-studies I and II, the generally acknowledged role for musicians in healthcare is to bring joy, energy, and entertainment to patients and the whole healthcare community through their music practices (e.g., Bonde, 2019; MacDonald, 2013). Given the findings (sub-study IV), healthcare musicians' work in healthcare units, such as hospital wards, engages with understanding patients as something more than objects of treatment (see Ruud, 2017), and is associated with exploring human interaction in relation to their environment. Understanding human interaction and relationships as part of shared music making connects musical work with care discourses that are interested in emotions, suffering, and recovery (Lynch et al., 2016; Stacey, 2003). As explained earlier (chapter 2), relational agency includes the ability and will to relate to other people's life situations through their own agency within those situations (Edwards, 2010, 2017). Furthermore, the findings highlight (sub-study IV) that musicians' ways of relating through emotional work to the needs of others is especially essential in healthcare, and strengthens their relational expertise as part of other-centered care. Therefore, it should be considered whether expressing joy, happiness, and energy in and through music provides a rather limited account of the musicians' work, which could instead be seen as providing the healthcare communities with the whole spectrum of emotional work (Hoover, 2021; in education see Jasper et al., 2013; Meyer, 2009).

## 5.2 Situational ethics in healthcare musicians' work

Relational work, as part of a dynamic social practice of crossing boundaries, produces many kinds of professional risks as such, because the practitioners cross many kinds of systemic boundaries, including organizational, hierarchical, and professional. Despite these risks, in many situations the healthcare musicians in this study took the effort to advance the interaction between professionals, instead of, for example, preserving a rigid professional normativity. As the findings indicate (sub-studies I and IV), working within the boundaries of different systems, or hybridity as such, does not mean living in professional or societal "anarchy", with no boundaries or limits at all. In addition to the rules, protocols, and procedures of specific institutions, limits on musicians' work were created through shared interprofessional practices that become visible through boundary work. In practice, this means that problem-solving and decision-making regarding the music practices in healthcare wards can be made through interpersonal collaboration, acknowledging the relational expertise of all the professionals involved in collaborative work and decision-making (Edwards, 2010). This changes the perception of the expertise of healthcare musicians from being specifically artistic and musical to being more relational (in education see Edwards, 2010, pp. 1–2). Hence, collaborative and trustful interprofessional negotiations in and through the music making unfold the possibilities for an *altruistic working approach* (e.g., Lynch et al., 2016, p. 44), which is highly relevant in care environments. Relational expertise is also important for many practical reasons, such as that musicians do not have access to the health records of the patients, and do not commit themselves as healthcare workers in any way.

As this study indicates (sub-studies I, II, III and IV), dynamic and expanding perspectives into music work require new kinds of professional responsibilities and efforts beyond solely aesthetic or artistic discourses. Ethical decisions that have to be made through reflecting on one's everyday music practices require a depth of understanding of the situations at hand, and an ability for self-reflection (see Dons, 2019, pp. 157–158). Paul and Elder (2005) term this sort of ethical reflection *ethical reasoning:*

> The proper role of ethical reasoning is to highlight acts of two kinds: those which enhance the well-being of others—that warrant our praise—and those that harm or diminish the well-being of others—and thus warrant our criticism. (p. 2)

The acts that manifested through musical interaction and warranting healthcare musicians' critical thinking are reflections on whether their music practices can in some ways be harmful to the participants, or whether the music can produce some adverse effects. As the findings of this study suggest—following the discussion of Sonke (2021)—in addition to so-called normative ethics, such as the ethical protocols of institutions and professions, a safe and trustful musical environment can be created through the recognition of each individual's professional expertise

and shared professional responsibilities in specific healthcare contexts. Therefore, the education of healthcare musicians should include a basic understanding of the specialized area they work in, such as pediatrics, geriatrics, or end-of-life care. In this matter the findings emphasize the importance of creating not just relational, but also contextually *relevant* relational expertise.

In this study, healthcare musicians' hybrid work and relational agency was seen as an example of professional work reaching beyond organizational professionalism (e.g., Faulconbridge & Muzio, 2008), where organizations or professionals working in the organizations define professionalism by setting certain values and competencies for practitioners and seek to realize those values, for example through ethical premises or professional certificates. It seems that working in unfamiliar contexts allowed healthcare musicians to develop the maturity to create much more situation-sensitive music practices than in their more conventional working contexts. In music education, this critical self-reflective approach has been termed *situational ethics* by Randall Allsup and Heidi Westerlund (2012). Within the scope of situational ethics, the ethical codes of the healthcare institution and artistic and aesthetic codes of the healthcare musicians meet in a very vague manner, which musicians nevertheless must navigate through. Another intriguing ethical issue—also discussed by Moss (2014) in the fields of the arts—is the healthcare musicians' ability to unpack the "aesthetic rules" of music making and take responsibility for socially engaged music making with the participants. Other-centeredness (Lynch et al., 2016, pp. 39–40)—emphasizing the other persons' worldview and actions in the moment, over musical meaning-making and other qualities—exceeds musical boundaries in a natural way and helps music professionals to understand the vulnerability of the others included in the music making. Through this notion, a broader understanding of the social contexts in healthcare—a socially engaged professional approach (Sugrue & Dyrdal Solbrekke, 2014)—becomes topical.

Beyond the vulnerability of the patients, socially engaged practices also expose music professionals to their own vulnerability in medical environments. Through this vulnerability, and simultaneously venturing to take social *responsibility*, which is part of the relational agency in socially engaged music work, music professionals may connect with rewarding virtues such as benevolence and caring for others. This is how and why understanding socio-emotional processes becomes important in such work (Swanson, 1989; see Sonke, 2021). A perplexing finding of this study was that in the efficiency-oriented working environment of healthcare, instead of being outwardly efficient and productive, musicians preferred to rest and take time for themselves to be able to provide hybrid musical services for the hospitals. Hence, self-care (Sonke, 2021, pp. 59–60; see Preti & Welch, 2013a, 2013b; Ruud, 2010, p. 157) as an ethical professional practice is a crucial matter that became visible through the findings of this study.





## 5.3
## A salutogenic orientation to expanding music professionalism

As envisaged in all the findings and discussion sections of the sub-studies, the relational agency and expertise of musicians in expanding working contexts should be better recognized and supported. Based on the sub-studies, musicians' relational work embraces socially, ethically, and musically relevant ways to respond to the needs of the patients, their families, and interprofessional colleagues that arise from the musicians' work in healthcare environments. These responses take account the diversified ways of participation and relational and changing agency of the participants, as well as their possible self-reflections in the music making situations. Overall, healthcare musicians' professional reflections on their work, and other resultant empirical material of this study, point towards considering *salutogenesis* as part of music professionalism. Salutogenesis is a health promotion theory focusing on the influential elements supporting health and well-being (Antonovsky, 1988, pp. 14, 16, 36). Here, health promotion is understood in its broadest meaning, as a communal and individual activity, and as the capability to provide welfare and wellbeing for all ( Johansson et al., 2009; WHO, 2010, 2017). Individualistic objectives, such as individual life satisfaction, eudaimonic wellbeing, or happiness in terms of life (or professional) goals may also be included in the salutogenic approach, but they are not emphasized here. Instead, resilience, which is often understood solely as an individual capacity, has been an important part of developing community-oriented views into a salutogenic orientation, and is emphasized through creating possibilities for the inclusivity and strength of communities (Antonovsky, 1987, 1988; Laverack, 2014, p. 24).

Scholars all over the world have sought to develop salutogenic orientations, which originally evolved to offer a choice for a medicalized discourse, and on the other hand to contemplate pathogenic knowledge construction, which studies the origins of diseases and ill-being (Mittelmark & Bauer, 2017, pp. 7–8). Although the orientation has been criticized, for example as being non-coherent, the salutogenic approach has also been viewed as possessing a great potential to solve the complex problems of societies (Mittelmark & Bauer, 2017). As a philosophical orientation, salutogenesis—the origins of health—encompasses a wide area wherein scholars and practitioners are invited to co-develop the interdisciplinary framework. Salutogenic orientation is further developed here, where the artistic, pedagogical, bio-psycho-social, and medical paradigms intertwine in complex ways. Lindström (2010) has integrated theoretical models for applying salutogenic perspectives within health promotion on a resource and asset-based umbrella (Lindström & Eriksson, 2010, p. 55), and Eriksson and Mittelmark

(2017) have collected some central concepts on salutogenesis in their respective umbrella (p. 103). Following their thinking on this visionary tool, and drawing from the findings of this study, I present salutogenic premises for *a good life orientation* in healthcare contexts, where one or more theoretical concepts or approaches may be reflected through practice and/or research (see Figure 2).


***Figure 2. A salutogenic good life orientation to expanding music professionalism in healthcare contexts.***



In its extended meaning, a good life orientation presents all individuals as *good life workers*, with an obligation and willingness to help, consult, and support each other (see Mittelmark et al., 2017; Nilsson et al., 2017; WHO, 2015). In professional work, a salutogenic view encourages professionals to pay attention and educate people through their work towards the means to find better ways of being and searching for inner balance in their lives (Nilsson et al., 2017, p. 21). The salutogenic orientation in this study sheds light on care, including care for the wellbeing of the music professionals *themselves* by: 1) finding inner and outer balance in one's working life; 2) anchoring one's work as contextually relevant; 3) finding meaningfulness for one' work in an existential dimension; and 4) being able to successfully navigate one's work between context-related value systems and hierarchies. Furthermore, this good life orientation adopts a broad understanding of the health promotion theorization in relation to everyday musical activities, to increase the wellbeing in healthcare units and other individual communities. Shared musical activity and agency, as interpreted through the findings of this study, can support salutogenesis that is realized through healthcare musicians' work and moves beyond a sole focus on individual behavior. Including a wide range of social and environmental activities and interventions, such shared musical activity aims to increase experienced wellbeing within healthcare environments, to strengthen healthcare communities, and to support personal life circumstances. Embedded within these "healthy music practices" is an idea of solidarity as a professional resource; the vulnerabilities and needs of people who are in a fragile state are not "for sale" or objectified through their liminal identity as hospitalized person(s) (see also DeNora, 2017; Fraser, 2014), but can be supported through shared musical situations.

## 5.4 Towards socially and emotionally responsible musicianship

The patients who participated in this study emphasized the emotional nature of healthcare musicians' work, and the ways in which music contributed to their aesthetic and spiritual needs during their hospitalization. Opposing these views, the findings also revealed a strong narrative, perhaps emphasized especially in the Finnish context, according to which musical emotions should not be expressed to others, or that music is just for the "musical individuals" who answer for the artistic responsibilities of the society (sub-studies III and IV). Accordingly, active resistance to the musicians' work was encountered, for instance among some eldercare patients, and healthcare personnel as well. In the interview data of the

musicians, there were some indications towards understanding this resistance as a useful tool in reflecting dynamic power relations between musician and participant(s) (see also Dons, 2019, p. 160). In addition, existential dimensions were deeply involved in some musical situations, but not in all of them; indeed, some situations could be described as very light-hearted in nature. It is essential to recognize that there were many patients and healthcare personnel who chose *not* to participate in musical situations at all. Many people may prefer solitude or other art forms than music, for example literature, dance and movement, or visual arts. Although this study has not explored these alternatives, they certainly are part of cultural wellbeing and/or arts services in healthcare (e.g., Theorell, 2021).

The need for musicians' ability to sustain emotions, both for themselves and for others, was perhaps the most important empirical finding of this study (sub-studies II, IV). If we think of institutionalized music practices, the nature of emotions that are nurtured through music may be rather normative, and what is experienced as a "positive" or accepted emotional response may receive increased support (cf. oppressive music practices, Baines, 2013; Jorgensen, 2003; music in and as torture, see Alanne, 2010). The professional work examined in this study was conducted with people of all ages, including intergenerational work with families and a variety of groups. Many musicians worked with children, families, adults, adolescents, and the elderly, but they could also have some specialized areas that required profound levels of attention, such as intensive care units. It could be reflected upon whether the otherness investigated here (Thornton et al., 2015; Weiner-Levy & Queder, 2012), such as the desolate life experiences of the families, the rich dynamics of ageing and illness, or the emotional complexity within the process of dying, are suppressed or lack confirmation in contemporary socio-musical and institutional contexts. Another crucial question for future music services is how to make all kinds of musico-emotional diversity and activity more explicit in a relevant and safe way.

In this inquiry, a multi-voiced research approach was constructed through the observations and interviews of the whole hospital community. Hence, the voices of the patients remained rather limited in the research process. This was partly due to the research ethics and the rigid protocols of the hospitals, meant to protect the anonymity and fragile situation of the patients. This methodological choice does not, however, exclude the reality of patients as active participants in music making in the hospital wards. As the findings suggest (sub-studies II and III), active participation in a fragile state of health may seem very different from what is usually understood as participation or agency in music. It seemed that all of the musician participants in the study understood patient identity as liminal (see DeNora, 2017, pp. 59–60), as based on a position where the patients ended up without choice.





Viewing hybrid professional work as a connective activity (Noordegraaf, 2016), and understanding hybridity as an altruistic service, became tremendously relevant in this study, where musicians represented a strong link between "normal" and hospitalized life for the patients. In some instances, professional hybridity signified a lack of stability in musical work. *Professional deprivation* could manifest in scarce resources, interruptions at work, or a disorganization of work, which may represent a rather brutal side effect of hybridity in artistic practices, as Gielen (2009, 2015) also has discovered. A future challenge will be to support music professionals in understanding the rewarding but demanding nature of the work, practicing relevant self-care, and finding as well as receiving peer support. As the findings of this study confirm (sub-studies I and III), musicians' work in healthcare is often professionally overwhelming for themselves, as Preti and Welch have also discussed (2013b). How can we assure that music professionals can overcome such a holistic professional experience, which could be called *boundary work regret*? This phenomenon, consisting of regretting, for instance, your own professional values, career choices, or other chosen work life paths, is characteristic for interdisciplinary boundary work and research, and has been discussed by Wansink and Ittersum (2016). All of the musicians in this study stated that the work in hospital wards was so burdensome that they preferred doing it only on a part-time basis (see Preti, 2009). In addition, there were many kinds of misunderstandings, such as difficulties in scheduling and managing the work, or raising awareness of the nature of music practices in the hospital wards. These issues could usually be understood as "professional failures", and as a need to prove one's competence, which was already at a very high level in the working frame of the musicians of this study. The musico-emotional processes in the work may also be burdensome at times. Rewarding emotional processes occur, but oftentimes the primary emotional takeaway may not be aesthetically successful or form a complete whole, despite the excellent performance of musical qualities.

The process of exploring hybrid, expanding professionalism in this study raised a further question of what kind of professional identity work might be helpful for future musicians (see also MacDonald et al., 2017). Perhaps here we could turn to the topic of higher music education institutions, by suggesting that they could already during basic studies offer clues to the students about the expanding working contexts that are available to them. Specialized contexts, such as healthcare, requires ethical and existential maturity, and the musicians will have to have time to develop their thinking to be able to *choose* a path as a healthcare musician. It would be beneficial for society at large if all students could have an idea of what emotionally relational work, or expanding professionalism consists of. This opportunity to explore professionalism as socially constructed boundary work (Akkerman & Bakker, 2011; Cribb & Gewirtz, 2015; Gieryn, 1983) related

to the processing and sharing of professional knowledge (Jensen et al., 2022) could be offered through a study module, or other study processes, that all students would go through, as is the case for example in the conservatories or other educational institutes that collaborate with the Musique et Santé training centre (Musique et Santé, 2022).

In sum, I would suggest that we take a further step and consider the "many faces" of music professionalism that were explored in this study through musicians' hybrid practices and changing professional identities in one exemplary context. As this study has revealed, there is a great diversity in musicians' ways of working, and thus understanding music professionalism could likewise be expanded in many alternative directions in future years. This would result in a more expanded sense of how music professionalism in the healthcare system is regarded, but would also require new kinds of professional responsibility and accountability. As Cribb and Gewirtz (2015) have stated:

> To adopt a professional role in health or social care is in many cases to take up a considerable ethical and emotional burden and at the same time to get the opportunity and social permission to use one's knowledge and capabilities to make a contribution to other people's well-being. Whatever formal systems of accountability are in place, there is no avoiding personal accountability for one's actual and potential contribution. (p. 156)

The turbulent recent years have raised a call for such accountability and potential on a personal *and* systemic level, as the professional game (Bourdieu 1990, 1991) has been at times very difficult to understand or join in for music professionals during the pandemic and/or other global crises. When the premises of the professional work become blurred in such a strong manner, Bourdieu's sociological term *hysteresis* (1990; see Graham, 2020)—illustrating a field going through a profound change where its rules and regularities may change in a fundamental way—would be a suitable way to describe the circumstances in which music professionals navigate their work and professional identities at the moment. In line with the endeavor to support this kind of fundamental social change(s), I propose that hybrid professionalism in expanding contexts should be understood not just through relational and proactive professional qualities in and beyond music (see Figure 1), but also as requiring situational ethical reflection and a salutogenic orientation. In this way music professionalism could be strengthened, and music professionals could be inspired to better confront the future systemic changes in our societies (see Figure 3).



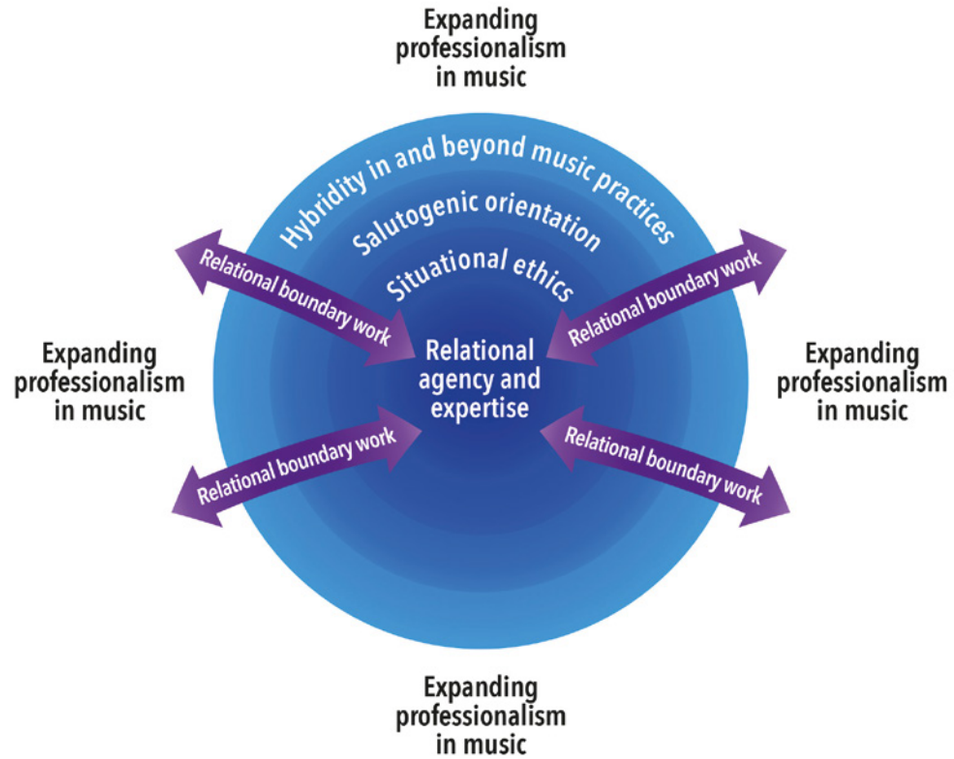


***Figure 3. Expanding music professionalism in healthcare contexts.***

# 6
# FINAL CONSIDERATIONS

This inquiry has been carried out by means of qualitative methodologies and a strong reflexive approach, including the researcher's own hybrid sphere as a music educator, music therapist, and researcher. Building on theoretical starting points wherein the concept of hybridity as manifested in and through healthcare musicians' practices was examined as highly relational boundary work, including relational expertise and agency, I have concluded that expanding music professionalism in healthcare also requires situational ethics and a salutogenic orientation towards wellbeing. In this section, I will first critically examine the limitations of and possible rival explanations for this inquiry, as part of demonstrating its validity and trustworthiness. Second, I will discuss the future research recommendations and opportunities that stem from the findings of the study. Finally, I will consider the overall process of this inquiry and its contribution to the field—which in this case entails, for example, music performance, music education, and healthcare organizations—and present a manifesto on the future of music professionalism in healthcare.

## 6.1
## Limitations and rival explanations

Case study research is very diversified by nature (Creswell, 2014; Stake, 1995; Yin, 2018), and is often carried out in the framework of qualitative research that consists of a variety approaches, which may include a wide range of methodological and theoretical traditions with manifold objectives and rationales for research. For this reason, studies that entail qualitative features "need to be evaluated in terms of their own logic of inquiry" (Levitt et al., 2018, p. 28). Although some checklists exist for presenting such limitations, here the overall strategy of validating the study and evaluating the trustworthiness of the research process lies in the premise that it has been managed in as open and systematic a manner as possible for a reflexive multiple case study.

Methodologically, the limitations of this study are rather traditional, such as considerations of the following factors: What number of cases is enough, or too much? How should the empirical material be generated and analyzed? What kind of generalizations should or should not be presented? These limitations were carefully considered throughout the whole research process, and I navigated through them individually at every stage of the inquiry. In educational and artistic research, the empirical material is often still generated by only one researcher, as was the case here, which may create some questions about the trustworthiness of the research. However, my own special and relational expertise in healthcare settings turned out to support the research process. I did not indeed recognize the potential of my own expertise at the beginning of the research process, but it first helped to facilitate the empirical phase of the research process, and later the whole inquiry. Many fundamental elements of the research project, such as the ethical complexity or challenges of conducting artistic or arts-based research in hospitals (Laukkanen et al., 2021), highlighted both the strengths and weaknesses of this interdisciplinary research process. Further on, I reflected on how to move towards generalizations in boundary research, and how to report (and for whom) all the needed aspects between multiple collaborating stakeholders. In my experience, peripheral boundary research may create biases for the researcher's thinking and reporting of the findings, just as it may create tensions in many disciplines and professions. To take this aspect into account, my research journey included ongoing reflection, which occurred in the form of ethical reasoning and abductive cycles of meaning-making.

In traditional case study research, *rival explanations* (Yin, 2018, pp. 21, 246–247; Dür, 2007) are an important part of evaluating the internal validity of the research findings. In this study, rival explanations are plausible theories, policies, and practices, which have emerged unexpectedly during the research process. Rival explanations not only challenge the findings but may also help to develop thinking and practices in-between the systems where music professionals work. Next, four plausible explanations are presented and reflected upon: hierarchy of evidence; economic prioritization; functioning with disabilities in life; and disruption of professions.

*Hierarchy of evidence*. In this study, the boundaries of medical and non-medical research became blurred in a complex manner. This may pose questions about what counts as relevant evidence, and for whom. Higher music education, and preferably all education, must be based on research, but the research evidence is created in a different manner than evidence-based practices in healthcare (Guyatt et al., 2008; see Clift et al., 2021). If we think of the outcomes that are created through music or music education research, most of the evidence does not meet the GRADE (Grading of Recommendations Assessment, Development and Evaluation Working Group; Guyatt et al., 2008) quality recommendations of the healthcare sector, or would be graded as very low- or low-quality evidence (mostly levels C and D). This primarily creates a biased setting situated beyond the realities of the differing epistemological and ontological interests of these intertwining systems.

*Integrating medical and non-medical research*. Despite the differences in knowledge-building, research in the field of music meeting the GRADE quality

recommendations has naturally been conducted (e.g., Bonde & Theorell, 2018, chapter 1; Schmid et al., 2018). However, it is rather difficult to implement evidence-based music *practice* without applied research methodology, which helps to understand *how* and *why* to apply socially engaged music to healthcare. Beyond the evidence hierarchy typical of medical research and practice, it would be beneficial for the music—or arts overall—in healthcare practices if stakeholders could expand the discussion to the *feasibility* and *efficacy* of different activities and/or interventions. Feasibility in healthcare studies examines the viability of a health service, and is essential for strategic planning, developing new services, or expanding service delivery practices. Efficacy as a concept represents the ability of an intervention or activity to produce the desired beneficial effect(s). These kinds of studies have been successfully conducted, for example, in the field of music therapy (e.g., J. Edwards, 2016; Kamioka et al., 2014).

*Non-humanistic future.* A rival explanation, which seems to be very plausible in the light of current discourses and trends, is the dominating economic paradigm and the understanding of global wellbeing and a good life as requiring continuous economic growth (Chatzidakis et al., 2020). A question that has gathered momentum in recent years, and especially during COVID-19, is whether there should be persons (at all) in, for example, eldercare to provide care. Remote services, virtual reality, robots, and artificial intelligence will most likely be used increasingly in many kinds of care services, and the ultimate question is, how much human contact is or would be optimal in care facilities in the future. Regarding the findings of this research, at this moment it seems that human contact is still valued in healthcare, and therefore it is argued that people-centered work will also be very important in the near future. By stabilizing people-centered artistic work it may be possible to support ethical care, which can actually then become part of economic prioritization.

*Economic prioritization.* Along with economic priority setting, there is a recognition that human beings, nature, and all living creatures should be treated fairly and that better premises for sustainability should be created. Paradoxically, these economic and equality priorities are often set against each other. In this global situation, where the music and arts professions meet economic realities, and even compete for scarce resources, new frameworks for measuring or accounting for the broader impact of specific activities—interventions, programs, policies, or organizations—would be valuable. For instance, Social Return on Investment methodology (SROI, Banke-Thomas et al., 2015) "has capacity to measure broader socio-economic outcomes, analyzing and computing views of multiple stakeholders in a singular monetary ratio" (p. 1). For smaller-scale arts activities, networks developing feasible and useful assessment have been established, such as the Creative & Credible (2021) evaluation for arts in the UK.



*Functioning with dis/abilities in life.* People-centered and humanistic views are often challenged by the categories for human deviances such as biomedical ICD-framework (International Statistical Classification of Diseases and Related Health Problems, ICD-11; WHO, 2022a), which serves as a grounding framework for medical diagnostics and healthcare services. To complement the ICD frame, the World Health Organization has introduced the bio-psycho-social framework, that includes ICF classification (International Classification of Functioning, Disability and Health; WHO, 2022b). Although all the WHO member countries have basically engaged to support the use of the ICF in, for example, rehabilitation services, it is not commonly understood or utilized as a theoretical framework or tool (Washington Group on Disability Statistics, 2022). This study supports the notion that this kind of intersectional frameworks would better take into account the environment and contexts people are living in, as the entire population may be understood as temporarily able-bodied, and the identity of any person may be in constant movement and/or alternate in-between dis/able.

*Disruption of professions.* The strongest rival explanation that challenges the study is the understanding that expanding boundary work examined in this study disrupts in a fatal manner the professional management or existing system of the music professions. This view has emerged in multiple ways throughout the research process, for example through the intersecting elements between musicians' and music therapists' professional approaches on theoretical, practical, and historical dimensions. Although the roots intertwine, and the professions come together in a great manner, they seem to possess different agency, and partly different objectives and means of work, as well as professional identities (e.g., Bonde, 2019; Ruud, 2012). Also, I had to exclude at a very early stage of this study the understanding of musicians' work in healthcare as entirely instrumental, merely contributing to the knowledge of some other disciplines or professions, such as neuroscience, cognitive psychology, therapy, or rehabilitation. As boundary workers, healthcare musicians receive inspiration from and work together with many parties, but according to the findings of this study, there seemed to be some unique reasons why these particular music professionals were given a possibility to work in hospital wards, and why they were wanted there.

## 6.2
## Recommendations and opportunities for future research

> *I would suggest, however, that in the near future, we will need a new kind of musician, therapist, community musician, and music educator—a health musician, if you will—with the necessary musical and performative skills, the methodological equipment, and theoretical familiarity, and not least, the personal, ethical, and political values to best carry out these health-musicking projects.* Ruud (2012, p. 95)

Based on the findings of my research I strongly agree with Ruud's above call for a new kind of music professionalism. Despite this kind of visionary thinking, it was rather impossible to imagine that in the 2020s the world would be turning into a huge test laboratory for many kinds of hybrid services in time and space, and that creative fields would be part of that rapid development. Likewise, when this research process started in 2016, it was inconceivable to see music professionals in healthcare, or other contexts, as delivering these services in ultimately hybrid, virtual, and/or remote ways, because the development of remote music services had been lagging behind over recent decades (King et al., 2019; in music therapy Agres et al., 2020). The pandemic has been an almost overwhelming test for the values, approaches, and visions of music professionals and their work, and for the meaningfulness and purpose of this study alike, and calls for more studies on the rapid development of music professionalism.

As described earlier (chapter 1), this research started as a very peripheral academic activity. It has subsequently become more centric in nature, as the cultural dimensions of wellbeing have been increasingly emphasized as part of cross-sectoral work globally. In the Finnish context, the conceptualization of cultural wellbeing has evolved, stemming from the cross-sectoral development and research in welfare services (Ilmola-Sheppard et al., 2021; Lehikoinen, 2019). This recent development in both the Finnish and international contexts shows that there is a need for new professional hybridity and networks that can produce academic knowledge and support social innovations. Aligning with this understanding and need for interprofessional work, I have also been a member of many innovative working groups during my doctoral studies. For example, we established an interdisciplinary program for the University of the Arts Helsinki open campus, introducing diverse perspectives on the boundary areas between arts therapies, and engaging a wide range of artists, social workers, and health promotion professionals to study these phenomena together. Another example of cross-sectoral engagement has been my opportunity to lead a policy brief group of the ArtsEqual Research Consortium.



When reflecting upon the need for future research and development, the findings of the study and the research process as a whole point to several interdisciplinary research paths, which I have identified by applying the future signals of the sense-making framework (FSFF, Kuosa, 2010) as follows:

1) *Shared agency* is a research area that should be developed in relation to participation in music, as well as cultural wellbeing (see Clift & Camic, 2016; Huhtinen-Hildén & Isola, 2019). The relational agency and expertise of patients and their families was not explicitly presented in this multiple case study. However, when musicians were making music with and for people in the hospital wards, the agency was shared in many situations, such as in the shared decision-making and discussions on the musicking with and for babies in the NICU.

2) The rapidly changing working life in creative fields requires new approaches to what professions are and what kind of boundaries and systems professions should support. A more generalized approach as part of music professionalism is one possible path to further explore in future research in music. Aligning hybridity as a contradictory concept, *generalized expertise* could be explored from the view of a professional who may possess "a renaissance attitude" towards the competence and knowledge that is to be gained from successfully managing arts practices in society. In the music profession, this would encompass research on how traditional power relations, such as the master-apprenticeship model, patriarchy, or male genius myth, could be deconstructed as less hierarchical and more equal in nature.

3) The meaning of the *concept of change* in musical practice, theory, and policy could be re-examined, as transformative experiences relating to boundary work require an awareness and willingness to revise a part, or parts, of a system beyond top-down organizational management. As has been presented earlier in this dissertation, related research efforts would perhaps be most fruitful if collaborative and co-creative practices could be implemented in the organizational culture more broadly. This way of thinking often necessitates everyday facilitation in systems—supporting in a better way the comprehension and performance of individuals and groups of people alike—to develop and enable change on a deeper level.

4) As this study has indicated through an exploration of healthcare musicians' spatial, less hierarchical music practices, *engagement as a*

*horizontal concept*—instead of a solely linear or time-related activity—may become increasingly important within expanding music professionalism, as community-oriented and intergenerational arts activities become more mainstream in (institutionalized) societies. The new challenges regarding this kind of work will at some point concern curriculum development and artistic quality issues, which may bring up contrasts regarding earlier cultural policy.

5) Beyond the active engagement of individual music and arts practitioners, organizational thinking should be researched more in the context of cross-sectoral collaboration. Developing *organizational and professional mindfulness* (or mindful organizations and professionalism) could be one way to support future social innovations in the field of music. Organizational mindfulness would deal not only with lean and agile thinking, but would also address failures, resilience, and decision-making, which have so far been analyzed mostly through individualistic frames despite their being also deeply collaborative in nature.

6) The facilitation of *ethically sensitive thinking in healthcare*, or "patient-centered culturally sensitive health care", as Tucker et al. (2011, p. 342; in special music education see Sutela, 2020) describe it, is still in its infancy in practice, at least in Finland. These themes were apparent during the data generation, and in the raw data, but were beyond the scope of this study. Inquiries that intertwine analysis of both empirical and theoretical views on sensitive music practices in healthcare would be a significant contribution to decolonization discussions and future research in the field of music (Westerlund et al, 2021; see Baines, 2013).

7) At the moment, in many music programs socially engaged work is viewed as process of "labels and to-do's", which are dealt with by organizations mostly through separate courses. A single study module may be life-changing for an individual person, but may as such present a fragmented palette of overwhelming practices, ever-moving ethicalities, and responsibilities that do not optimally serve the potential of students. Another risk of these separate courses is that they may remain a discontinuous educational practice—a kind of aspiration and voluntary work depending on the individual teachers and practitioners—within the organizations. Therefore, future research should address more clearly how to help *develop educational systems in music* to better respond and, indeed, proactively embed institutional logics into these societal themes instead of reactively doing the opposite.



## 6.3 Unsettledness as the power of hybrid professionalism

I started this research process with a rather intuitive understanding that there is something unique in the ways healthcare musicians relate through their music practices to the worldviews of the patients, their families, and healthcare personnel in hospitals. During this inquiry I have contributed to the existing research by describing how this uniqueness and the inspiring practices of the musicians integrate the hospitalized life with the everyday life outside the healthcare units. In relation to earlier empirical research on the topic (e.g., De Wit, 2020; Dons, 2019; Preti, 2009), I have especially focused on the interprofessional and intergenerational collaboration and organizational requirements, as well as the salutogenic aspects, that would better balance the musicians' societal work in relation to the institutions they work with(in).

Although there are burdensome and ethically stressful aspects present in healthcare musicians' work, as in any other care-related work (in care see e.g., Aungst et al., 2012; Lynch et al., 2016), the empowering nature of hybrid music practices is essential to recognize. To create meaningful musical situations together, by seizing the moment through very spontaneous music making and by acknowledging the yielding emotional atmosphere(s), requires a lot of *courage* from musicians and may transform unsettledness into a great inclusive strength of the work. The existential and spiritual dimensions that usually remain unspoken and implicit in musicians' performative work, emerge in a new light within the shared musical journey in a healthcare context. Acknowledging the need for supporting salutogenic resources in healthcare in and through musicians' work, and creating possibilities for the musicians to reflect on and develop this kind of emerging music professionalism, may significantly ease their individual professional burdens.

As an iterative learning process, this inquiry has pushed me as a researcher to continuously reconsider the meaning and usefulness of the concept of hybridity, as it has challenged my worldview throughout my doctoral years. In practice, professional silos may be deeply constructed in-between professions and through education. Crossing boundaries is not an easy task, and boundary work does not always succeed. Also, in the academic world, the researcher must often construct disciplinary silos and then deconstruct them to crystallize the phenomenon and gain new knowledge. Although I have tried to exclude myself as a researcher

from the professional jungle, or establishing silos in-between professions, such as musicians, music educators, or music therapists, I have found myself repeatedly in the middle of conflicting boundary situations. Still, at the heart of this uncomfortableness and professional unsettledness lies the wisdom in recognizing the developmental needs of the boundary areas at hand.

A question has emerged throughout this inquiry: Is an individualistic approach always the most appropriate for a welfare system, when we are seeking to develop our public services? Or, should the emphasis rather be on interdependency, in other words understanding the social system in which the person is working and living, interrelating, and interacting with people, groups, and/or systems? Instead of the never-ending competitiveness and overly individualized gaze, the findings of this inquiry point towards considering the resources and value of communities within music, care, and healthcare systems. This aligns with the reflections of Westerlund et al. (2017), who suggest, referring to self-absorbed professional activity, that "by expanding professionalism in music education through inter-professional collaboration, it is possible to break the institutional silos" (p. 27).

Now it seems that societal change, if such a thing is preferred, aspires to a relational and proactive approach that is collaborative in nature. I could not agree more with Chatzidakis et al. (2020) when they argue in their care manifesto on behalf of care environments that could better support our flourishing and sense of belonging, as follows: "We need conditions that enable us to act collaboratively to create communities that both support our abilities and nurture our interdependencies" (p. 45). The captured understanding of hybrid music professionalism in this research process speaks for a need to develop ethical care communities and care societies where the ability to relate becomes manifested and supports social sustainability. As a conclusion, I would like to end this dissertation by presenting my own statement on the future of music professionalism in healthcare:

> *Hybrid music professionalism in its broadest sense unfolds an approach where music practitioners understand the origins of not just wellbeing and musical self-care for themselves and the people and communities they work with, but also the meaningfulness of life itself. This salutogenic orientation does not ignore the notion that professional life is often very stressful and emotionally burdensome; however, through an exploration of manifold relational experiences and ways of musical work, these processes may be seen as part of professional growth and hybridity, including an aim to practice music in a socially sustainable way, and to strive towards a good life for all. A good life orientation in and through music opens up possibilities to understand health and wellbeing as collaborative processes that can be supported by all music practitioners through the interrelationship of the individuals and communities their work is associated with, and the societies and societal systems they belong to and within which their activities are situated. Extending beyond musical excellence and expertise, and even musico-emotional capabilities, music professionalism seeks to provide music practitioners with a culture-sensitive and context-sensitive comprehension that can serve as a premise for understanding their work as a relational part of any social situation in societal system. This orientation, which may also be called expanding professionalism in music, instills music practitioners with the generosity of spirit to understand that artistic excellence can be embraced through their own vulnerabilities and by seizing the empowering potential within the unsettled nature of their work.*

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# PART II

*The articles and policy recommendation included in the dissertation*

# ARTICLE I

Koivisto, T.-A., & Tähti, T. (2020). Professional entanglements:
A qualitative systematic review of healthcare musicians' work in somatic
hospital wards. *Nordic Journal of Music Therapy, 28*(5), 416–426.
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# PROFESSIONAL ENTANGLEMENTS: A qualitative systematic review of healthcare musicians' work in somatic hospital wards

## ABSTRACT

**Introduction:** The purpose of this review is to explore research literature beyond music therapy and music medicine studies that addresses healthcare musicians' work in hospitals. Music-related and intersectoral collaboration in contemporary healthcare may appear as if all music practitioners, including music therapists and healthcare musicians, maintain the same professional stance, harmonized goals, and orientations in their work. We argue that this is not the case, either in practice or in research, and therefore this complex field is in need of conceptual clarification as well as educational guidance.

**Method:** A systematic search of peer-reviewed literature with PRISMA yielded 16 studies relating to healthcare musicians' work in somatic hospital settings. These studies were analysed with the quality appraisal tool CASP, utilizing the descriptive statistics and thematic approach, and assessed with the ROBIS tool.

**Results:** Within the scope of the review, the quality of the studies, as well as the reporting of methods and analysis, were very diverse. The review indicates that the hybrid professional work of healthcare musicians in hospitals does not stem from the practices of music therapy. Instead, the healthcare musicians' work draws from different historical, societal, and philosophical contexts, developed mainly in the twenty-first century.

**Discussion:** Despite the rich descriptions of the healthcare musicians' practice and work presented in this review, it remains questionable whether the profession of healthcare musician is already internationally established. However, the emerging movement of expanding professionalism, which healthcare musicians are a part of, needs to be addressed more clearly in practice, research, and education.

**Keywords:** healthcare, hospitals, musicians, music profession, systematic review



## INTRODUCTION

In today's working world, professionals – including art professionals – perform their duties by navigating an ever-changing web of politics, values, and societal structures. In these turbulent contexts, the healthcare sector is also characterized by uncertainty and continual change. In the field of music and health, music practitioners who are not music therapists are navigating both their own shifting and transforming identities and those of others who share the field with them. Within hospital environments, this means that music educators, musicians, and other music professionals – referred to in this study according to their professional roles as healthcare musicians – are contributing to interprofessional work with their music practice. Essentially, healthcare musicians encounter situations where they have to take a stance on building intersectoral work; that is, they must practice individual and organisational collaboration through various societal sectors in order to solve broader societal challenges. This work requires new kinds of interprofessional explorations, responsibilities, and efforts targeting novel goals (Evetts, 2009, 2013; Sugrue & Solbrekke, 2014), which are shared and achieved with intersectoral and interprofessional collaboration. This claim is founded on the perspective of modern occupational restructuring (Evetts, 2009, 2013; Sugrue & Solbrekke, 2014; in music education see Väkevä et al., 2017), and through the argument that global as well as local societal changes in developed countries are changing working life to a significant degree (Bauman, 1999; Evetts, 2003).

Similarly, the roles and identities of arts practitioners in Western societies are in a turbulent state (Gielen, 2009; Gielen & Bruyne, 2009), as occupational as well as academic boundaries and structures become increasingly blurred (Christiansen et al., 2017; Faulconbridge & Muzio, 2011) and intersectoral work is being promoted as a means of inclusion and equal opportunities for all citizens (ArtsEqual, 2019; Creative Health, 2017; Fancourt & Finn, 2019). For policy makers, medical doctors, and other healthcare professionals considering intersectoral collaborations with healthcare musicians, it may appear as if all the various music practitioners in the field would maintain the same professional stance, harmonized goals, and orientations in their work. To clarify this complex field, consisting of many overlapping musical contexts and music practitioners, a classification developed by Bonde (2019) divides music agency in healthcare into five different areas, each of them having their own agents: music therapy, music medicine, health musicians, music as a health promotion, and music as a diversion/entertainment. However, many music practitioners may not see themselves as contributing to people's health status as such, but merely their wellbeing, understood in a wider, holistic sense. Therefore, in place of the concept of

*health musician* (see Bonde, 2011; Ruud, 2012; Stige, 2012), the less-contested concept of *healthcare musician* (see Musique Santé, 2019) has been adopted as the focus of our research.

It can be assumed that there are professional tensions between music therapists and other music practitioners that need to be revealed in order to understand the novel professional spaces, and need for interprofessional collaboration, that healthcare musicians are creating in healthcare environments. Music therapists are here understood as one of a broad range of healthcare professionals, whose work is legitimized and directed by current legislation and regulations when providing healthcare services. Healthcare musicians in general are assumed to be professionals who have an education in music and may have had in-service training in the fields we call, for example: music, health, and wellbeing; community music; or music education and wellbeing. In the context of healthcare musicians' work in hospitals, their contribution is not only to "create joy, engagement and improved quality of life for patients in hospitals and care centres through specially organized and personalized live performances" (Bonde, 2019, p. 11349), but also to engage with more relational, sensitive, and situational music practices (see Allsup & Westerlund, 2012). The underlying hypothesis of this study presumes that the education of professional healthcare musicians, as well as their professional approaches, incorporates an understanding of socially responsible and accountable work (Englund, 2016; Sugrue & Solbrekke, 2014; see Westerlund & Gaunt, in press). This entails the notion that the populations that the healthcare musicians are working with, as well as the professional spaces they create in different kinds of healthcare environments, are expanding and diversifying healthcare musicians' professional approaches. Consequently, healthcare musicians' practices may consider larger societal frames, such as cultural wellbeing, public services, or social justice issues. When invited into a collaboration within these networks, both the healthcare musicians, and the institutions and organizations they are associated with, need to have the appropriate knowledge and professional strategies (Alvesson & Willmott, 2002; Pekkola et al., 2018) to respond to and facilitate these demands.

Within this dynamic professional view (see Freidson, 1994, 2001; Noordegraaf, 2015; Saks, 2016; Siljander et al., 2012), music-making has different meanings in different places, and the primary goal of the services offered is often not as straightforward as demonstrating learning, performing, or a presentation of skilful practice. Rather, the goals of healthcare musicians' work can be that of working in interrelation with others, as well as understanding that they can be part of interprofessional teams offering solutions to manifold social problems (Pekkola et al., 2018). In order to identify and analyse these complex practices and professional insights, the professional frame explored here includes the following elements: describing healthcare musicians' musical skills, competences, and relevant practitioner knowledge in healthcare settings; conceptualizing music practices and professional spaces; and exploring the professional identities of healthcare musicians.

## RESEARCH QUESTIONS

The aim of this qualitative systematic review is to explore the research literature addressing healthcare musicians' work and professional space in somatic healthcare wards in hospitals. After identifying the PICO(T) elements (see Systematic Review Protocol, 2019), the research questions guiding this review were constructed as follows:

1. What kind of professional practices and professional space are represented in the reviewed literature concerning healthcare musicians' work in somatic hospital wards?
2. According to the reviewed literature, in what ways can the work and professional space of healthcare musicians be conceptualized?

## A PROFESSIONAL SPACE FOR HEALTHCARE MUSICIANS IN HOSPITALS

Somatic healthcare in hospital wards refers especially to bodily diseases, such as oncological, paediatric, dementia, emergency, palliative, or intensive care wards, where people are spending their days and nights in full-time inpatient care. In this review, professional space is an unfixed and ever-changing area, which is socially constructed and understood differently by different people in different environments (Cribb & Gewirtz, 2015; Dent et al., 2016). The concept of hybrid artists and their manifold professional working spaces has been introduced in recent literature (Gielen, 2009; Gielen & Bruyne, 2009). However, in-depth research considering healthcare musicians` work and practices in healthcare beyond the spheres of music medicine and music therapy (e.g. Edwards, 2015; Horden, 2017; Killian et al., 2013) has remained surprisingly scarce. Some researchers have explored music-making and music education, but more generally in care settings and regarding overall health promotion (e.g. Creech et al., 2013; Hallam et al., 2016).

In this study, music practice is understood as engaging in a music activity for the purpose of utilizing it in occupational, conceptual, and organizational contexts.

The quality of the music practice is not judged only by skilful playing, careful planning of repertoire, and joint musical activities, or the aesthetic qualities of the music-making, but also by the quality of the relationships, collaborative efforts, and innovative ways of creating that these practices promote within a community (see Clift & Camic, 2015; MacDonald et al., 2012). A healthcare musician engages not only with practitioner knowledge, but also joint interprofessional knowledge that is able to be shared with the broader hospital community. Music practices in healthcare are described as sensitive, highly reflexive action (see Clift & Camic, 2015; Stickley & Clift, 2017) that reach beyond more conventional, positional music making and musicianship. Similarly, professional space refers to any place or situation – in a hall, ward, single room, or personnel facilities – that healthcare musicians enter into, in a hospital or other healthcare environment; the difference being significant when compared to working within a fixed space and place in a dedicated music institution (e.g. an event in a classroom, a concert hall, or a community house). In many circumstances, the professional space is not even an actual place or space (see Jorgensen, 2011), or strictly defined as such, but is a relative concept that is constructed in the minds, attitudes, and reflections of the people engaged.

The diversified context of the study, itself a professional space, is delineated by many concepts that have been introduced and/or are overlapping with the healthcare fields wherein healthcare musicians operate. For example, the rather new and expanding field of community music, which may be understood as an umbrella term for healthcare musicians, aims to increase access to music activities outside of conventional educational settings (Bartleet & Higgins, 2018; Hallam & MacDonald, 2008). Moreover, the term music and health covers concepts such as health musicking/musicing (Bratt-Rawden et al., 2009; Ruud, 2012; Stige, 2012; see also Bonde & Theorell, 2018), an area including professionals from various fields, and volunteers engaged in health promoting music practices in social and health care. Also deriving from the field of health musicking, care music is music-making mainly in care environments, such as in eldercare facilities (Foster, 2014). Moreover, as music education offers a growing field of special music education literature (see McPherson & Welch, 2012), the concept of special music education is included in the systematic review of this study only when it refers to the professional music practices that are implemented within healthcare or hospital wards. Educational action here refers to being in a relationship with others, asking questions about life together with them, thinking and exploring together the aims and means to facilitate their growth (Biesta, 2006). Although all of the above-mentioned concepts are included in the literature review in this article, none of them are emphasized; rather, there is a wish to address the conceptual diversity of the professional music practices in healthcare. In order to more specifically focus on expanding knowledge in the field of healthcare musicians' work, and to support and reveal different kinds of agency in the field of the arts and health, music therapy was excluded from the scope and concepts of the review (Table 1).



# METHOD

The systematic review was conducted by following the Preferred Reporting Items for Systematic Review and Meta-Analysis (PRISMA, 2018) guidelines, where applicable for a qualitative review (Moher et al., 2009). Systematic review procedures were employed to identify, screen, and include the articles that met the eligibility criteria of the study. The first author created the study design of the systematic search procedures. Next, a Systematic Review Protocol (PRISMA-P) was created (Shamseer et al., 2015), and an independent review group was established, with the two main authors and an advisory group of three people. Systematic searches were conducted during February 2019 by the first author, and double-checked independently by the second author. At every stage of the review process the authors sought to work independently to increase the reliability of the review, but at the same time held discussions to find a consensus, and also consulted the supervisors when necessary (see Systematic Review Protocol of the study, 2019).

## Eligibility criteria and search procedures

Peer-reviewed articles in scholarly journals that described to the professional work of healthcare musicians were included in the review. Book chapters, project outcome publications, and grey literature (reports, working papers, white papers etc.) overall were excluded to ensure a sufficient quality and consistency. Articles that had a title or abstract referring exclusively to music therapy, music medicine, or areas outside the healthcare or hospital environments, e.g. music practices in elderly care homes or other social care environments, were excluded. Articles dealing with mental health or psychiatric settings other than somatic healthcare, as well as articles considering arts practitioners on a general level, were also excluded. Due to the development of the knowledge in the recent decades in this field, the timeframe of the search was limited to the years 2008–2018, and only articles that were written in English were included.

Four electronic databases and/or search engines, consisting of multiple databases (Dimensions, ProQuest, Google Scholar, and EBSCO), were searched

with different Boolean phrase variations to identify eligible articles (for the comprehensive search strategy see the Systematic Review Protocol of the study, 2019). Additionally, seven peer-reviewed articles that appeared within the research time-frame (Bonde, 2011; Guillermo & García, 2016; Huhtinen-Hildén, 2014; Longhi & Pickett, 2008; MacDonald, 2013; Moss & O'Neill, 2009; Preti & Welch, 2011) were extracted manually by the first author.

### Study selection and data extraction

The selection of eligible articles went through a process of identification of relevant titles and abstracts, through database searches and additional manual records searches. After identification, the articles were screened, duplicates removed and, based on the eligibility criteria and included conceptual contexts, irrelevant articles were excluded (Table 1). At this stage the titles and abstracts, as well as the inclusion and exclusion criteria, were screened and discussed, and problematic issues were resolved between the authors, where necessary by consulting the advisory group. After screening, the full-text articles were assessed for eligibility, and at this final stage articles that did not meet the inclusion criteria were excluded. A modified version of Critical Appraisal Skills Programme (Critical appraisal skills programme (CASP, 2018) qualitative checklist was employed in assessing the quality of the included articles (see Hadgraft et al., 2018, pp. 3–4).

### Analytic procedures

The included articles were analysed descriptively for the purposes of reporting. As a first stage analytic tool, descriptive statistical data relevant to the specifically thin data set was presented as follows: (a) General publication characteristics of articles; (b) Descriptive characteristics of studies with empirical data; and (c) Studies with no empirical data. Next, a deeper qualitative analysis was undertaken in the form of a deductive thematic analysis with sub-themes as follows: (a) Musical skills and competence; (b) Other relevant skills and competences; (c) Professional practices; (d) Professional concepts; (e) Professional identity features; and (f) Alternative professional themes. In addition to the top-down deductive coding, novel professional views and conceptualizations were sought out inductively, bottom-up. After that, with the notion of coherence, the meaningfulness and relevancy of the data was assessed in relation to the entire search results, in order to identify and synthesize the potential codes as nuanced themes following specific key themes (Braun & Clarke, 2006): i.e. as related to professional practices and spaces in somatic healthcare. The synthesis of the identified themes was narrated on the basis of the second stage analysis. Finally, the risk of bias was assessed with the ROBIS tool (Whiting et al., 2016).

## RESULTS

### Search results

Altogether 205 articles were collected for review: the search strategy utilizing databases retrieved 198 search results for screening, and seven additional peer-reviewed journal articles were identified by manual searches. First, duplicates (35) were removed and titles and abstracts screened; based on this process, 186 articles of the 205 were excluded. Articles excluded at this stage, except the duplicates, were those considering music medicine (22), music therapy (or other therapies) (16), and music professionals' health (32), or were published in other forms than peer-reviewed articles (e.g. book reviews, commentaries, reports, abstract reviews) (20). Also excluded were articles that did not include healthcare or hospitals (18), interviews of cultural personalities (8), medical articles not relating to music (8), or otherwise irrelevant articles, for example considering other professionals in healthcare, written in other languages than English, or spiritual articles missing the key concepts of this study (27). Finally, 19 full-text articles considering healthcare musicians' work in somatic hospital wards were assessed for eligibility; in this final stage, three articles that did not meet the inclusion criteria (a project report, an evaluation report, a study that did not include hospital environment) were also excluded.

The 16 studies meeting the inclusion criteria were organized and coded using descriptive statistical data analysis. Next, the final level of analysis was conducted, combining both top-down and bottom-up (i.e. deductive and inductive reasoning, see Braun & Clarke, 2006) thematic analysis procedures. Figure 1 depicts the flow chart of this process.

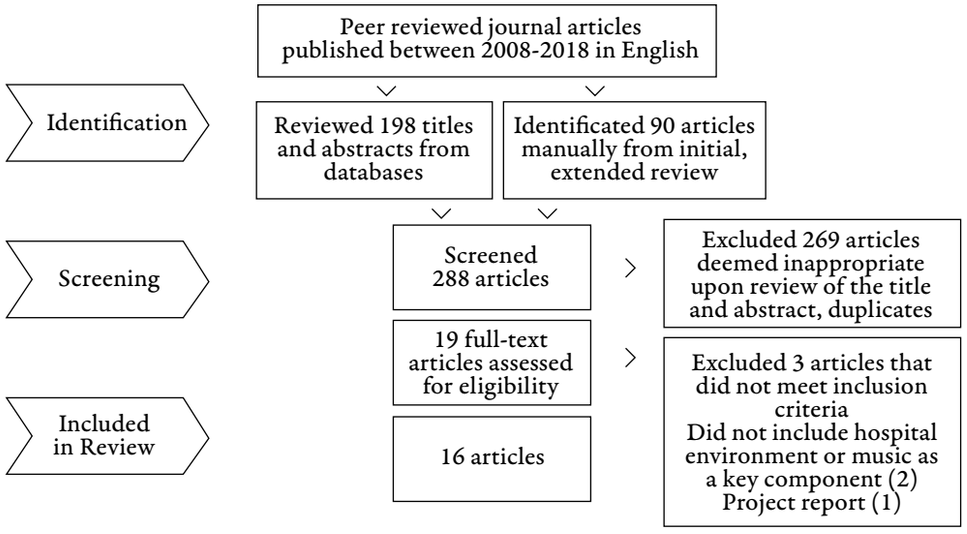


***Figure 1. PRISMA flow chart of the study search and selection process***

The CASP analysis revealed that the majority of articles (14) favoured a clear statement of aims in line with a clear statement of findings (13). All 16 articles represented the value of the research to a significantly high level, but only 5 of the articles discussed the limitations and credibility of the studies. Qualitative methodology was favoured, and was appropriate for the study design in all qualitative studies (15); only one of the studies used quantitative methodology. A high-moderate level of the studies (7) did not report data analysis in a sufficiently rigorous way, and four (4) of the total eleven (11) empirical studies did not report whether ethical issues had been taken into consideration. Overall, the CASP assessment revealed a great heterogeneity within the reviewed articles, identifying a fragmented research field with variable methodological standards overall. The criteria of the assessment and rating summaries are presented in Table 2.

## General publication characteristics of the included studies

Twelve of the reviewed articles had different authors, and in the remaining four articles from the years 2011 through 2013, the authors were Preti and Welch. The articles were published in various scientific journals; two were published in Music and Medicine, and two in Psychology of Music. The empirical data was collected in the United Kingdom, Australia, Italy, Spain, Sweden, and the USA. Two of the studies entailed cross-cultural data, with the empirical work being



***Table 1. Included and excluded contexts of the review***

| INCLUDED CONCEPTUAL CONTEXTS | EXCLUDED CONCEPTUAL CONTEXTS |
|---|---|
| Community music | Music for self-care |
| Care music/music care | Music in non-professional (voluntary) use |
| Health musicking/musicing | Music medicine |
| Music education | Music therapy |
| Musicianship | Transprofessional learning in medicine through music* |

*E.g. doctors learning teamwork from jazz-musicians (Penny, 2017).

***Table 2. Summary of quality appraisals across studies (k = 16)***
***(CASP Critical appraisal skills programme, 2018; see Hadgraft et al., 2018)***

| ITEMS ASSESSED | YES (k*) | NO (k) | CAN'T TELL (k) |
|---|---|---|---|
| SECTION A: ARE THE RESULTS OF THE STUDY VALID? | | | |
| 1. Was there a clear statement of the aims of the research? | 87.50% (14) | 12.50% (2) | - |
| 2. Is a qualitative methodology appropriate? | 93.75% (15) | - | 6.25% (1)** |
| 3. Was the research design appropriate to address the aims of the research? | 68.75% (11) | 31.25% (5) | - |
| 4. Was the recruitment strategy appropriate to the aims of the research? | 50.00% (8) | 18.75% (3) | 31.25% (5)*** |
| 5. Was the data collected in a way that addressed the research issue? | 68.75% (11) | 6.25% (1) | 25.00% (4)*** |
| 6. Has the relationship between researcher and participants been adequately considered? | 25.00% (4) | 43.75% (7) | 31.25% (5)*** |
| SECTION B: WHAT ARE THE RESULTS? | | | |
| 7. Have ethical issues been taken into consideration? | 43.75% (7) | 25.00% (4) | 31.25% (5)*** |
| 8. Was the data analysis sufficiently rigorous? | 56.25% (9) | 43.75% (7) | - |
| 9. Is there a clear statement of findings? | 81.25% (13) | 18.75% (3) | - |
| SECTION C: WILL THE RESULTS HELP LOCALLY? | | | |
| 10. How valuable is the research? | 100% (16) | - | - |
| 11. Limitations discussed/credibility of the findings | 31.25% (5) | 62.50% (10) | 6.25% (1) |

*Number of studies, ** Quantitative study, ***Non empirical studies.

conducted in two different countries. Studies with empirical data were also recorded, if they were reported to be an impact study (I = 4), effect study (Ef = 1), or evaluation study (E = 1). The difference between an impact study and effect study refers here to an "effect" dealing with somewhat moderately complex phenomena, and entailing features of some kind of causal relationship between the assessed items, with "impact" dealing with greater and more complex phenomena, and requiring assessment, for example, of social, societal, or economic factors.

JUFO Classification (2018), a Publication Forum by the Finnish scientific community for journals, series, conferences, and book publishers has four levels, which were recorded (0 = not received rating yet, 1 = basic, 2 = leading, 3 = top). Hence, the JUFO rating has some bias, as do other rating systems (e.g. Impact Factor), and the quality of the articles was assessed by other means. Also, the majority of the articles (10) were published in JUFO 1 journals, two articles in JUFO 2 journals, two articles in JUFO 3 journals, one of them possessed a JUFO 0 rating, and one of the journals did not have a rating. The Google Scholar citation rates were also included in the general characteristics, showing that the articles have not been highly cited. The included articles and their characteristics are presented in Table 3. The SHERPA/RoMEO (2018) database rating was also included in order to give some additional information considering the rating characteristics. The majority of the articles (9) were graded as green in the SHERPA/RoMEO rating, possessing the highest level of open access by publisher policies. Six of the article publishers were ungraded (journal or publisher is not rated), and one had a yellow rating (pre-prints are allowed to archive).

## Descriptive characteristics of the included studies

The majority of the studies were conducted in paediatric hospitals or paediatric wards in hospitals; other identified environments were elderly care wards, acute wards for people with dementia, adult wards, hospital schools, hospital lobbies, and intensive care units. It is notable that none of the non-empirical studies (5) identified the specific area or environment in which the inquiry was conducted, but focused generally on healthcare settings. Only two studies were clearly addressed as music education studies: Ruiz and Álvarez (2016) studied hospital schools in Spain and Sweden, and Issaka and Hopkins (2017) studied special music education that took place as a project with chronically ill children in a paediatric hospital.

The studies were mixed and diverse, in the sense that many data collection and analysis methods were used, and were furthermore conducted in a range of



***Table 3. General publication characteristics of individual articles***

| Author(s) | Journal | Country where empirical data were collected | JUFO 2018, SHERPA/ RoMEO | Google Scholar citation rate of the article |
|---|---|---|---|---|
| Bonde (2011) | Music and Arts in Action | Denmark | 1, Ungraded | 89 |
| Daykin et al. (2017) | Dementia | UK (I*) | 1, Green | - |
| Edwards (2008) | Voices: A World Forum of Music Therapy | - | 1, Green | 18 |
| Hawley (2018) | International Journal of Community Music | UK (E*) | 1, Ungraded | - |
| Issaka and Hopkins (2017) | International Journal of Educational Research | Australia (E*) | 2, Green | - |
| Longhi and Pickett (2008) | Psychology of Music | UK (I*) | 3**, Green | 33 |
| MacDonald (2013) | International Journal of Qualitative Studies in Health and Well-Being | - | 1, Green | 103 |
| Moss and O'Neill (2009) | Medical Humanities | - | 1, Green | 23 |
| Preti and Welch (2011) | Music and Medicine | Italy (I*) | 1, Ungraded | 22 |
| Preti and Welch (2012) | Arts and Health | Italy (I*) | 1, Green | 15 |
| Preti and Welch (2013a) | Psychology of Music | Italy | 3**, Green | 6 |
| Preti and Welch (2013b) | Musicae Scientiae | UK, Italy | 2, Green | 5 |
| Richardson et al. (2015) | Journal of Applied Arts and Health | UK (Ef*) | 0***, Yellow | - |
| Ruiz and Álvarez (2016) | European Education | Spain, Sweden | 1, Green | - |
| Wagner (2016) | Approaches: An Interdisciplinary Journal of Music Therapy | - | 1, Ungraded | - |
| Zhang et al. (2018) | Music and Medicine | USA | 1, Ungraded | - |

* I = Impact study, E = evaluation study, Ef = Effect study ** In Denmark and Norway 2 *** In Denmark and Norway 1 (Note: in these countries JUFO has only 2 grades).

environments. The studies utilizing empirical data all used qualitative methodology, except for one of the studies that reported using mixed methods, and one study did not report the methodological approach utilized, and was interpreted here as a quantitative study. The studies were rich, but at the same time inconsistent as a group methodologically; a majority of the studies used a multi-method approach for research methods, where data collection consisted of a literature review, interviews, observation, audio and video recordings, and field notes. The majority of the studies also utilized some unique, interdisciplinary applied data collection methods that other studies did not.

When it comes to the larger methodological frameworks, in the empirical studies one study reported that an ethnographic approach had been used, another reported being exploratory in nature, another being an initial service or pilot study, and two studies were identified as case studies. Two of the non-empirical articles solely used literature as data and literature review as a research method, with neither one of them being systematic reviews. Two of the non-empirical articles were theoretical, descriptive, and conceptual inquiries in nature, one review was historical, and one review used a broadly multi-method data collection system. The ratio or relation between the analysis stage (or the "story line" between theoretical framework and results section) and the resulting synthesis in the included review studies were discovered to be fairly thin. The descriptive characteristics of the studies with empirical data and the studies without empirical data are presented in Table 4.

Next, the qualitative themes relating to healthcare musicians' professional practices and spaces in somatic healthcare are narrated through deductive thematic analysis.

## The emerging professional space of healthcare musicians in hospitals

The degrees and educational backgrounds of the healthcare musicians in the reviewed studies displayed a great variety. One article (Preti & Welch, 2013a) mentions the basic education of the healthcare musicians, for example having a conservatory diploma or being graduates of music colleges. In six of the articles the musicians were described as having some further training, in which they had specialized in the arts and health fields. Such further training or courses are described very broadly, and in some articles the training is merely mentioned in a subordinate clause. There is a vast spectrum of training reported, with different lengths and contents, depending on the organization or project organizing the training.



## *Musical skills and competences beyond formal training*

The described musical skills and competences seemed to go beyond formal and conventional training, and novel, relevant, and reflexive skills that determined the course of the music-making were represented. The ability to alter the intensity of the sound in the ward environments, the ability to choose relevant instruments that could produce a high quality music session, utilizing musically responsive techniques, using facial and bodily expressions, playing with different sounds, exploring the musical vocabulary of vocal sounds, and paying attention to translating an emotional situation into music were all introduced. Distinguishing

***Table 4. Descriptive characteristics of the included articles (k = 16)***

| Descriptive characteristics of studies with empirical data (k = 11) | | | |
|---|---|---|---|
| *Data collection methods** | *Data analysis methods* | *Healthcare environment the study was conducted in** | *Nature of music interventions and approaches** |
| Interviews 37.5%<br>Observation 37.5%<br>Self-reflection or reporting 18.75%<br><br>*Other reported data collection methods***<br><br>Questionnaire, literature review, audio and video recordings, DCM dementia care mapping, document analysis, measuring physiological responses, discussions, focus groups, flow experience model | Thematic analysis 37.5%<br>Grounded theory 31.25%<br>Content analysis 12.5%<br>Analytical method not presented 12.5%<br><br>*Other reported data analysis methods***<br><br>Descriptive statistics, WIB well-being / ill-being score | Pediatric ward 37.5%<br>Elderly care ward 12.5%<br>Acute ward for people with dementia 12.5%<br><br>*Other reported healthcare environments the study was conducted in***<br><br>Adult ward, hospital school, hospital lobby, intensive care unit | Participatory music sessions 25.00%<br>Performing musicians 25.00%<br>Professional inquiry 12.50%<br><br>*Other reported interventions and approaches***<br><br>Impact of musicians` playing on the hospital staff, music education in hospital schooling |

| Descriptive characteristics of studies with no empirical data (N=5) | |
|---|---|
| *Methodology ** | *Nature of approaches** |
| Literature review 18.75%<br>Conceptual and theoretical review 12.5%<br>Empirical vignettes 18.75% | Presenting models and programs 25.00%<br>Professional inquiry 6.25% |

* % of the reviewed studies (N=16) **only 1 of each.

and understanding the relevance of the repertoire, being flexible in what kind of repertoire one uses, and musicing from memory were all valued as musical competences; on the other hand, the range of musical modalities, improvisation techniques, having a flexible repertoire, and placing musical activity within the sphere of broader perception by employing methods that were relatable for the participants were prioritized. This contextualization of music within ward life was an approach that was emphasized in many of the studies: *"I always have a plan, but it's never a rule, for I drop things as the moment dictates, pick up something else, take on extra music, and encourage requests"* (Preti & Welch, 2013b, p. 369).

## *Skills and competence(s) beyond music practices*

The studies revealed skills and competence(s) that can be understood as non-musical. The skills were: *" – partly learned in a period of professional preparation, prior to employment, and partly identified and elaborated by musicians themselves through their developing craft knowledge acquired during their long-term experience in a variety of healthcare settings"* (Preti & Welch, 2013b, pp. 371–372). The identified skills were relative to the healthcare musicians themselves: the ability to comprehend the way one feels on that day; the musicians' self-determination and self-confidence; individual abilities to react to a situation in real time; the interpretation of participants' needs at that moment in time to select the music; and a sense of humour.

## *Specific skills in healthcare settings*

Specific skills in social interaction, that in many cases have non-verbal and tacit elements, were also identified, e.g. empathy; intuition; special sensitiveness; establishing, creating, and carrying on a relationship with the participants and their families. The studies also emphasized skills and competencies at the institutional and organizational level. An institutional understanding of the hospital environment was emphasized: understanding how participants' health conditions are monitored in the ward; an awareness of the medical stability and instability of the participant; observing reductions in high heart rate readings and increased oxygen saturation rates. An organizational level understanding of a hospital as a system was also highlighted: knowledge of the healthcare settings' rules and regulations; the ability to be aware and be sensitive to the reactions and processes of the hospital staff; the ability to organize a timetable in a relevant manner.





## *Professional entanglements*

In the selected studies, the required professional practices were described as being highly flexible and relating to the time and space at hand, and the studies did not develop or present fixed practices as such. However, there were some consistent features throughout multiple studies that were emphasized as practical approaches: observing the practices of other professionals in the hospital wards; facilitating in music-making in such a way that both the participants (e.g. parents of a child) and the healthcare musicians can act; combining musical exploration with other professional practices in healthcare, e.g. combining reminiscences and music-making in a dementia ward; and sensitively negotiating relationships (of any kind) in a complex multidisciplinary environment. The studies also revealed the need to flexibly fit music-making around the acoustic 'norm' of the healthcare environment, e.g. the machinery alarms that are tuned to a distinctive pitch in order to be easily heard; communicating intentionally through music; and construing a situation in the hospital ward in a short time. This was thought to require that the healthcare musicians are *"extremely open to feedback on their interactions with people – and use it to inform their interactions in future sessions"* (Richardson et al., 2015, p. 314).

## *Novel conceptualizations in healthcare musicians' work*

Many of the studies described practical ways and means to work in hospitals in general, but conceptualizations regarding professional methods were more infrequent. However, some concepts regarding professionalism were emphasized. Daykin et al., 2017, p. 12) use the concept of "mediated affordances" to study how the impacts of music making on wellbeing and on the ward environment were strongly mediated by staff responses and hospital organization. This concept is linked to the notion of musical affordance (DeNora, 2000). "Decoding" was a concept introduced by Preti and Welch (2013b). Decoding could be described as something that the healthcare musician processes immediately when entering a room, or when encountering a situation in a hospital ward. Decoding is about reading the reality of people, and the clear or not-so-clear clues they give off, and reproducing them musically (Preti & Welch, 2013b, p. 12). "Tangible musical space" (Hawley, 2018) is a concept describing how hospital wards, which in principle are not necessarily musical spaces, are transformed and conceptualized by the healthcare musicians to become musical spaces. According to the studies, it is also important to notice silence as a counterpoint to musical space in a hospital ward.

### *Emerging identity struggles*

The reviewed articles represented the identity of healthcare musicians as complex and transformative, and as being in a struggle with the expectations and demands that they experienced, or that they interpreted as coming from various stakeholders. The studies were illustrated with images of juggling, and depicted the struggling, emotionally and physically draining and stressing, and demanding nature of the work. These features, along with the overall workload, became entangled with the healthcare musicians' professional identities, and in some cases were also tied to a relatively tight monthly personal income, *"conveying the impression of a rather 'out of breath' routine"* (Preti & Welch, 2013a, pp. 652–653). In addition to these demands and struggles, the articles stated that healthcare musicians also had self-centred reasons and motivations for working in health settings: moral ideas of making a positive impact on peoples' lives through music, a sense of being in the world and being in harmony with it, or spiritual motivations – and the work was also seen as emotionally rewarding and attractive.

### *Conceptualizing the professional space of healthcare musicians in hospital wards*

The following themes regarding the hybrid professional space of healthcare musicians were identified in the synthesis of the review.

The professional space of healthcare musicians is hybrid in various ways:

- *Relational* – depending on the context, music-making in the hospital wards may involve performing as an artist, participatory music-making, socially engaged music education practices, or more conventional learning and teaching.
- *Polarized* – the contemporary practices are non-systematized, unsettled, and unfixed in a troubling way; but, on the other hand, they are reflexive, sensitive, rewarding, and made to fit the existing healthcare framework.
- *Reflexive* – through shared music-making, healthcare musicians are decoding, combining, negotiating, responding, and facilitating the variety of relationships and situations within the healthcare environment.
- *Struggling* – previous professional identities, as well as ethical and moral ideals, are becoming fragmented or are under the strain of transition and transformation.



## DISCUSSION

In this study, the work and professional space of healthcare musicians in somatic hospital wards was explored. Literature focused on music therapy or music medicine was excluded, in favour of addressing the state of this highly fragmented field of music professionals beyond music therapists. Music practitioners, referred to in this study through their working context as healthcare musicians, are operating within their own professional frameworks, having for example a pedagogical, societal, or performative emphasis. However, the challenges and possibilities of the research and development of the emerging profession of healthcare musicians, as well as the interprofessional work in hospitals between music therapists, healthcare personnel, and healthcare musicians, were critically analysed. The findings revealed the heterogeneous state of the field, as well as the diverse quality of the studies. The methods used for analysis and reporting within the reviewed studies were also very diverse. Although the literature search also identified evaluation studies regarding healthcare musicians' work and music projects in hospitals, only one quantitative study was found.

In sum, healthcare musicians' practices and music work in somatic hospital wards are manifold in nature, as are their research methodologies, and the ward contexts they are working in. Our analysis determined that healthcare musicians should acquire hybrid knowledge and orientations (see Gielen, 2009) beyond their 'formal' practices in societies; for example as musicians, music educators, or other music practitioners. The agency of music as such, and the arts generally, is increasing (e.g. Creative Health, 2017; Fancourt & Finn, 2019) in our societies, and there is robust evidence of how music can affect our health and wellbeing, as well as serve our needs for cultural experiences and facilitate equality (ArtsEqual, 2019). However, the findings from this review affirm that the agency of music practitioners, in this case healthcare musicians under the umbrella of health musicians (Bonde, 2019), needs to be clarified and supported in order to implement music work and (inter)professional music practices in hospitals and healthcare in a relevant, sustainable manner. Furthermore, the quality of the research could be increased by sharing knowledge, practices, and educational curriculums internationally in culturally sensitive ways.

The findings from this review emphasise the importance of reporting on research in as conceptually and contextually clear and rigorous a manner as possible, as well as better recognizing publication bias such as emphasizing the positive findings (see Fancourt & Finn, 2019) of studies, or not reporting possible risks and challenges in practices. Furthermore, in order to engage with socially responsible work (Allsup & Westerlund, 2012; Sugrue & Solbrekke, 2014) in the future, the themes have demonstrated that there are many unclear issues in

the work of healthcare musicians that should be addressed and developed. These problematic topics concern issues such as how healthcare musicians' work could be better supported economically, structurally/institutionally, and emotionally; how different kinds of music agency could be better articulated at the policy level; and how the specific goals and objectives of the music work of different kinds of practitioners could be better addressed.

In the following, some reflections and suggestions are presented on developing healthcare musicians' work, as well as interprofessional work between music therapists, healthcare musicians, and healthcare professionals in somatic hospital wards and other healthcare environments.

## Conceptualizing healthcare musicians' work

As the previous enquiries into the field of health musicians suggest (e.g. Bonde, 2011; MacDonald, 2013; Ruud, 2012; Stige, 2012), it is challenging to conceptualize the overlapping and complex contexts of these types of activities. Nevertheless, it is important to articulate and conceptualize different practices and professional spaces in the field of music and healthcare, in order to better collaborate with other professionals, such as medical doctors, nurses, or administrative personnel. In this research, the concept of *healthcare musician* was built on the contextual premises, rather than through the aims and goals of healthcare musicians' work. The findings from this review indicate that healthcare musicians in hospitals have their own kinds of practices, drawing mainly from non-medical underpinnings and goals, which may help in balancing professional roles and tasks between them and music therapists. Furthermore, the hybrid identity of these music professionals, who in this research are called healthcare musicians, does not appear to stem from the profession of music therapy, but draws from different historical, societal, and philosophical contexts, developed mainly in the twenty-first century (see Musique Santé, 2019) and answering to the needs of our contemporary and transforming society (see ArtsEqual, 2019; Väkevä et al., 2017; Westerlund & Gaunt, in press).

## Hybrid and expanding professionalism

It is important to understand that there may be music practitioners in this complex field who do not regard themselves as healthcare musicians, although their work nevertheless falls within the scope of this review. Many art practitioners, in addition to healthcare musicians, may embed a hybrid professional identity (a term introduced to the arts by Gielen, 2009, in sociology e.g. Noordegraaf, 2015), as well as hybrid practices and even hybrid relationships with people, within the healthcare system. This complexity means that their work is highly reflexive and relative in nature, and instead of creating rigid professional silos, hybrid music practitioners adopt situational, more generalist-types of professional identities in the different contexts within which they work. This approach is part of a movement of expanding professionalism (e.g. Westerlund & Gaunt, in press) that should in the future be acknowledged in our education systems, so that music practitioners, including healthcare musicians, could undertake further education.

## The education and training of healthcare musicians

An underpinning of this study was that healthcare musicians have an education in music and may possess in-service training in the fields of the arts, health, and wellbeing. However, only one of the reviewed articles stated the exact education of the healthcare musicians. Other studies referred to professional degrees or titles, such as musician, music educator, or special music educator, which may include a variety of educational backgrounds, the content of which remains unknown. Zhang et al. (2018) point out that long-term formal musical training and experience in public performance were common backgrounds to all healthcare musicians in their projects and were cited as being important to their work.

After conducting our analysis of this study, it seemed to us as researchers that it is still a common perspective in care and healthcare that the role of musicians is to bring joy and energy to patients, while their broader connections to rehabilitation, social justice, and cultural rights are not yet widely recognized. However, nowadays there is a growing perception that the professions of musician and artist are more socially responsible and accountable (Englund, 2016; Sugrue & Solbrekke, 2014) so that the influence of musicians' educational background is also becoming more significant. In some of the articles studied here, tension appeared between different music practitioners working in the field of the arts and health with different educational and professional backgrounds. When defining education for healthcare music professionals, it is extremely important to develop the kinds of educational solutions that support interprofessional work and guide students to appreciate the expertise of other music practitioners in the field.

On the basis of this review, it can be suggested that there could be two ways to enhance the education of healthcare musicians: (a) create a separate in-service

training or (b) embed the education within other curricula, for example, within a higher education degree. Of course, an individual education programme for healthcare musicians could also be built, but at the moment, based on the premises reviewed in this article, it would require a large amount of intersectoral, integrative policies and collaboration. In any case, a great concern would be how ethical or sustainable it would be to establish a new course of professional education in such a fragmented and unsettled field.

## Developing interprofessional work

A dynamic view of professions (see Freidson, 1994, 2001; Noordegraaf, 2015; Saks, 2016) includes an understanding that manifold problems can be revealed and solved through interprofessional collaboration when diverse professional views are acknowledged and co-developed (see Pekkola et al., 2018; Siljander et al., 2012). In hospital organisations, interprofessional work typically means working in collaboration with healthcare personnel, but it may also mean work conducted between different music professionals. As reported in this review, in music-based collaborations that take place in hospitals, a healthcare musician's work may often be constructed through the lens of the projects they work on, or in developing music interventions that are relevant not just to people in hospitals, but also to people in a broader societal context.

When invited to take part in a collaboration within these networks, both the individual healthcare musicians and the institutions or organizations they are associated with need to have the appropriate educational and professional strategies (Alvesson & Willmott, 2002; Pekkola et al., 2018) to respond to and facilitate the demands of the work. The fragmented nature of the work, the challenges involved in handling the workload, and the sometimes overwhelming emotional burdens require reorientations from the art institutions and organisations they work in or with, or by which they are funded. Healthcare musicians are often forced to make short-sighted choices because the existing financing instruments may offer short-term funding for inventing new ways of bringing music into hospitals or other healthcare institutions. More stable financing, agreed upon and implemented through intersectoral collaboration, would offer steadier and possibly full-time opportunities to healthcare musicians and would alleviate the unpredictability of the profession. Healthcare musicians could also use the support of a community of practice since they often work alone. In addition, based on the reviewed studies, there are concerns about the wellbeing of the healthcare musicians themselves, and art institutions could take better care of their local freelance healthcare musicians by constructing networks and offering peer support and professional guidance.



## Limitations of the study and risk of bias

The review of literature was strictly limited to studies published in English, and it seems that this may have excluded potentially relevant studies in countries which have a local research branch within the field of music, health, and well-being, and wherein the English language is in minority use, such as France and other French-speaking countries. In addition, grey literature, book chapters (of which many may also be peer-reviewed), project evaluation reports, and other potentially relevant literature were excluded, and may have narrowed the data extraction. However, by including only peer-reviewed journal articles a more consistent and systemized review process was presumably created. The empirical data were all conducted in Europe (except for one study in Australia), and may indicate that these kinds of approaches are mostly western practices. The fact that four of the articles were produced by the same authors, Preti and Welch, may have also affected the results.

The risk of bias was assessed with the ROBIS (2018) tool and considered low for the eligibility of the studies, identification and selection, and data collection and study appraisal sections. However, the between-study variation, that is, the heterogeneity of the reviewed articles, was high overall. Despite this concern, the authors decided to include all of the articles, which were already somewhat few (16). Additionally, bias in the primary studies was addressed and assessed, when relevant, but could not be minimized. Despite the concerns in the synthesis and findings stage, the risk of bias in the whole review is assessed as low: the study addressed all of the concerns that the risk of bias domains presented, the relevance of identified studies to the research question was appropriately considered, and the authors did not emphasize results on the basis of their statistical significance.

## CONCLUSIONS

Despite the rich descriptions of the healthcare musicians' practices and work overall, this review cannot conclude whether such a profession as a healthcare musician, health musician, or hospital musician already exists internationally. However, on the basis of this review, there is a group of professionals in the field of music who occupy a professional space in hospitals where they engage with people and practice music in various, dynamic, and reflexive ways. Their work could be conceptualized as a type of hybrid professionalism, as they implement their highly situational, sensitive, and contextual music practices in hospitals, as well as in a transforming web of societal politics, values, and structures.

At the moment, the work of healthcare musicians mostly occurs in projects or small-scale interventions and is temporary in nature. It seems that, although their work is appreciated by the healthcare system(s) and healthcare personnel, and many times they work in collaboration with music therapists, the overall picture of healthcare musicians' work is one of being non-systematized, unsustainable, and economically vulnerable in nature. There are many ways to practice music with and for people in hospitals beyond music therapy practices, and more knowledge should be gained on how the practices of healthcare musicians could be more systematically supported; likewise, research should examine what kinds of relevant educational programs already exist internationally.

In conclusion, the emerging hybridity and expanding professionalism in the field of the arts, a movement that healthcare musicians are a part of, should be better addressed and included in the studies of transformative professional research, practice, and policy in our societies. By recognizing, granting, and narrating different kinds of agency in the field of the arts, such as the agency of music therapists and healthcare musicians, the wider field of the arts, health, and wellbeing can become a legitimate and acknowledged resource in our societies.

## DISCLOSURE STATEMENT

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# ARTICLE II

Koivisto, T.-A. (2021). Making our way through the deep waters of life: Music practitioners' professional work in neonatal intensive care units. In. H. Westerlund & H. Gaunt (Eds.), *Expanding professionalism in music and higher music education – A changing game* (pp. 115–128). London: Routledge. https://doi.org/10.4324/9781003108337-10

# MAKING OUR WAY THROUGH THE DEEP WATERS OF LIFE: Music practitioners' professional work in neonatal intensive care units

## INTRODUCTION

In this chapter I discuss the work of music practitioners in neonatal intensive care units, where newborns and their families are in great need of support in the midst of a multi-layered physical, psychological, and emotional crisis. In exploring the expanding professionalism of musicians in various contexts, music practitioners' work in hospitals offers an interesting case. Increasingly often, music practitioners are invited to work with families in hospital wards as part of a comprehensive support effort through music making. When a family enters a neonatal intensive care unit (NICU), whether with a preterm or full-term infant, it is typically due to complications during labour, premature birth, or a severe medical condition in the newborn, meaning that the parents are unable to take care of their child without medical assistance. Within the NICU ward environment these newborns, their families, and healthcare personnel are struggling in life and death situations. In this context, music practitioners contribute to the holistic wellbeing of families rather than exclusively the physical wellbeing of the newborn. Naturally, music practitioners are not expected to be responsible for the health of the individuals, nor is their work necessarily expected to have a measurable impact on their medical health status. Nevertheless, music making may be considered to have a positive impact on the ways in which newborns and their parents experience and sense their overall health and wellbeing.

The work of professional music practitioner in the context of neonatal intensive care must be firmly based on evidence, taking into account what is already known about the significance of music in healthcare in general and music practices in the care of newborns in particular.[1] A review of earlier research indicates that there is so far fairly limited knowledge or theoretical conceptualisation concerning the work of music practitioners referring to themselves as hospital musicians, healthcare musicians, or health musicians (e.g. Bonde, 2011; Koivisto & Tähti, 2020; Musique & Santé, 2019; Ruud, 2012). Recent decades have, however, seen a growing body of music therapy research on the medical care of premature infants (see Loewy et al., 2013; Shoemark & Dearn, 2016; Van der Heijden et al., 2016). This research has focused on topics such as mother–child bonding, the medically informed use of music, and music psychotherapy. The overall development of medical and nursing sciences has transformed NICUs into more parent-friendly and people-centred environments, in which parents are also in current practice encouraged to take care of their infants as much as possible. Cuddling, parental singing, and kangaroo care (skin-to-skin contact) are understood to be highly beneficial for the development of the infant, helping parents to bond with their child (Kaye, 2016; Shoemark & Dearn, 2016).

Music practitioners—in this case, musicians and other music professionals who work in healthcare contexts—come from a variety of backgrounds, such as performing arts or education. They usually hold an academic degree in music and have attended in-service training in preparation for work in sensitive healthcare environments.[2] In addition to their work with healthcare and ward personnel, professional music practitioners have begun working in interprofessional settings. These expanding practices require them to acquire a higher level of integrated understanding, such as familiarity with medical practices, principles of patient safety, and trauma-informed care. These new circumstances obviously differ from the more traditional professional spaces of music practitioners. They thereby work in rapidly changing environments where these new settings are not only changing at a rapid pace but are, on a deeper level, constantly being socially re-constructed and understood differently, requiring professionals to adopt novel ethical and relational approaches (Allsup & Westerlund, 2012; Cribb & Gewirtz, 2015; Sugrue & Solbrekke, 2011).

## MUSICKING AS A SOCIAL PROFESSIONAL PRACTICE IN THE NICU

To explore the nature of expanding professionalism for musicians working in the context of healthcare, I use a conceptual lens of "musicking" introduced by Christopher Small (1987, 1998) and draw on a qualitative case study that I conducted in a neonatal intensive care hospital unit. According to Small (1987, 1998), musicking is a socio-cultural phenomenon and about living and learning in relationships. The core dimensions of musicking—highlighting that music should not be made *at* people but together *with* and *for* them and also emphasising the significance of social dimensions in interpersonal exchange and the aspect that everyone is entitled to musicking—are essential principles for music practitioners in healthcare (Odendaal et al., 2014; Small, 1987, 1998). From the perspective of music practitioners, making musicking possible for *all* involves harmonising contradictory sets of values, practices, and ways of working in their novel professsional approach(es). This approach has been conceptualised as *hybrid professionalism* by Gielen (2009) and Noordegraaf (2015).

Musicking as the socio-cultural action of making every kind of music *with* and *for* people while engaging in relationships with them resonates with the recognition of music making at the NICU ward being "not about me, but about them". This ethically and relationally unsettled and non-traditional professional stance is an essential source of transformative change for the music practitioner's professional identity and practice. Music practitioners at the NICU initiate *people-centred musicking*, which means sharing and taking into account the involved families and their emerging emotions in a difficult life situation. Moreover, people-centred musicking involves the healthcare personnel with their duties and working practices. Entering a family room at a NICU ward with shared music making intentions creates new demands for music practitioners and their practices. Their task involves supporting the wellbeing of newborns and their families through singing or playing, but there is also a need for continuous evaluation and decision-making regarding where and when, and what kind of musical choices, instruments, or ways to contribute with music would suit the present circumstances, if at all. In all cases, music practitioners observe and reflect on the situations at hand, mirroring them on their previous knowledge and experiences of music making.

People-centred music making provides opportunities for developing the openness of values, actions, and interactions through musicking (Odendaal et al., 2014, p. 165). Taking into account the emerging emotions of families and the web of relationships at the ward requires moving beyond traditional forms of music and implementing varying and highly relational musicking practices. Adapting one's professional thinking, or that of an entire professional community, does not mean having to work without shared goals or values; however, in the healthcare context, the meanings of the music making arise strictly from the situation at hand and through creating shared meaning in the moment. Moreover, broader understanding of this phenomenon may lead to "changing the professional game" (Bourdieu, 1990, 1991) in and through the interprofessional collaboration and higher music education more broadly.

## Overview of the case study

In the case study, I observed musicking, that is, social interaction and relationships between a music practitioner and the newborns, their parents, other relatives (such as grandparents), nurses and physicians in the ward lobby, corridors, and patient rooms.[3] In addition to observing one music practitioner's work, I interviewed two music practitioners, two neonatal nurses, and family members. Through a reflexive (Alvesson & Sköldberg, 2009) and thematic (Braun & Clarke, 2006) analysis, I explored the complex ways in which music practices were co-constructed at the NICU ward by music practitioners in collaboration with the families and the hospital staff. Throughout the interviews and observations, metaphors emerged as a way for musicians and members of the hospital community to make sense, construct, and understand meanings of the musicking as well as everyday life in the ward. Therefore, I utilised *metaphorical thinking* (Lakoff & Johnson, 1980) as a theoretical tool for analysing the empirical material. While highlighting the hybrid (Gielen, 2009; Noordegraaf, 2015), relational, and transactional nature of musicking in the intensive care of neonates, my guiding questions for the empirical material were:

> *What kind of musicking emerges when professional music practitioners work in neonatal intensive care units?*
>
> *What kinds of metaphors were used by the music practitioners, NICU personnel, and families in their reflections on the musicking situations?*
>
> *How may these metaphors help to conceptualise music practitioners' professional work in neonatal intensive care units and more broadly in other healthcare contexts?*

During the study I have reflected on my own background as a musician, music therapist, and music educator in relation to the professional space and work of music practitioners in the NICU setting. While having been involved in collaborative, intersectoral work in the field of the arts and health for over two decades, I have felt the need to reflect on the implicit, tacit assumptions regarding not only the study participants or the people I work with, but also myself. As a result, my background and experience have helped me to understand the musicking practices and interprofessional thinking examined in this study.

# MUSICKING IN A WARD ENVIRONMENT

Music practitioners' work in the NICU setting contains the underlying premise, as envisioned by Small (1987, 1998), that everyone, including fragile neonates, has the ability to celebrate life through musicking. Musicking should be open to anyone, and everyone's abilities qualify. Musicking may include performative elements, improvising, sharing emotions and thoughts, as well as listening, observing, and reflecting on the musical entities created together in the situation

at hand. When encountering families in a vulnerable position, musicking as a way to celebrate everyday ward life is a way for music practitioners to emphasise that "all musicking is serious musicking" (Small, 1998, p. 222). The notion that everyone is able to engage with music, and that no music or way of musicking is "intrinsically better than any other" (p. 222) makes music available to all families and healthcare personnel at the ward. Beyond the individual rooms, musicking takes place in the whole ward environment: corridors, nurse stations, halls, and entrances. With this in mind, the music practitioner has to be capable of managing the administration, planning, and organisation of music making in the neonatal ward. Within this study, five kinds of musicking situations were identified when the people in the ward engaged in music making. These situations did, of course, display a significant degree of hybridity but can be subdivided into the following categories:

1. *Musicking solely with and for the newborn*. Very simple, smooth, and tranquil, even sedative music was utilised in these situations, such as improvising a lullaby or modifying various kinds of traditional music. An appropriate situation for the music might be, for example, when the newborn was waking up, or during nursing or treatment. Using both sound and silence, as if they were a light and a shadow playing together, was seen as important when intertwining the music with the newborn's experiences and sensations of the world. If the infant was sound asleep—which is a crucial element of healing between the continuous care procedures and their frequent interruptions—the music practitioner moved to another room.

2. *Musicking during the therapeutic or care procedure.* When it was decided to bring music into the room where some procedures were taking place, the music practitioner often started the musicking by probing the atmosphere, for example, by playing just a few strings from a Finnish kantele and/or humming in hardly audible, low tones. This situation might take place, for example, within therapeutic or care procedures, or when feeding the child. Sometimes there could even be a small surgical procedure taking place, but this was not necessarily considered "everyday practice" for the music practitioner. Parents and/or a nurse were listening while taking care of the baby as gently as possible. Parents sometimes joined in the singing or had a request for a particular song. The atmosphere in the room was generally drowsy, and the only sounds were the music and the beeps and alarms of the monitors.



3. *Musicking with and for the family*. When the families were not in a hurry and felt that they were willing and that the time was appropriate, many kinds of musicking—humming, singing, improvising, listening—and reflecting could take place. Either one or both parents, and occasionally one or more nurses, could join this moment. Sometimes the mother would simultaneously prepare breast milk for the child. Many times, when the mother was otherwise occupied or resting, the father took the newborn to his chest and sang for, cuddled, and stroked his child gently.

4. *Musicking with and for an extended group.* This collaboration could take many forms: a small performative kind of moment, relaxation through listening, experiencing music holistically, or reflecting intergenerational memories through music. Emotions could change dramatically within the music making. Relatives or friends could be included, and a grandparent could either simply observe the shared music making or actively join the musicking by playing an instrument or singing, narrating his or her own memories or the situation at hand.

5. *Musicking with and for the hospital personnel.* The tone of soft chimes, harp, sansula, or vocal sounds echoing in the ward environment also touched the healthcare professionals. For the hospital personnel the moments of live music were brief moments of rest, where they could take a break from the hectic rhythm of the working day. Musicking with and for the personnel was not an isolated situation in a separate place that could be focused on them alone, but calming moments during their shift. For the personnel in this study, musicking together was primarily co-constructive participation, reflection, interprofessional observation, and about receiving information during the musicking situations, rather than active musicking with the others.

These categories illustrate how the conceptual lens of musicking allows the understanding of music professionalism in a healthcare setting as a social phenomenon more complex in nature than traditional views of music professionalism might suggest. Consequently, music practitioners may reach a point where their own fundamental values are challenged, and they begin asking what kind of core values underlie their practices. In the everyday work of music practitioners, this means that an understanding of the importance of situational ethics becomes crucial and a "constant re-organization of values for the good or the growth of oneself and other" takes place (Allsup & Westerlund, 2012, p. 126). This entails

a professional maturity, which can be called professional altruism; the will to see working with other professions as a fruitful collaboration instead of a threat to or problem for one's own professional existence (Axelsson & Axelsson, 2009). This kind of professional transformation stems from the development of professional fields overall (Cribb & Gewirtz, 2015; Sugrue & Solbrekke, 2011).

Although the music practitioners examined in the study could be considered to be at the fringe of the healthcare hierarchy, musicking was consistently seen as a highlight of the ward life by those working there regularly. The nurses made an effort to open up space for the music practitioners' work and musicking in the ward so as to give as many families and newborns the opportunity to participate. Finding a way towards more sustainable practice through continuity of musicking was stressed as a very urgent issue by all of the participants interviewed, but there were hardly any tools—such as time for interprofessional development processes, economic resources, or organisational aims and strategies—available to put the music practitioners' work in the ward on a systematic footing.

## REFLECTIVE MUSIC PRACTITIONERS IN THE WARD: FOUR GROUNDING METAPHORS

Exploring new ways of thinking about one's profession, such as music making, speaking, and what I call expressing narratives through metaphors, requires sensitivity and negotiation. This sensitivity seemed to help music practitioners in engaging the interprofessional setting and discovering how their musicking practices and musicianship were related to the situations of the families in a meaningful and relevant way. In the content analysis of the interview material I noticed that the participants used metaphors in their reflections on the musicking in the healthcare unit. Although their speech was vernacular, they made use of metaphors to emphasise their experiences. Metaphorical thinking thus became central to understanding the phenomenon.

Four grounding metaphors were identified from the empirical material and shaped through my reflexive analysis, bridging musicking and life in the ward together. According to Lakoff and Johnson (1980), metaphors allow a domain of experience to be understood through other concrete, understandable terms. The emerging metaphors were reflected from different viewpoints: considering the sensitivity music practitioners should have when reflecting on their work before, during, and after the musicking takes place; navigating with musical practices through different situations in the ward; and in relation to future opportunities to develop the work of professional music practitioners. Experiencing, speaking, and learning through metaphors may be thought of as an unfeigned production of human nature. A metaphor is neither a "true" nature nor a factual truth about aspects in the world, but it is not purely symbolic, either. Rather, it is our way to conceptualise, experience, or comprise the world (Lakoff & Johnson, 1980). In the context of my study, metaphors helped the music practitioners and healthcare professionals crystallise the implicit thoughts and knowledge held by themselves and the families they worked with in the ward.

### Metaphor 1: Earthquake

The context of the study was underpinned by the understanding that the families were going through chaotic and conflicting experiences. Simultaneously, the healthcare professionals and music practitioners were concentrating on handling the different situations in the ward in an ethical, practical and professional way. Described through the metaphor of an earthquake, the state of affairs was shaking the basis and solidity of the various families. The parents' ideas of parenthood and their baby's early childhood may have been shattered, and much of their time was likely to revolve around the neonatal unit and its routines and procedures within the hospital. The parents could be reconstructing the collapsed dreams and visions of family life: "Well, it isn't a place for a child or family to be in an intensive care unit, and the parents' special thoughts about parenthood and that baby time have collapsed, and one has to build a kind of new life and start anew" (neonatal nurse). Similarly, the parents could be wrestling with their fear of the child's death, their fear of the baby having a severe disability, or the situation after what had been considered a difficult delivery.

In these kinds of situations, any possible interruption of the ward atmosphere by the music practitioner was considered not only as a priority for the child but also for the family. Parenthood, the role of parent(s), was described as very limited in the flux of the ward, though the policies of the ward were considered very modern, with kangaroo care, supporting parenthood where possible, and seeking to endorse the individual situations of families. In the musicking situations, tears would often burst from the eyes of the adults in the families. These events with the music practitioner were seen as an opportunity for the parents to see their newborn child through the musicking as 'just a child', clearly and completely, without inhospitable medical interventions and devices:

> In a way it kindles such a connection and intimate moment [when musicking together], that the parents see their child without any hospital equipment, any meters, even if there were alarms ringing, or the child would be in a ventilator, or whether they would have any kind of

medical infusion going on at the same time—in that situation they are somehow able to just see their own baby, and it is a very irreplaceable moment. (Neonatal nurse)

## Metaphor 2: Deep waters

Some families perceived music as something that takes them through "deep waters". This metaphor mirrored their times of great difficulty and inability to resolve the challenges ahead on their own. The interviewed parents felt that musicking contributed to the wellbeing of the families, and it was interpreted as a sign of life from the outside world, allowing them to comprehend that even in hard times life will carry on. This hope, and processing the experience of parenthood, were seen as important benefits of providing the families with music making, although the risk of going too far was also recognised: "Sometimes I am thinking whether we are going into too deep waters. But instead, every time I have seen only positive impacts, and parents have been brought closer to the baby or given an opportunity to process difficult feelings or issues pertaining to their parenthood" (neonatal nurse). Musicking in these deep waters could give parents, or a single parent, an opportunity to reflect on the life situation they were now in as a family:

> Then the mother asked [the grandmother of the baby] if she had requested from the music practitioner too sensitive a song, and her mother said that no, that is a fine song. Then we sang it together, and the grandmother started crying overwhelmingly. Afterwards she went to blow her nose and wash, but the mother [of the baby] was all the time, in a way, very happy. (Music practitioner)

## Metaphor 3: Flow of flux

The experience of time and space in the NICU ward was described by the metaphor of flow, where time flowed in waves or pulses, in an ever-changing way, and differently from everyday life outside the ward. Within this flow, the families were facing continuous change and innumerable shades of anxiety relating to the health of their baby. Additionally, their daily schedules, as well as future plans, were in a constant state of flux. Within the timescape of the ward, music was included as a soft, integral element, sensitively modifying the ward atmosphere between its smooth and cottony and, to some degree, more energetic moments.



The combination of the fragility of the newborns, the concerns, fears, and hidden anxieties of the parents, and the sensitive music making of the music practitioner created sensations of pausing, where time seemed to stop. Words were not necessarily needed: "When the music practitioner enters into the situation, she takes us momentarily to another place. And it is quite exciting to see how everything, in a way, comes to a halt at that moment. In that situation, words could have ruined a lot" (neonatal nurse).

Taking into account the transitions between life and death was one of the most important dimensions of the music practices implemented by the music practitioners. Within the overall flow of the ward, a music practitioner could be attending to various kinds of situations, and urgent attention was sometimes required in the case of dire events, as in the case of the death of a newborn. The moments of grief and loss could come as abruptly as any other situation in the ward:

> Once, there were two babies [from different families] in the room. One of the babies had just died. And there was a nurse beside her. I noticed that she was in sorrow. Of course it touches you. Just a moment ago I was asking myself, what could I do now for them. But then, I decided first to sing for that nurse to support her [and then turned to sing for the other baby]. (Music practitioner)

Such examples were also used by the interviewed music practitioners when reflecting on whether the work would be suitable for everyone. Though the work was seen as unique, meaningful, and momentous, in turn it may be revealed as sometimes being quite miserable as it exposes scenes of life that one may have trouble coping with. The musical flow in the ward also included reflections on how the professional awareness of the personnel affected the soundscapes and the vocal sound environment as a whole.

## Metaphor 4: A path and a journey

The image of music professionals travelling alongside the families was apparent throughout the research data, and many families wanted to share these moments with the healthcare personnel and music practitioners, observing and reflecting on the reactions of their babies together with them. The music practitioners' journey with the infant was seen as special and important:

> Labour had been hard and heavy. The mother of the baby was a few floors above, and reportedly in very much pain in her back. But the fa-

> ther was at the musicking moment, behaving in a completely beautiful manner with that baby … Then he had to go and see his wife. He asked if I could stay for a little while to sing for his baby, so that she would not be left alone. (Music practitioner)

The challenging situation influences the lives of whole families; something in the lives of these people has changed forever, permanently, and the family will now go on to another place along this path. The musical event was depicted as an interruption, allowing the whole family to metaphorically travel to another space or place. When taking a musicking journey together, music may help the family members create a novel narrative of their life. This kind of shared event was also described as highly intimate and sensitive for the personnel and the music practitioners. Apart from the metaphorical journey of the families, the metaphor of professional music work as a pathway with many bends was continuously raised; this path opens up the possibility for professional change and transformation in a meaningful manner.

## Ethical considerations

The case study I have presented in this chapter brings into focus some of the ethical and moral challenges of musicking in hospitals and other healthcare contexts. For music practitioners in healthcare, relational and situational music work means moving beyond fixed musical spaces and approaches towards more flexible, hybrid ways of working with music and people, as Gielen (2009) and Noordegraaf (2015) have suggested. Noordegraaf presents hybrid professionals as being "likely to have the capacity to bridge divergent logics" (2015, p. 8) within their organisations. This means that hybrid music practitioners are moving towards independent ways of planning, reflecting on, and managing music making within the ward. What becomes essential is a conscious turn towards reflexivity and relational ethics, or, as proposed by Allsup and Westerlund (2012), situational ethics. Noordegraaf (2015) states that we should even go beyond this kind of hybridisation, and see professionalisation as reflexive in such a way that hybridity and its dimensions of managing professional spaces would form a normal part of future work. For example, encountering the world of sorrow and grief in relevant ways—and at the same time, being peaceful and full of hope—helps music practitioners interact with families and the whole ward community, as well as to reorganise their practice in these ethically challenging and situational processes. This is one of the main reasons why the education and knowledge of music practitioners' expanding professionalism and hybrid work in healthcare and other intersectoral contexts need to be developed further.



According to Gielen (2009), every kind of hybridity may also function as a hinder in artists' professional lives, excessively shaping their professional identities and working contexts. In music practitioners' work, this means that the hybrid nature of the profession is unnecessarily dominant; music professionals' ethical positioning, their music practices, and the relationships they create in their work become impossible to manage, which may be troubling and demotivating. In order to prevent this, future music practitioners must articulate and open up about their transforming positions and practices in society on an interprofessional basis. It can, therefore, be argued that an expanding, hybrid professionalism should be recognised in higher music education, acknowledging the transformation and change of artists' positions in societies.

# CONCLUSION

The metaphors described in this article illustrate the nature of expanding professionalism for musicians working in new, specific healthcare contexts, simultaneously creating "new rules for the game" (Bourdieu, 1990, 1991) in the professional field of musicians and artists. Exploring the hybrid practices through metaphorical language and thinking (Lakoff & Johnson, 1980) helps to understand how music practitioners simultaneously expand their professional space and music practices in a hospital ward through co-constructing interprofessional work and (re-)creating people-centred musicking together with the hospital community. Metaphors may help musicians and artists in new work environments in at least two ways: firstly, by creating mutual understanding in interprofessional communities. Music practitioners use interprofessional language that emerges through their musicking practices to build and bridge relationships with the families and the hospital ward community. Using metaphors helps music practitioners to engage in the interprofessional work and practices in healthcare environments with other professionals. Secondly, using metaphors helps music practitioners to settle in the ever-changing time and space of the healthcare environment to foster mutual trust and accountability in their collaboration with healthcare professionals, and to justify the relatively high degree of professional autonomy that is appreciated in and required from music practitioners working at the ward.

To understand the practices, rules, and requirements—the *doxa* (Bourdieu, 1990, 1991) of a new field—music practitioners have to engage not only in interdisciplinary learning in their own institutions but also, more broadly, in the interprofessional sharing of knowledge. In order to enter novel social and cultural spaces successfully, individual music practitioners are obliged to recognise and embed some of the core principles of such new contexts in their work. In

addition, they have to be capable of engaging with the people in the ward in a musically adequate manner, which also must take an ethically relevant and suitable form. They must then situate their practice in relation to the fundamental issues and principles in the ward, such as supporting the wellbeing of families and babies with musicking, understanding the highly relational and reflexive nature of music practices in different care situations, or acting professionally when healthcare personnel must carry out medical procedures. Crystallising the implicit, tact, and embodied thoughts and knowledge, using appropriate language when speaking to other professionals and the families, and situating the musicking practices and one's musicianship in a meaningful and relevant way in the ward environment becomes the focus of music practitioners' work.

Metaphorical thinking may be one way to navigate, develop, and co-construct interprofessional work in complex healthcare contexts, as well as to break down the boundaries of expertise professionalism in which music and musical quality are predominant values. Metaphorical thinking helps music practitioners to identify musicking in healthcare as a wider phenomenon in relation to understanding and communicating music as a public service, freely available to *all*. New musical elements have a variety of impacts on the hospital ward environment. The music practitioners themselves create new ways of thinking and acting by musicking in a NICU environment in a way that goes beyond their customary practices of performing, teaching, and playing musical pieces together. In the professional spaces that thus open up for them, which hold a very different logic of action from what music practitioners are accustomed to, music practitioners must have a particular sensitivity and awareness regarding close relationships with families, nurses, and other people within the ward environment. In addition to helping identify the socio-cultural benefits of musicking beyond the technical aspects of traditionally skilled music making, metaphors may also help music practitioners to engage emotionally in the diverse situations in which families find themselves. Most importantly, the emotional and relational engagement of music practitioners may help families explore their emotionally unique situation: the birth of a child in a medicalised and difficult environment.

Experiencing, speaking, and learning through metaphors may be a valuable asset for music practitioners, providing ways to bridge music practices with the time and space in the ward, but also to engage with their own expertise and existing professional identity. Furthermore, bridging emotional experiences and metaphorical language in musicking with families, as well as finding and celebrating the brief, precious moments of shared wellbeing, may integrate the hospital ward socially in such a way that the families and their challenging situations are supported in a relevant manner. Co-constructing metaphors through musicking makes ethical and moral challenges more visible, highlighting their overall importance and the meaningfulness of music practitioners' work. This does not instrumentalise music or music practitioners' work, but rather expands their professionalism in a flexible manner. It also suggests novel directions for the development of higher music education in the future.

## Call for action: Building the futures of expanding music professionalism through higher music education

As a final thought, I will briefly reflect on some misconceptions in the work of music practitioners in somatic healthcare. These misconceptions also appeared in the case study presented here, highlighting the importance of taking them into consideration when organising higher music education in the future (see also Koivisto & Tähti, 2020). (1) Although music practitioners are often seen to bring joy and energy to the people in the hospital wards while engaging and empowering both patients and healthcare professionals to consider their own wellbeing, broader contexts of social justice, rehabilitation, and cultural rights are not yet widely recognised in practice, academic research, or the professional education of music practitioners. (2) Although the music practitioners usually see their work as highly rewarding and important in healthcare, the fragmented nature of the work creates challenges in handling the workload and may produce overwhelm- ing emotional burdens for music practitioners. This requires reforms in higher education as well as in the institutions where music practitioners will work. (3) Although music practitioners are increasingly welcome to work in healthcare settings and learn "on-the-job", higher music education students should be equipped through educational solutions with proper professional understandings of how to work in socially and ethically hybrid and unsettled contexts, surrounded by ever-changing relationships and processes. This should include resolving issues such as gatekeeping practices of healthcare systems, professional and organisational boundaries, and appropriate musicking practices in the ward environment.

In conclusion, music students in higher education would benefit from acquiring and developing relational and metaphoric interprofessional thinking to reach beyond established musical performance practices and traditions. This positive and fruitful type of hybridity could be achieved by increasing interprofessional collaboration in higher music education and by engaging in work between organisations in different fields.

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## NOTES

1 Expanding practices requires broad understanding. For example, some hold the view that music can be detrimental to the premature infant's development (see Standley, 2003) through neurological overstimulation or exceeding sound level recommendations. It is therefore crucial that the education and professional knowledge of music practitioners is evidence-based when entering these fragile environments.

2 In this chapter, a music practitioner is a professional holding an academic degree in music. He or she may be a music educator, a musician with a background in folk, jazz, or classical music, or an ethnomusicologist. Their practices often seem to be intertwined with a variety of professional approaches, and music practitioners may not necessarily identify themselves a priori as, for example, pedagogues or musicians, but refer to themselves as representing both professional categories. Thus, they are not music therapists, having their own professional niche in hospitals or being understood as healthcare professionals bound by laws and regulations when providing healthcare services.

3 A research permit for the study was granted by the hospital district in 2018, and an ethical statement from the Research Ethics Committee of the University of the Arts Helsinki was also submitted.

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# ARTICLE III

Koivisto, T.-A., & Laes, T. (2022). Music professionalism promoting gerotranscendence: An instrumental case study of healthcare musicians in an eldercare hospital. *International Journal of Music Education*. https://doi.org/10.1177/02557614221087340

# MUSIC PROFESSIONALISM PROMOTING GEROTRANSCENDENCE: An instrumental case study of healthcare musicians in an eldercare hospital

## ABSTRACT

The effect of ever-increasing life expectancy on global demographics has had a significant impact on many professional landscapes, not only in social services and healthcare but more broadly. This instrumental case study explores professional healthcare musicians' work through their collaborative, socially engaged music-making practice in eldercare hospital wards. Two healthcare musicians were interviewed, and their work and professional practices were observed in the infection and orthopedic wards of an arts-promoting eldercare hospital. The empirical material was analyzed using thematic analysis, and finalized by instrumentalizing the case through the theoretical lens of gerotranscendence and music professionalism. The findings of the study open up a diversified understanding of aging as a transformative process of change and development, and reveal how professional music practices can support a holistic care and healthcare approach. Furthermore, it is discovered that healthcare musicians' work as a socially engaged approach to professionalism reframes musicianship as part of an expanding professionalism, and calls for further development of higher music education as well as in-service training in the field of music.

Keywords: aging, eldercare, gerotranscendence, healthcare, music professionalism

Due to the increased life-expectancy of large segments of the world's population, the lives of many aging people are increasingly characterized by prolonged independence and activity. On the other hand, this impactful global demographic development (World Health Organization [WHO], 2015) can be accompanied by increasing health issues and a decline in wellbeing for some individuals, which makes them more dependent and care-reliant at this point in their lives. This development leads to new service demands that consequently are changing professional landscapes around the globe, not only in social services and healthcare but also in fields such as music. The use of artistic and arts-based approaches in healthcare contexts is becoming increasingly common, as the preventive nature and holistic characteristics of social work and healthcare are emphasized (All-Party Parliamentary Group on Arts, Health and Wellbeing, 2017; Fancourt & Finn, 2019; Stickley & Clift, 2017; WHO, 2015).

In this case study, we will explore two healthcare musicians' collaborative, socially engaged work and music-making practices in eldercare hospital wards in Finland. Methodologically, the case serves the instrumental purpose (Stake, 1995) of identifying connections between music professionals' transformative work and elderly care needs. The study aims to exemplify how the work of healthcare musicians expands when their professional responsibility, as a significant aspect of their overall professionalism (Cribb & Gewirtz, 2015; Sugrue & Solbrekke, 2014), encompasses more than the musical skills or pedagogical needs of the participating people. By professionalism we refer to the qualities that characterize the specialized and professional attitude and competences of a person, viewed as an asset that should not be taken for granted (Cribb & Gewirtz, 2015). The qualities of music professionalism have usually been manifested through musical competence(s) and skills, but following Cribb and Gewirtz we suggest we should make an effort to understand music professionals' work more broadly, as contextual and relational (Westerlund & Gaunt, 2021). This kind of professionalism, considering various working contexts such as eldercare or healthcare, has been conceptualized as transformative, socially engaged professional work (Sugrue & Solbrekke, 2014), and has been characterized as an *expanding professionalism* in music and higher music education (Westerlund & Gaunt, 2021). Through a reflexive and thematic analysis (Alvesson & Sköldberg, 2018; Braun & Clarke, 2006) we address the hitherto underutilized interprofessional possibilities in eldercare that arise when bridging music professionals' work with holistic medical and care approaches.

In the recent attempts to reframe professionalism in the music field from the perspective of emerging workspaces in healthcare contexts, a solely medical discourse has been characterized as being insufficiently diverse (see Ansdell & DeNora, 2016; Ansdell & Stige, 2015) to frame socially engaged music practices. Hence, music scholars have started to construct a wellbeing discourse with a more holistic approach to healthcare. However, this discourse has been considered as too uncritical, individualistic, and idealistic (ArtsEqual, 2021; see Ganesh & McAllum, 2010), demanding further scrutiny and scholarly confirmation. In this study, expanding professionalism is considered significant in terms of accessibility and equal opportunities for participation in music education, throughout our changing society (ArtsEqual, 2021; Stickley & Clift, 2017).

# THEORETICAL LANDSCAPES

## Music professionalism in healthcare contexts

Research on musicians' and music educators' work in medical and healthcare environments, especially in somatic and general hospital services, has remained scarce so far, and musicians working in hospitals represent a rather new occupational group (see, however, De Wit, 2020; Dons, 2019; Koivisto & Tähti, 2020; Preti, 2009; Preti & Welch, 2013). Nevertheless, music has been practiced and performed for a long time in general and psychiatric hospitals by the eldercare patients themselves, hospital personnel, and volunteers, as well as professional musicians and music educators. The range of activities has varied from giving concerts and artistic residencies in hospitals (e.g., Edwards, 2008), to musicians and music educators working in veterans' hospitals after World War II (Gilliland, 1944), to bedside music practice in children's hospitals (Preti, 2009). While historically many hospitals have had a rich legacy of supporting collective cultural communities, contemporary healthcare environments are mostly dedicated to medical recovery from somatic diseases, relating to the diseases solely in a physical way (see Berwick, 2009). Whilst the music therapy profession was established in the early 20th century, since then music-making in hospitals has become more medically and diagnostically oriented, creating the understanding of music as a form of treatment to be offered by professionally educated therapists (Bonde & Wigram, 2002). This led later to the need for more holistic frameworks such as *community music therapy* (Ansdell & Stige, 2015; MacDonald et al., 2012) and *music as health promotion* (Bonde & Theorell, 2018), bridging the medicalized music therapeutic practices with more conventional music education and the emerging community music perspectives.

Music interventions and practices in eldercare have been explored by, for example, Batt-Rawden and Storlien (2019), Hallam et al. (2014), and Garrido et al. (2020). Only a few researchers have focused on the professional music-making practices in eldercare beyond music therapy or the everyday uses of music (e.g. De Wit, 2020; Dons, 2019). Previous studies of professionals facilitating music-making in healthcare and hospital contexts feature terms such as *health musicians* (Ruud, 2012; Stige, 2002) and *hospital musicians* (Dons, 2019; Preti & Welch, 2013). In this article, we coin the term *healthcare musician* to highlight the importance of the *interprofessional work* (Cribb & Gewirtz, 2015) in musicianship that takes place broadly in all kinds of healthcare and care contexts, and without necessarily emphasizing the expectation of implications for people's health conditions that are prevalent in music therapy. Healthcare musicians' professional responsibility may be considered from multiple criteria of quality (Laes et al., 2021), and can contribute to the quality of the individual's life in care and healthcare environments, including the eldercare patients, family members, and staff, as well as the overall quality of the healthcare system as a whole (see Creech et al., 2014, 2020).

## A critical perspective on aging in eldercare contexts

Studies of aging have long examined individual's quality of life, social (dis)engagement, and general wellbeing from a rather positivist perspective (Bengtson et al., 2009; Tornstam, 2005). Researchers have criticized these past perspectives on aging populations as being too narrow, defining the aging population first and foremost as a societal and economic burden (Bengtson et al., 2009; Tornstam, 2005; Walker, 2012). The current discussion regarding later life in social, educational, and healthcare contexts highlights *active aging* (Bengtson et al., 2009; Hage & Lorensen, 2005), which stresses the importance of staying physically and socially active. In healthcare and eldercare contexts, this discourse has been accommodated by encouraging professionals to "activate" the elderly, often without deeper reflection on the meanings of individual experiences of aging, wellbeing, and quality of life (Bengtson et al., 2009; Hage & Lorensen, 2005; Tornstam, 1994, 2005).

Social gerontologist Lars Tornstams' meta-theory of aging, termed *gerotranscendence* (1994), treats aging as a process of moving beyond physical needs and even realities into a sphere of increased satisfaction with life (Tornstam, 2005). The theory stems from the insight that the prevailing social gerontological views do not fully coincide with the lived experiences and self-reflections of older people themselves. Gerotranscendence challenges the normative understandings of aging by introducing the perspective of *continuous* change and development into old age (Tornstam, 2005; see Hage & Lorensen, 2005;). Drawing from the concepts of *transcendence* and transcendental change, without their religious or metaphysical meanings, gerotranscendence signifies a shift "from a materialistic and rational perspective to a more cosmic and transcendent one, normally followed by an increase in life satisfaction" (Tornstam, 2005, p. 41). The meaningful experiences and goals of aging are understood as being based on the individual's own definitions, not those of others (such as care professionals).

Gerotranscendence is a little explored phenomenon in the field of music (in music therapy, see Halverson-Ramos, 2019), especially lacking any empirical

studies. Playing together, listening to music, reflecting on experiences and emotions evoked through music, or singing with and for the eldercare patients, may generate a broadened understanding of the identity, self, and roles a person has had and still has in their life. Engaging in reciprocal musical reflection, for example through musical memoiring and selecting personally relevant and meaningful music either to listen to or to play and sing, may facilitate the experiencing of life satisfaction and ongoing transcendental development, despite an individual's actual physical condition or their overall declining state of wellbeing (see Halverson-Ramos, 2019; Tornstam, 2005).

## DESIGN OF THE STUDY

As an instrumental case study (Stake, 1995; see Crowe et al., 2011), this work facilitates a broader understanding of a phenomenon, by utilizing the case study to gain knowledge about the underlying principles of healthcare musicians' work in the healthcare context, and to help understand eldercare more broadly in relation to it. Our overarching task is to initiate critical discussion in order to encourage a deeper understanding of the means and effects of expanding music professionalism within the healthcare and eldercare contexts, as well as to better respond to the ongoing changes in society and science in general.

The research task is guided by the following questions:

1. How is the nature of the work in eldercare hospital wards reflected by the efforts of healthcare musicians?
2. How may the understanding of these music professionals' work contribute to the development of expanding professionalism in music and higher music education?

### Study context and data

The context of this study is a newly established, arts-promoting eldercare hospital. Specialized in inpatient and outpatient treatment and rehabilitation, the hospital was designed to support the ability of people to live longer in their own homes. Since the establishment of the hospital in 2017, numerous artists, among them the professional musicians in this study, have been invited to support the health and recovery of the eldercare patients with music and art practices. This study is part of a multiple case study project of the first author—who is a music therapist, music educator, and health promotion expert—on healthcare musicians' work in somatic hospital wards, including a children's hospital and eldercare hospital. A research permit for the multiple case study was granted by the municipalities in charge of the hospital administration. In addition, an ethical statement for the research project was approved by the Research Ethics Committee of the University of the Arts Helsinki.

The generation of the empirical material took place over 2 months in Fall 2018, in the infection and orthopedic ward of the hospital. The data, generated by the first author, includes (1) observational data in the form of a researcher's observation diary, (2) individual semi-structured interviews with two healthcare musicians, and (3) written professional narratives from both healthcare musicians. The observation phase, which took place over 5 days in the wards, included observational data on the music sessions, social and contextual interaction, and relationships that took place beyond the shared music-making. The rigid medical context and research permits did not allow any audio or video recordings during the data gathering process. To create reflexive (Alvesson & Sköldberg, 2018) and relevant understanding of the case (see Butler-Kisber, 2018; Stake, 1995) the observational diary was organized on the temporal order of the interactions under the following categories: (1) musical interaction in-between healthcare musicians and participants; (2) verbal and embodied communication; (3) selected musical instruments, tools, and approaches; and (4) interprofessional and collaborative ways of working in the ward.

The first author conducted two interviews with each healthcare musician, of approximately 1 hour each, which resulted in 4 hours of interview data altogether. The interviews were recorded, and the transcriptions were returned to the musicians for a member check. The professional narratives served as a source of professional background of the musicians. Healthcare musician A is a freelance music practitioner with approximately 5 years of work experience in healthcare settings at the time of the study, including different kinds of hospital and care environments. She has pioneering experience in developing in-service training for healthcare musicians, collaborating with various stakeholders within healthcare and music. Healthcare musician B is a symphony orchestra musician with an international career as a musician and instrument pedagogue. He started to work as a healthcare and care musician as part of downshifting his career, approximately 1 year ago during the data generation. Both musicians have a higher education degree in music and an extensive in-service training background in their occupational fields.

## Analysis of the data

The analysis of the empirical material was conducted on three levels. First, the first author classified and coded the interviews, condensing the data into thematic ideas (Braun & Clarke, 2006). Second, the first author sought to interpret and understand the professional phenomenon through the interviews, observational data, and professional narratives, creating a reliable and solid knowledge basis through data triangulation (Butler-Kisber, 2018; Stake, 1995), as well as attempting to avoid sources of researcher bias such as misinterpretations of the observational data. Third, both authors finalized the analysis by instrumentalizing the study through the theoretical lens of gerotranscendence and music professionalism in changing contexts, in favor of contributing to eldercare and expanding overall professionalism in music/arts collaboratively.

In a qualitative instrumental case study there are limitations to how far a researcher can remove oneself from the data (see Stake, 1995), and the context-specific features of the case—such as the first author being a single researcher in the hospital wards and the limited amount of data—created limitations for the study. We have therefore adopted a more insight-driven rather than a solely data-driven approach to the analysis (Alvesson & Sköldberg, 2018, p. 344). In the more positivist research tradition the status of the first author—a music therapist, music educator, and researcher in the field—might be seen as a bias, but here it was considered a strength and innovational aspect, as it enabled conducting a non-medical study within and beyond the medical protocols and procedural ethics (e.g. for arts in health protocols see All-Party Parliamentary Group on Arts, Health and Wellbeing, 2017; Fancourt, 2017; Fancourt & Finn, 2019; Stickley & Clift, 2017). While the data for this study consists of material from two interviewees, observations of their work in the hospital ward, and professional narratives written by the healthcare musicians themselves, the analysis is also affected by the first author's deeper knowledge and understanding of the wider study context as part of her research project (Alvesson & Sköldberg, 2018, p. 11).



# FINDINGS

## Healthcare musicians' work in eldercare hospital wards

The healthcare musicians, who worked individually within the ward environments, described their work in the hospital wards as free and rather improvisatory. Although their visits to the wards were pre-scheduled, they were able to change the nature of the ward space on the spur of the moment, as they were making music by playing and singing with and for the eldercare patients in the ward halls, lounges, recreation rooms, and individual rooms. Healthcare musician A used her voice and many kinds of instruments (e.g. Finnish kantele and percussions) in her work, with singing being the main element; healthcare musician B mainly used his main instrument from the orchestra, which was a brass instrument, and he had many kinds of smaller instruments with diverse soundscapes in his repertoire. Both musicians described their music work as involving a great deal of interprofessional collaboration, such as working with music therapists, giving lectures and workshops to the nurses, participating in hospital community seminars, and attending the nurse station meetings. Through these multiple tasks the musicians integrated themselves into the hospital community, without directly attending the nursing or medical work.

Five themes were defined through the thematic analysis of the musicians' interviews and the first author's observations.

*Considering other people's reactions.* The first theme attends to the way the healthcare musicians reported their awareness of taking into account the wishes and desires of the eldercare patients and their families, nurses, and doctors regarding music-making situations. According to both musicians, the eldercare patients, their family members, and the healthcare personnel had varying reactions to the invitations to participate in shared music-making, and it was important to consider beforehand how to enter the ward space in the first place: "It is very essential, how you start the work and how you enter the ward space. It all relates to the process of entering as a healthcare musician into a community" (Healthcare musician A). The previous musical experiences of the eldercare patients and their families were vital in music-making situations; they could refuse or simply be unable to participate in the music-making, and there were many other particular challenges to their participation in the singing. The identification and recognition of these reactions were an inseparable part of shared music-making in the wards, and could be called *active resistance,* rooted in the nature of the recent

decades' music education. Many time the experiences that the eldercare patients described to the healthcare musicians during the music-making were intertwined with their prior experiences of making and learning music:

> May I tell you a story? When I was seven years old and went to school, we had a Christmas party there. It happened that I and the other pupil did not have a good enough voice to sing. The teacher put us in the choir and told us that you cannot sing. — Wasn't that a horrible thing that teachers could do back then? (An eldercare patient to the musician/Researcher's observation diary)

According to the healthcare musicians, the eldercare patients and their family members sometimes hesitated to participate in singing or music-making despite their obvious *desire* to participate. Navigating within these different experiences of the eldercare patients required a great understanding of how to implement music practices in the ward, and how to include rather than exclude participants in the shared music-making. In contrast to the negative memories, many eldercare patients and nurses told stories of how they had been supported and appreciated in their musical efforts during their lifespan.

*Appreciating silence and silent participation.* The two musicians described the importance of learning to appreciate the "non-participating eldercare patient" and silent participation during music-making situations, in other words providing space for many ways of participating:

> I think I have learned to take advantage of silent moments. You don't have to use all of the time in doing something, such as singing or playing. Many times, if you as a musician have the patience to be silent, the listener will soon say something or give you some kind of sign on how to proceed. (Healthcare musician A)

When hospitalized, some eldercare patients may find themselves in more vulnerable positions than they have ever been before in their lives. Some may apologize for being in such a sensitive mood during the music-making. Sometimes the identity of an ill, disabled person, was reflected through music or the healthcare musicians' work: "But I cannot sing. I have turned 80 years and I am sick. Anyway, thank you for your songs" (An eldercare patient to the musician/Researcher's observation diary). The shared music-making, being a voluntary activity for the participants, could in many cases seem impossible to start, and it required many attempts and much effort to draw the person into social interaction. Sometimes an eldercare patient would use their "right to remain silent" and *not* to participate in music-making with healthcare musicians. Mirroring the situation through silence was a conscious working tool for healthcare musicians, and a way-of-being and lingering in the moment for the eldercare patients, and required a great sensitivity from the healthcare musician to acknowledge.

*Tolerating incomplete situations and shapeless processes.* The third professional theme relates to tolerating the pending, unaccomplished issues when healthcare musicians worked in the wards, where the hectic work of the nurses and the eldercare patients' often slow pace intertwined:

> We had a rich discussion after the music-making with one person. Then, a nurse came to draw him away in his wheelchair, and that was the end of it. — It may feel like the nurses could be heartless. But, they have their schedules, and they have many eldercare patients to take care of. (Healthcare musician B

According to the observations, and the musicians themselves, oftentimes the healthcare musicians' visits were surprising situations for the eldercare patients and personnel, even though the visits were scheduled beforehand: "There are some wards, and it happens regularly, where they ask and wonder [with humor]: Whose son are you?" [an old Finnish saying] (Healthcare musician B). In practice, the music work was disrupted at some point. This demanded the healthcare musicians' conscious decisions about how to settle oneself professionally in the ward environment and orientate oneself in the situational and contextual work: "I decided that I will get used to the interruptions and learn how to focus on this kind of practice — in this work, you will have to take into account that interruptions will happen sooner or later" (Healthcare musician B). Rather than considering the environment as unappreciative, the unsettledness was even seen as a rewarding context, where a healthcare musician had to be able to be open with all of their senses and understanding: "I work here-and-now, in the moment. And I see you now in this moment, and came here to be with you" (Healthcare musician A to an eldercare patient/Researcher's observation diary).

*Celebrating life and acknowledging despair.* The fourth theme emphasizes how professional musicians' work can relate to life as a celebration by simultaneously acknowledging, instead of minimizing or ignoring, the existence of personal despair:

> The door is open. A woman is laying on her side in the bed, her face towards the hallway. The situation appears to be so fragile that I

> decided to stay outside the room. Her eyes are just half-open. The healthcare musician sings two peaceful songs for her. The moment seems very sensitive in nature. (Researcher's observation diary)

Some of the eldercare patients may end up spending long periods in the wards and may be transferred from one hospital to another depending on the rehabilitation framework or the necessary care procedures. The routines in the hospital may enclose an aging person within what could be called a hospitalized life. Many eldercare patients reflected on this with the healthcare musicians:

> I am having a difficult situation. I have lived for forty years in my own house. Life is crazy, it is a pity that everyone will have to go through this in life. Music has brought so much meaningfulness to my life. I don't know whether it had some kind of meaning when my musicianship ended. — It was mentally a very heavy situation for me when I had to sell my house. I should also polish my trumpet, and sell it. (An eldercare patient to a healthcare musician/Researcher's observation diary)

Celebrating and affirming the life cycle together, and managing time and space through music-making, becomes very important, although sometimes much elicitation and effort is required to convince and enable an eldercare patient to join in a music-making situation. When hospitalized and presumably spending a lot of time in bed, plunging into new activities may not be as easy as in normal living conditions outside the hospital. Healthcare musicians also serve as alternative facilitators in the hospital soundscape, with its beeping and buzzing equipment. During the observations, many eldercare patients expressed experiencing pervasive, continuous pain and suffering, and the healthcare musicians usually responded to these experiences with music, without necessarily occupying the space with their own words. Without exception, the initiative came from the eldercare patients, through their words or actions; and the healthcare musicians confirmed this in their interviews:

> There was an eldercare patient in the room who seemed to be suffering and a little bit tired. — She told me that she was feeling a little bit nauseous, but asked me to come in, close the door, and open the window. So she wanted silence for the music-making. When making music, I could see how her breathing slowed down, how she relaxed, and she closed her eyes after a while. I sang a little bit more, and she somehow expressed how this singing could relieve her from being there. And she listened to the words of the songs very carefully. (Healthcare musician A)



*Taking up the challenge of expanding their professional identity.* The fifth professional theme relates to the challenge of integrating professional identities within changing working contexts. When organizing their work in a healthcare context, musicians might be seen as "free" and bohemian artists who may struggle with settling into the highly hierarchical healthcare system:

> The hierarchy I was part of as a professional musician was not of any help, naturally, when I started to work in this hospital, because the hierarchy here was completely different. — When working in healthcare you plan your work by yourself, and you have both freedom in and responsibility for your music practice. (Healthcare musician B)

Simultaneously, professional music practitioners can be bound to the professional hierarchies and rigidities of their music field, and there may be a desire to expand on the image of the bohemian artist and its affiliated professional identity:

> This musicianship was my world, and in that world, I had a narrow portion, which was my instrument. That drew me forward in life. I did not need anything else, because that road in front of me was so beautiful. Then, it was no longer such a beautiful road. I got older and did not have the strength anymore. (Healthcare musician B)

The healthcare musicians of this study worked within their own frameworks, which consisted of their individual professional experiences and expertise, including traditions within different musical genres. On the one hand, the healthcare musicians may recognize these instrument-specific professional boundaries as limitations that make it difficult to expand their practices in changing and sometimes surprising care and healthcare environments. On the other hand, the hospital environment was seen by them as a free environment within which to (re)build their professional identities in general, and their individual professional identities as healthcare musicians more specifically. The level of engagement with the community was seen as an opportunity, rather than as a challenge: "In this environment, I am able to develop my own thinking and give myself some professional freedom" (Healthcare musician B).

## Emerging expanding music professionalism

In the analysis of the healthcare musicians' work in this eldercare context, we distinguished both opportunities and challenges when utilizing contemporary

music professionals' practices in non-traditional contexts, such as hospitals. First, the musicians understood themselves not simply as experts in music or a particular music genre(s), but also as responsible practitioners socially engaged music work, without making a dichotomous division between the two. Musicians integrated their professional responsibility with the needs of elderly people, depicting themselves as practitioners who are responsible for implementing high-quality music practices in different societal sectors. Second, they challenged themselves to be versatile in terms of participation, including silent participation, and supporting the different and sometimes conflicting attitudes that the eldercare patients had toward their own aging. Third, a great opportunity to expand professionalism can be seen in the musicians' reflections on the incomplete and unpredictable nature of their music work, which are filled with images of navigation through the "professional jungle" of the eldercare hospital wards. Being truthful and revealing the potential and the challenges of music practices can open up new professional approaches wherein interprofessional learning may take place through mutual negotiations and reflections, beyond taken-for-granted professional boundaries.

## CONCLUSIONS

The findings of this case study indicate that healthcare musicians' work can support a socially engaged approach to professionalism (De Wit, 2020; Dons, 2019; Sugrue & Solbrekke, 2014), as well as the holistic and integral wellbeing of eldercare patients in care and healthcare contexts (Creech et al., 2020; WHO, 2015). The work may unfold diversified understandings of aging as a transformative process of change and development (Bengtson et al., 2009; Tornstam, 2005). A deeper approach to such professional work includes musical encounters where the eldercare patient's own lived experience and self-reflections are emphasized. This approach may be manifested in, for example, how the healthcare musicians show respect toward the eldercare patient's independent choice for silent participation.

Music professionals have the potential to invigorate gerotranscendence within care relationships in eldercare contexts in and through musical encounters, by perceiving elderly people as having their own agency over how they relate to the process of aging. The ways in which healthcare musicians were able to change the nature of the whole ward space, through free improvisation and sensitive ways of utilizing music beyond the usual healthcare and artistic intentions, shows how engaging with transformative processes can facilitate holistic change, and most importantly can provide a chance to *understand* the processes of transformative change and developmental aging occurring in a larger community. Beyond collaborative discussions and reflections with the eldercare patients and healthcare personnel, gerotranscendence was manifested in the actual music practices, such as synthesizing speech, humming, and playing; transforming the medical realities within the wards into very beautiful and ethereal musical world; and opening up considerations and possibilities for cultural change and engagement.

Gerotranscendental music making is not restricted in time and place, but happens at the nexus of an individual's being-in-the-world, whether the eldercare patient might be oriented within their past, present, or future at that moment. Social engagement with music practices in the eldercare context, facilitated by music professionals, can therefore contribute to a novel understanding of aging that goes beyond activity and disengagement theories and celebrates transcendental change and growth (Tornstam, 2005). Considering the increasing number of aging people in our societies, there is a need to pay attention to how "good aging" is defined. The recognized risk of current wellbeing discourses, which uncritically instrumentalize the role of music and the arts to "cure" people, requires attention from higher music education professionals to sharpen the discourses and practices that highlight the multifaceted potential of music professionalism in broader contexts than those traditionally ascribed to music education, or as previously defined by music therapists.

While interprofessional collaboration in hierarchical organizations such as healthcare might seem a challenge for music professionals, it enables expanding professionalism through practicing musical skills and imagination in diverse ways, being proactive, and seeing possibilities for music practices where other agents in the context or policy levels of organizations might not yet see them (e.g., Ansdell & Stige, 2015; Ruud, 2012; Stige, 2002). Hence, instead of being narrow professional advocates of their own field (Cribb & Gewirtz, 2015), or solely serving the medical health agenda, the healthcare musicians of this study were welcomed into somatic hospital wards to support the gerotranscendence of the eldercare patients—from the celebration of life to sharing moments of despair. Higher music education could consider how to better support students by creating opportunities to practice similar professional imagination (Laes et al., 2021), for example by understanding and navigating different structural possibilities outside of the silos of music professions (Westerlund & Gaunt, 2021). In this way, music professionals expand their own work opportunities, and increase the broader societal relevance and institutional resilience of their profession (Koivisto & Tähti, 2020; Laes et al., 2021).

Considering the expanding professional landscapes in the music field, we identified three emerging educational and professional tasks that should be emphasized in professional (pre-service) training and continuing education: (1) Supporting future music professionals' capacities for navigating the administrative

and economic environments within the varying organizations they work with; (2) encouraging musicians to reflect on how to make music practices more accessible to and visible in all sectors of society and public services; and (3) avoiding merely advocating for an art and wellbeing discourse in healthcare and, instead, actively engaging in innovative ways of supporting the holistic wellbeing of all participants, integrating the whole professional community into the ongoing creation of novel musical spaces.

This study supports the view wherein holistic approaches, including arts approaches, should be considered an active part of decision-making and social policy in the future, as an integral aspect of efforts to promote the wellbeing of all citizens. If we overlook the qualities that healthcare music-making and gerotranscendence can illuminate and strengthen—growing, living, and learning *together* within social relationships—we may abandon an important part of our aging population in eldercare facilities to lesser lives than they either are capable of or deserve.

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# ARTICLE IV

Koivisto, T.-A. (2022). Healthcare musicians and musico-emotional work: An in-depth case study within the context of end-of-life care. *Approaches: An Interdisciplinary Journal of Music Therapy.* First view.

# HEALTHCARE MUSICIANS AND MUSICO-EMOTIONAL WORK: An in-depth case study within the context of end-of-life care


## ABSTRACT

The purpose of this in-depth case study is to explore the work of musicians in end-of-life care. In this study, a healthcare musician is considered to be a professional who has both an academic degree in music and in-service training in music and healthcare settings. In addition to working with healthcare personnel, they often collaborate with music therapists to provide integrated healthcare services for the best patient care. In the study, six musicians who had experience in end-of-life care settings were interviewed. Their reflections on their socially engaged work were analysed through the emerging theoretical lens of emotional work. This resulted in the identification of three themes beyond that of pure performativity in music professionalism, relating to the emotional work in end-of-life care. Furthermore, the emotional processes that were encountered, which were deeply social in nature, were conceptualised as musico-emotional work. This other-centred work aligns with music therapy research, and is an essential part of music therapists' end-of-life work. In conclusion, the similarities between music therapists and musicians, as well as the interprofessional potential of their cooperation, are reflected upon.


Keywords: emotional work, end-of-life care, healthcare, musicians, music therapy

One of the growing trends in research on music professionals is the exploration of their work as part of a particular worldwide professional transformation, a phenomenon called expanding professionalism (Westerlund & Gaunt, 2021). This professional approach features a conception of artists as a 21st century "professional decision-maker practitioner who works responsively with clients and other practitioners" (Edwards, 2010, p. 1). In this view, musicians' capability to expand their professional practices beyond artistic expertise and excellence is emphasised. This allows artists, as well as institutions, to respond in relevant ways to rapid societal changes (Väkevä et al., 2017; Westerlund & Gaunt, 2021).

Increasingly there are musicians working with diverse populations in healthcare contexts. These types of roles correlate with writings on 'socially engaged music practitioners' (Dons, 2019; Preti, 2009; Sugrue & Solbrekke, 2014). Their socially innovative approaches, entailing interprofessional possibilities and ethical challenges, call for further empirical research (Batt-Rawden & Storlien, 2019; Koivisto & Tähti, 2020; Siljamäki, 2021). In this study, this phenomenon is explored through reflections upon musicians, sometimes referred to as health musicians (e.g., Bonde, 2011; Ruud, 2012) or hospital musicians (Musique et Santé, 2021; Preti, 2009). Here, the concept of a healthcare musician is utilised to signify the working context. The concept helps to emphasise the inclusive wellbeing approach in their work (De Wit, 2020; Dons, 2019; Siljamäki, 2021) rather than the direct health benefits which may also occur (Fancourt & Finn, 2019; Hoover, 2021). Within this study, a healthcare musician is a professional who has an academic degree in music as well as in-service training in music and healthcare settings. They have their own artistic identity, which may often intertwine with diversified professional approaches such as music education, ethnomusicology, or community music (De Wit, 2020; Dons, 2019; Ruud, 2012). Healthcare musicians may come from diverse professional backgrounds, including musicians from any genre, music educators, or community musicians (Preti, 2009; Preti & Welch, 2013).

In addition to working in collaboration with healthcare personnel, musicians often work with music therapists to provide integrated healthcare services for the best patient care (Hoover, 2021; Zhang et al., 2018). In this study, a music therapist is understood to be a healthcare professional, bound by the same laws and regulations as other healthcare professionals when providing healthcare services. This notion does not exclude the understanding of music therapists as being highly sensitive and transformative music professionals, or as possessing their own artistic identity as musicians (Ansdell & DeNora, 2016; Ansdell & Stige, 2015; Moss, 2014). A clear articulation of music agency helps healthcare professionals to understand these overlapping professions in a relevant and fruitful way (Bonde, 2019). For example, in relation to an artistically or pedagogically oriented healthcare musician who is not a clinician, in this view a music therapist possesses more medically informed knowledge and practices (Bonde, 2019; Zhang et al., 2018).

In many countries, end-of-life care is developing at a fast pace to support healthcare systems in providing good quality end-of-life care and bereavement support (MacLeod & Block, 2019; WHO, 2016). In the Finnish healthcare system, wherein this study is conducted, the field of end-of-life work is also evolving rapidly. This study explores healthcare musicians' work in end-of-life care, which includes the following diversified working contexts: palliative care, hospices, and/or the general wards of hospitals. Music therapy research has accumulated extensive knowledge on palliative care and end-of-life care overall over recent decades (e.g., Clements-Cortés & Klinck, 2016; Gallagher, 2011; Hilliard, 2005).

Beyond the field of music therapy, this study also draws on educational research (Preti & Welch, 2013; Moss & O'Neill, 2009) into understanding musicians' work. This represents an effort to strengthen interdisciplinary knowledge, which could help to reconstruct higher music education and the in-service training of music professionals overall. There is also great potential in social prescribing – a way for local agencies to refer people to holistic workers – as a non-medical referral tool (Bickerdike et al., 2017; Clements-Cortés & Yip, 2020). According to Bickerdike et al. (2017), strengthening this social prescribing tool requires more insight-driven and systematic research into mapping arts-based practitioners' work.

Altogether six musicians were interviewed who had experience in musical end-of-life work in diverse care and healthcare contexts. As this case was non-medical and educational in nature, the descriptive evaluations of the effects and impacts of music work were excluded. The focus was on investigating musicians' reflections on their socially engaged and responsible work beyond clinical and medical interpretations or discourses. Epistemologically, this study adopted a reflexive frame (Alvesson & Sköldberg, 2018; Guillemin & Gillam, 2004; Subramani, 2019), wherein the ethical aspects of end-of-life care, the research methodology, and theory construction intertwined and created the potential for critical perspectives. The author's professional identity, consisting of experience not just as interdisciplinary researcher but also as a music therapist and music educator in diverse working contexts, served as an insight-driven competence when analysing and interpreting the rich data from the interviews.

## SOCIAL AND EMOTIONAL UNDERSTANDINGS OF MUSICIANS' END-OF-LIFE WORK

The use of music to support individuals and communities through the process of dying is embedded in many cultural traditions. In Western music, which the musicians of the study mostly utilised, musical keening, traditional lamentation, and classical performative requiems have been developed as vocal responses to the passing souls (Walter, 2012). A clinically developed approach to performance for a dying person is called music thanatology (Freeman et al., 2006). More recently, music therapy has been successfully elaborating music practices in collaboration with institutionalised end-of-life care. For instance, research has been conducted on the benefits of music therapy for pain reduction, anxiety, and mourning (e.g., Clements-Cortés & Klinck, 2016; Gallagher, 2011; Gallagher et al., 2018; Schmid et al., 2018). There is promising research on experiences of utilizing everyday music in end-of-life care, such as group singing and listening to music (DeNora, 2012; Young & Pringle, 2018), as well as to support the mourners (Fancourt et al., 2019). There is some data specifically on musicians working in end-of-life settings, but research in this area has remained scarce so far (De Wit, 2020; Dons, 2019; Fancourt & Finn, 2019).

From a socio-emotional perspective, end-of-life music work requires emotional understanding. Emotional understanding emphasises comprehending and seeking to understand one's professional work through emotional processes (Denzin, 1984; Hargreaves et al., 2001; Lynch et al., 2016; Swanson, 1989). This leads to better interaction and decision-making (Denzin, 1984; Hargreaves et al., 2001; Humphrey et al., 2015) in socially engaged working situations. Specific research on emotion regulation has classed emotions at work as a burden (Grandey et al, 2015; Humphrey et al., 2015). These apparently burdensome emotions have been presented as hard to manage, creating stress and pressure (Goleman, 2005). From the educational viewpoint, emotional stress, workload, and the emotional processes are something music professionals should not misinterpret or try to push aside (Meyer, 2009; Sonke, 2021). Instead, these processes could be seen as something to be learned from, and the learning processes could be developed as a holistic working approach (Hargreaves et al., 2001; Kurki, 2017; Meyer, 2009). Reflecting on emotional processes is also important for musicians' self-care, and can assist in recognizing own professional boundaries (Preti & Welch, 2013; Sonke, 2021).

For this study, emotional work is primarily considered an emotional process (Denzin, 1984; Hochschild, 2012). As a free flow of emotional experiences, emotional processes are regarded as an important part of professional reflection (Meyer, 2009), entailing decision-making, personal growth, and learning between patients, their families, and professionals (Jasper et al., 2013). According to Hargreaves et al. (2011), these kind of ethically and practically valuable professional processes could manifest as an emotional investment. Lynch et al. (2016) describe these 'investments' by conceptualizing them as other-centred work. In end-of-life music making, other-centred work may become a key to understanding the emotional work, described as "emotionally engaged work that has as its principal goal the survival, development and/or well-being of the other" (Lynch et al., 2016, p. 42). This does not deny the power structures or differences that may lie between people, which are numerous in healthcare overall, but acknowledges the 'reality' within the care relationships (Lynch et al., 2016). Perspective of emotional processes at work may help to understand emotions as a process, which includes embodied, implicit, and intuitive knowledge (Jesper et al., 2013). Meyer relates this kind of emotional work as

professionals being "constantly engaged in emotional processes that help them understand with others, and guide these interactions" (Meyer 2009, p. 74).

## RESEARCH TASK

As part of a multiple case study (Creswell, 2013; Yin, 2003), this in-depth case study (Stake, 1995) explores the professional practices of healthcare musicians in 'real-life contexts' (Yin, 2003). These contexts include Finnish hospitals, and other public services in the healthcare system. The purpose of this study was to explore healthcare musicians' emotional work in end-of-life care, as reflected on by the musicians themselves. The research questions were:

1. How do healthcare musicians reflect on their end-of-life work with the patients, their families, and healthcare personnel?
2. According to the musicians' reflections and experiences, what kind of professional and emotional work is involved in end-of-life care?

## METHOD

### Participants

For this case study interview data taken from a larger multiple-case database was utilised, comprising ten interviews of six healthcare musicians. The interviewees were recruited during the research process from the collaborating research hospitals and cultural institutions, using a purposeful sampling strategy (Creswell, 2013). The eligibility criteria were: 1) a professional degree in music or music-related areas; 2) in-service training in the field of the arts and health; 3) several years of experience practicing music in healthcare and/or care settings; and 4) working experience in end-of- life care (e.g., eldercare hospital, children's hospital, palliative care wards of a general hospital, and/or hospice care units).

The musicians in the study were all very experienced in their own professional musical genre(s). After their in-service training, they had been working for approximately one to six years in various healthcare environments. Some of them were supervisors or trainers of other healthcare musicians and healthcare professionals. They mostly worked as part-time healthcare musicians in addition to their other work. Their funding (i.e., salaries) was provided variously by foundations, cities, or culture organisations. All of them worked in a highly independent manner in the healthcare units. Collaborative contracts were usually made with healthcare stakeholders, but supervision or other support was not provided through them, or by any other institutions. Some musicians had formed their own working groups, or shared general information in a supervisory dialogue with a colleague. Some had a supportive team provided by cultural or other organisations, such as a symphony orchestra. For more detailed information on the recruited research participants, see Table 1 (Description of participants).

| MUSICIAN (A-F): CONTEXT1 | SEX: AGE2 | EDUCATION, PROGRAMME | PROFESSIONAL POSITION |
|---|---|---|---|
| A: 1, 2, 3a | F: 55-60 | M.Mus, Music Education (Healthcare musician[3]) | Lecturer of Music (Voice, string instruments) |
| B: 2, 3a | M: 55-60 | M.Mus, Classical Music (Healthcare musician[3]) | Orchestra musician Healthcare musician (French horn, percussions) |
| C: 1, 3c | F: 40-45 | M.Mus, Folk Music (Healthcare musician[3]) | Vocal musician Pedagogue (Voice, Finnish kantele) |
| D: 3a, 3c | F: 55-60 | Church Music[4], Vocal Arts[4] | Healthcare musician (Voice, piano, percussions) |
| E: 3b | F: 35-40 | M.Mus, Music Education (Care musician[3]) | Music teacher (Voice, guitar, wind instruments) |
| F: 3b, 3c | F: 45-50 | M.Mus, Church Music (Community musician[3]) | Parish community musician (Voice, piano, guitar) |

***Table 1: Description of participants.***

*1 Working context: 1 = Research hospital 1 (Eldercare hospital), 2 = Research hospital 2 (Children´s hospital), 3a = Palliative and hospice care, 3b = Eldercare hospital, 3c = Healthcare contexts generally.*
*2 Female, Male, Other.*
*3 In-service training and/or degree in healthcare music, care music, or community music.*
*4 Equivalent to master's degree.*

# RESEARCH PROCESS AND ETHICS

As the leading researcher of the project, the author utilised her professional background as a music therapist, community musician, music educator, and health promotion expert in developing the design of this study. As Yin (2003) emphasises, "you cannot start as a true tabula rasa" (Yin, 2003, p. 75) when elaborating case study research. By ignoring implicit knowledge, a researcher may get 'lost' during the case study process. Instead, one may use a pre-existing theoretical orientation in explicit decision-making – such as choosing the contexts, participants, and developing data collection methods – within the fieldwork (Alvesson & Sköldberg, 2018).

During the research process the author came to understand her strong expertise in working within boundaries of different disciplines and organisations, and that one must not assume that other researchers or practitioners necessarily share the same experience. At the same time, it became explicit how the musicians of this study related in a very responsible manner to their professional and ethical boundaries, although they were simultaneously practitioners and learners in new working contexts. Their dedication to develop their work helped to facilitate the research process in an ethically rigorous way (Guillemin & Gillam, 2004; Subramani, 2019).

The research procedure followed the ethical guidelines of the Finnish Advisory Board of Research Integrity (TENK, 2019). The ethical statement for the research project was approved by the Research Ethics Committee of the University of the Arts Helsinki, and the research permits for the two collaborating hospitals were obtained by the organisations in charge of the hospitals' administrations. Before the interviews, the participants were provided with an informed consent form and notified of ethical considerations. To ensure the reliability and validity of this qualitative case study, and to strengthen the evidence overall, every stage of the study has been reported as openly as possible.

## Data

A robust evidence base (Herriott & Firestone, 1983; Stake, 1995) for the multiple case study was generated by recording multiple sources of material for the case study database – participant observations, interviews, professional narratives written by healthcare musicians, the researcher's diary, and literature reviews – in addition to collecting grey literature and other varieties of practical documentation.

The semi-structured, one-on-one interviews were adapted to the working context of each participant. Discussions included end-of-life music work and associated professional and interprofessional themes: professional tasks and work in somatic end-of-life care; the objectives, aims, and meanings of music work; implementation of interprofessional and/or intersectoral collaboration; the possibilities and challenges of the music work; and the imagined future of the music work in healthcare. The author had worked with healthcare musicians A and B during the previous stages of the multiple case study, and empirically observed their work in a children's hospital and eldercare hospital. Their interviews, which were conducted in Fall 2018, supplied the grounding body of the empirical material for this study. The interview data was complemented with interviews with four other musicians, whose work was not observed within the project. The interviews were recorded and transcribed, and a member check was conducted after the analysis accordingly.

## Analysis of the data

The method of analysis followed the reflexive frame in trying to understand the in-depth case through significant "reflexive moments" (Subramani, 2019, p. 2) wherein music practice, methodology, ethics, and theory intertwine. In this case study this refers to the critical reflexivity of the researcher, and to the experiences of the interviewed musicians. This led to understanding the case study as a unique entity with an emerging theme (Stake, 1995): emotional work. Combining the thematic analysis approach of Braun and Clarke (2006) and the theoretical framework of emotional work (Denzin, 1984; Hargreaves et al., 2001; Hochschild, 2012; Jasper et al., 2013) served the purpose of giving depth to the case. Interpreting the subjectivity of the case as an opportunity, rather than an obstacle (Guillemin & Gillam, 2004; Subramani, 2019), unfolded possibilities for reflection and a broader professional analysis reaching beyond the scope of the unique case.

The analytic process started with the data immersion. First, the meaningful situations, problematic issues, and emerging emotional themes in the musicians' end-of-life music work were entered. Secondly, the analysis was structured by moving reflexively between deductive and inductive analytic circles. During this stage, tables were used to code the thematic categories. Thirdly, three emerging thematic categories were identified through this analytic process. The data were then coded into all three categories, which were utilised to construct emerging emotional and ethical reflections on end-of-life music work. Finally, the data was condensed from the emerging thematic categories with further analytic cycles, which led to constructing a synthesizing category, as presented in the Discussion section.

# RESULTS

Based on the musicians' reflections on their work in end-of-life care, three emerging categories were identified in this study: 1) Supporting end-of-life patients in and through music practices; 2) Sharing musical and emotional space with patients, families, and healthcare personnel; and 3) Engaging as a music professional in holistic emotional processes.

## Supporting end-of-life patients in and through music practices

When the healthcare musicians began working in end-of-life care, many of them experienced the working environment as desolate – the opposite of the energetic, growth-emphasizing, and recreational contexts in which musicians and music educators often work. This context was contradictory in many ways. The music making situations were filled not only with grief and sorrow, but also moments of happiness, joy, humour – and hope:

> The patient may have hope within the process of dying in the near future. If you know you have very little time left, you may hope that you could spend the day without pain and suffering. Hope in this case may be a wish that a friend would visit and hold your hand. My work as a musician includes the presence of hope, when I facilitate and create wellbeing in-the-near-future, within that very moment. (Healthcare Musician A)

The healthcare musicians received feedback on their musical visits indicating that they brought pleasure, gratitude, and consolation to the whole ward community. The musical situations included diverse singing repertoires; for instance folk, classical, and popular music. Instruments – for example the Finnish kantele, percussion instruments, piano, or xylophone – were played softly by the healthcare musicians, and sometimes by the patients and their families. According to the musicians, the end-of- life patients and their families had various musical preferences depending on their age, life experiences, and personality (e.g., spiritual, pop, rock, classical, or children's music). The patients' musical preferences were familiar to them, and sometimes reminded them of earlier meaningful life experiences, for example weddings or other celebrations. If the musicians did not know the preferred music, they would learn the new piece together, listen to it together, or find a new piece similar to the requested one.



The musicians experienced their work as unique, including very special features of music making. They became familiar with a musical world full of qualities that do not exist anywhere else, rooted deeply within end-of-life care:

> When a person knows she will have five days left, there is no fantastic life for her. But, on the other hand, we may have a musical memory lane together, just like in Sibelius's Valse Triste: a woman thinks about her younger years, dancing and so on. The music ends like a morendo, dying and fading away. It is somehow a beautiful thought – trying to create beauty as well as you can in the situation. (Healthcare Musician B)

## Sharing musical and emotional space with patients, families, and healthcare personnel

According to the musicians' reflections on their end-of-life music practices, the focus was on wellbeing in the moment, where including the families and friends of the patient was an important part of the musical interaction. In its simplest form, bedside music was extremely quiet, and fading vocal sounds or humming was used to support the breath of a patient. Sensitive tones or slow-paced chords on an instrument created a soundscape and space where the person could rest. The frailer the person was, the softer, plainer, and lower the sounds were. Even extremely quiet sounds, or musical landscapes that were too lengthy, could make the patient experience the music as physically painful. This kind of understanding, incorporating a holistic musical, embodied, and emotional sensitivity towards the person in very fragile health, was seen as crucial knowledge for supporting end-of-life patients with music practices:

> I rather seldom use musical instruments when a patient is already very tired and physically fading away from life; songs with a slow pace are enough. Overall, I am aware of my boundaries. I may sing and be present for a short moment, but I won't save or heal anybody with my music practices. I give my time to the patient, listen to their life stories, show empathy and kindness. (Healthcare Musician A)

Encountering terminally ill people of all ages urged healthcare musicians to build reciprocal social relationships in and through music making situations. This not only meant playing music for people, but also engaging socially with them when playing, listening to, and singing the music favoured and selected

by the patients and their families together. Oftentimes the musical pieces led to conversations and shared emotional processes, wherein the musicians had to (re)orientate their professional work:

> Dying is part of our life. If you become familiar with it, not just as a professional, but also in your own life, it may lead to patients feeling more secure during the music making – not just with their own lives, but also in relation to their family life. (Healthcare Musician A)

The musicians in this study reflected on their professional competence in end-of-life music work as an ability to confront mutually shared emotional experiences with the patients and their families. In some situations, healthcare musicians offered a practical way for families and friends to share emotional processes and communicate through music making with their loved ones. The incurable and progressed conditions of some patients had already largely excluded them from interaction with others. Through shared music making they could still communicate with words, gestures, and bodily expressions. These musical connections could soothe the emotional puzzlement of families and friends themselves. Musicians reflected this to support the understanding that emotional processes do not disappear with the progression of the disease, even though some of the visible, physical faculties of a dying person might fade away.

## Engaging as a music professional in holistic emotional processes

Healthcare musicians considered their end-of-life music practices primarily as a way to be in contact with an individual person who happens to be in the middle of the holistic process of dying. They understood the concept of dying overall as bringing into existence a series of individual sensations, emotions, and perceptions throughout the period. This understanding was the same whether the musical situation was shared with a new-born, a child, an adult, or an aging person. The musicians felt that they generally had not been supported in their previous education or in-service training to implement music work: "In my opinion, I have not had the support in my education to confront the end- of-life stage, or to engage in my music work with the process of dying" (Healthcare Musician A). On the other hand, some emphasised the support of *all* of the education and lifelong learning they had been part of: "As a healthcare musician, everything I have learned during my life, whether it was music education, interaction skills, or living life itself – all of this learning and education has helped me in my work" (Healthcare Musician E).



According to the musicians' reflections, emotional work in end-of-life care was not just a professional tool, but was also regarded as a holistically embodied process. This process intertwined with the relationships and contexts in which the musical work took place. Sometimes both the celebration of life and the morendo of life – the slow fading away – was very concretely and simultaneously present in the music work:

> To make music with a person at the end of their life is an open and pure situation, which you cannot experience anywhere else. I can speak with a person today, and I know she will probably not be there tomorrow. What may happen during the day is that when I play, at the same time, men in black walk into the hospice ward, and they take away a bed with a curtain on it. And at that very moment, I am playing my French horn there in the distance, in the hallway. (Healthcare Musician B)

Healthcare procedures such as patient safety and aspects of hygiene regarding infection prevention and control, and the patients' overall rights and responsibilities, were important factors to be aware of and take into consideration. In musical care within such places as eldercare homes and other facilities, touching and soothing are usually part of the practice. Within the healthcare environment, however, physical contact was not seen as quite so important, in part because of the hygiene protocols. Instead, the music itself was seen as a symbolic way for people within the ward to be touched and cared for.

# DISCUSSION AND CONCLUSION

In this in-depth case study, professional healthcare musicians' work in diverse end-of-life care contexts was explored. As described earlier, the musicians engaged in their work through holistic emotional processes. These emotional processes were manifested in their own performative work and music and were also deeply social in nature. As a framework for this phenomenon, I introduce the concept of *musico-emotional work,* drawing from the socio-emotional understanding of emotions (Swanson, 1989). Musico-emotional work is thus an important part of music professionals' work, intertwined with a socially and ethically responsible approach to their work. Within this concept, the processual

nature of emotions is emphasised. Instead of being a separate or subordinate part of our thinking and learning, the emotional work is an on-going, fruitful, and transformative process. Musico-emotional understandings create opportunities for other-centred, interprofessional reflection and reciprocal learning for music and healthcare professionals.

Socio-emotional growth – here, experiencing and sharing emotional processes with end-of-life patients, their families, and the personnel – transforms musicians' mastership of music. Reaching beyond the traditional bounds of performative musicianship, they engage with a continuous *flow of musico-emotional knowledge.* To create beauty, support wellbeing in the moment, nurture reciprocal social relations, and share emotional processes entails both relative and contextual competence. This competence, which reaches beyond performative music professionalism, depends on the social, emotional, and musical focus that manifests in a specific musical situation. It requires the musician's ability "to read the room" (Hoover, 2021, p. 60), a delicate understanding of when, where, and how to make the music available for the patients. Through recognizing ethical conflicts – for example how to support the wellbeing of a dying person, or how to simultaneously be a professional musician and a compassionate end-of-life companion – musico-emotional understanding can improve the quality of contemporary societal and institutional care. This approach to musical care, as a part of emotional understanding (Hargreaves et al., 2001), can also help to build up a larger ecosystem of culture and wellbeing in healthcare (Koivisto et al., 2020; Moss, 2014).

In this study, musicians related to the burdensome experiences that occur when working in end- of-life contexts. Rewarding and meaningful work in healthcare may expose music professionals to work-related stress, workload pressure, and even burnout (Preti, 2009; Preti & Welch, 2013; Sonke, 2021). Socially engaged work (Sugrue & Solbrekke, 2014) in healthcare brings forward a spectrum of emotional work that could be better addressed in higher music education. Focusing on how professional identity is created through emotional experiences and processes already in the early stages of studies (Meyer, 2009) could help future music professionals to conduct their work in diversified contexts. It is important to understand that musico-emotional knowledge – emotions aroused in and through music – entails ethically complex emotional processes that more traditional professional literature has suggested should be suppressed (Denzin, 1984; Goleman, 2005; Humphrey et al., 2015; Meyer, 2009).

Based on these results, professional support – for instance in the form of supervision, reflective workshops, or collegial working groups – should be understood as a natural part of future music professionals' work in healthcare contexts. A stronger focus on opportunities to experience culturally diverse working contexts overall,



such as working in social care, immigration services, occupational health, or care homes (Siljamäki, 2021; Westerlund & Gaunt, 2021), would support music students in their later careers. In-service training and low threshold mentor programs could be established to strengthen healthcare music practices. "Emotionally empty" (Meyer, 2009, p. 90) grey literature, such as texts on the strategies, visions, and curriculums of institutions, could be revised to support the global changes in artistic work. In addition to separate courses and programs, there should be a consideration to include discussions on the socially engaged artistic practice throughout all music programs. Many types of these innovations could be implemented simply through reallocating existing resources through social innovations (Väkevä et al., 2017), which would not necessarily require significant additional funding. Encouraging visiting teachers and lecturers, exchanging musicians and healthcare professionals between organisations, and sharing visions and programming could all be a part of such an effort.

The results of this study align with the work of music therapists and end-of-life music therapy research (e.g., Aldridge, 1998; Gallagher, 2011; Hilliard, 2005; Schmid et al., 2018). Musicians' reflections on the themes embedded in professional end-of-life work – emotional, comforting, connecting, reflective, musical – are an essential part of music therapy in many contexts. Both professions seem to have shared goals in end-of-life care; to increase the beauty (aesthetics) of the healthcare environment, as well as to decrease suffering and cultural deprivation (Clements-Cortés & Klinck, 2016; Moss, 2014). Musicians may in some circumstances contribute to the therapeutic and clinical benefits of the arts, as music therapists do, but this did not seem to be the primary goal for the musicians in this study. The wellbeing of the healthcare personnel seems to be equally emphasised in both professions, as does individualising the patient experience. Professionally, it seems that wellbeing, social justice facilitation, and the socio-emotional understanding of music making are emphasised in both end-of-life care frameworks, for both music therapists and musicians. Hence, there is an interprofessional opportunity – or perhaps obligation – to acknowledge and support both professions as providing musical, cultural, health, and care services, and as public services available to the whole healthcare sector.

## Limitations, and future research

Aside from the generalisability of case study research, which is typically marginal, there are a number of intriguing implications that are beyond the scope of this qualitative case study and its methodology. The gatekeeping practices of some

healthcare units limited access to the research sites, which in turn prohibited the researcher from conducting participant observations in hospice and palliative wards with some musicians. The urgent nature of the work and the pressure on healthcare professionals in the healthcare organisations hindered the practical exploration of the topic in hospitals. The combination of medical and non-medical research contexts and traditions created potential bias, but was, at the same time, an interesting theme to explore within this study.

This study has been an attempt to illuminate the growing number and role of music professionals, such as healthcare musicians, in the field of arts and health. Encouraging research and theory development to reach beyond the traditional aspects of performativity in music professionalism may help to develop reciprocal discussions between musicians and music therapists. By collaborating and codeveloping 'music in healthcare' together, music therapists and musicians could strengthen humanistic, artistic, and cultural understanding broadly in health and wellbeing services. One goal could be to further develop and more rigidly evaluate musicians' and other arts practitioners' work in healthcare, which could be the social prescription for a non-medical referral tool in primary healthcare (Bickerdike et al., 2017; Clements-Cortés & Yip, 2020; Moss, 2014). Another issue that could strengthen collaboration and research between music therapists and other music professionals in this area is the better facilitation of arts-based research in healthcare institutions. This should include cultural recording as a part of healthcare documentation and making such documentation available to researchers (Koivisto et al., 2020). As such, patients' rights to reasonable self-determination, integrity, and a meaningful and high-quality end-of-life experience as much as possible should be advanced.

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# ARTICLE V

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# CULTURE AND THE ARTS IN HOSPITALS AND OTHER HEALTH SERVICE ORGANISATIONS

*This policy brief is intended for healthcare authorities and health service organisations, producers of art, artistic activities, and art-related services, educators and students in the health and social service sector and the cultural sector, and decision-makers in all these fields.*

**The policy brief aims to encourage health service organisations to pay attention to the cultural contexts of health and integrate culture and art into their activities to promote health and wellbeing.**

According to the Universal Declaration of Cultural Diversity of the United Nations Educational, Scientific and Cultural Organization (UNESCO), culture should be regarded as the "set of distinctive spiritual, material, intellectual and emotional features of society or a social group, and that it encompasses, in addition to art and literature, lifestyles, ways of living together, value systems, traditions and beliefs" (UNESCO 2001). However, health service organisations may overlook the cultural aspects of health and wellbeing as well as people's cultural wellbeing because of their strong focus on the provision of medical care and efficient operations. The international Lancet Commission has noted that the neglect of culture in the healthcare sector presents one of the most significant challenges to improving people's health (Napier et al. 2014).

The operating environments of health service organisations should become the focus of increased attention. Hospitals, for example, have developed over long periods, and the current facilities, infrastructure, and various organisational cultures bear traces of past ideals and ideologies. We know from history that 2,000 to 3,000 years ago, patients in Egypt received care in temples, while in Ancient Greece, they were treated in military hospitals. On the other hand, modern hospitals are clinical centres that bring together various medical professions and technologies. Their objective is to provide safe and secure operations with state-of-the-art diagnostic services and effective treatments and therapies. In this environment, however, the role of culture and the arts remains marginal.

Consequently, health service organisations should use all the available resources to promote the patients' recovery, health, and wellbeing. The importance of culture and the arts becomes particularly pronounced when a patient is treated in a somewhat isolated environment with no access to art or culture. Hospitalised patients suffering from a long-term illness have especially often pointed this out. Just like with any other form of treatment, the efficacy of culture and art can be measured. For example, there is compelling evidence of the beneficial effect of music on patients' recovery (Fancourt & Finn 2019; Särkämö et al. 2011). The impact of culture and the arts also becomes apparent when an individual's self-reflected experiences concerning participation in the arts and culture are examined.

## Culture and the arts in health service organisations

We propose that the organisations working in the health service sector should implement the following procedures into their operations and adopt a holistic approach to improving people's health and wellbeing through culture and the arts:

## Strategy planning and the development of health service organisations

1. *A cultural wellbeing plan for healthcare districts*. Each healthcare district needs to revisit its strategic plans and policy documents to amend them to include a list of regional objectives and procedures on cultural wellbeing based on existing domestic and international research. The goal of the cultural wellbeing plan is to make it possible for patients receiving care to enjoy and participate in cultural and artistic services, to be able to express themselves, and to reflect upon their condition by the means afforded by art and culture. The municipalities should implement cultural wellbeing principles as part of their municipal strategies, service pledges, and welfare reports. Private service providers should also formulate their goals related to cultural wellbeing and finalise an action plan based on them.

2. *Cultural wellbeing needs to be adopted as one of the strategic core values of the health service organisation, and measures should be implemented throughout the organisation.* The organisations should consult experts in culture and the arts in their planning and decision-making processes. A designated culture and art committee needs to be formed to promote artistic and cultural activities. An expert in cultural wellbeing should be appointed to the board of the health service organisation.

3. *Hiring a Cultural Wellbeing Coordinator.* Health service organisations should employ or appoint a Cultural Wellbeing Coordinator (e.g., for a

fixed proportion of the total working time), who will be responsible for the everyday coordination and facilitation of the cooperation between various agents and organisations (administration, personnel, patients, family members, professionals in the fields of culture and the arts, art organisations, volunteers). The coordinator will also seek to identify members of the personnel with an interest in culture and the arts and explore opportunities to train them further to promote cultural wellbeing as part of their everyday work.

## Monitoring, evaluation, and research

4. *Monitoring and evaluating cultural wellbeing initiatives.* Ministries should launch a project in collaboration with the healthcare districts to develop cultural wellbeing services in general healthcare by using existing international models and current research. Health service organisations should include the documentation and evaluation related to cultural wellbeing ('cultural record') as part of their documentation and registration procedures (Siponkoski 2020). Patient and customer databases should also contain information about the customers' cultural needs and wishes, their participation in cultural and artistic activities, and subsequent effects of the involvement in these activities.

5. *Monitoring and evaluating the cultural wellbeing of the patients and people living in the region*. The municipalities should complement and collect indicator data acquired from a benchmarking service on how the activities that promote cultural wellbeing are realised (see TEAviisari, THL 2020). Information about the facilitation of cultural wellbeing activities can be exploited in knowledge-based management within the ecosystem of cultural wellbeing.

6. *Research collaboration. National Institutes (e.g., The Finnish Institute for Health and Welfare) should promote multidisciplinary research collaboration with universities, higher education institutions, and health service organisations.* The information on people's cultural wellbeing collected by the health service organisations will be made available for multidisciplinary research purposes following sustainable and ethical research principles.



## Proactive measures and health promotion

7. *Promoting the participation and cultural wellbeing of health service customers.* Health service organisations should support the patients' participation in artistic and cultural activities through collaborative efforts that cross the established sectors and administrative branches (e.g., healthcare, social care, culture, education and early childhood education, physical education, environmental services, and parish work).

8. *Supporting the patient's self-management through art and culture.* Health service organisations should adopt a range of measures to introduce art to communicate and interact. They should use art that is already in place in the organisation and encourage the personnel, patients, and family members to realise their artistic and cultural potential. The patients' connection to art can be supported, for example, by social prescribing (see Dayson & Bashir 2014).

9. *Promoting health and wellbeing by making use of art in communication*. Health service organisations should use artistic forms of expression and cultural media in health-related communication and the distribution of popularised information to various target groups.

## Treatment, management, and recovery

10. *Integrating a holistic view of people into the treatment.* Each patient needs to be treated as a bodily, sentient, conscious, and psychosocial individual whose prior life experiences and cultural background affect their health and wellbeing. The patient's needs and wishes about their cultural wellbeing, as well as the observed wellbeing impacts, should be registered into the patient database systems (see Siponkoski 2020).

11. *Reinforcing the status of art therapies.* The possibilities afforded by various art therapies should be recognised, and the therapies should play a more substantial role in the patients' treatment and recovery. This holistic approach to treatment should use the potential that exists in the multidisciplinary collaboration between art therapists, other art professionals employed in the health service sector, and healthcare professionals.

12. *Establishing artist-in-residence programs in hospitals and health services.* Health service organisations should allocate resources to the organisation of socially engaged, professional artists working on a long-term and wide-ranging basis (e.g., hospital musicians, artists-in-residence, dance ambassadors, literary artists, hospital clowns).

## Supporting the personnel and improving occupational health

13. *Reinforcing the personnel's relationship with art and culture.* Health service organisations should support the personnel's relationship with art and culture as part of lifelong learning in collaboration with institutions that provide education in health and social services and art and culture. Such an approach will allow the personnel's relationship with culture and their personalities to come through in their everyday work. Health service organisations should also promote occupational health by encouraging their personnel to participate in cultural and artistic activities within the working community.

14. *Recognising the role of art in health services from the perspective of occupational health and work-based learning.* Health service organisations should implement contemporary culture- and art-based approaches into their activities. Doing that allows them to develop their operating culture and to promote the personnel's occupational wellbeing.

## Operating environments in healthcare

15. *Recognising the environment's relevance to wellbeing.* Professionals responsible for the construction and renovation of health service organisations' facilities should carefully consider the patients, family members, and personnel's opinions in their planning and decision-making processes (e.g., architectural solutions, design, service design, and landscaping). The construction and renovation projects should pay close attention to the acoustic environment's quality, the colour scheme used in the facilities, and the amenity of the lighting and interior design, for example, and consider using the facilities from the perspective of special groups and accessibility.

16. *Implementing the extended percent-for-art principle in the operating environments of health service organisations.* By extending the current percent-for-art principle, a discretionary percentage of the health service organisation's budget can be allocated to art and cultural activities in patient care, customer service, and occupational wellbeing. Furthermore, the current percent-for-art principle, which pertains to the provision of funds for the purchase of art in the total project budget, should continue to be followed in construction and acquisition projects. All health service organisations should make this principle a standard policy.

17. *Making use of new technologies and virtual solutions.* Health service organisations should identify and pursue the possibilities afforded by modern technology to encourage people to take part in cultural and artistic activities in their units. Health service organisations should acquire cultural content from art organisations through streaming platforms and network downloads. The hospital personnel, patients, and family members should receive instruction in the use of the remote services and, more concretely, to use the necessary technology.

## Practical examples of how health service organisations can promote cultural wellbeing

- *Example 1.* Supporting the patient's agency and self-management through art and culture: a) Listen together to an exciting program on the radio and discuss the thoughts it provokes. b) Help the patient reflect on their condition employing literary art.

- *Example 2.* Promoting health and wellbeing through artistic communication: a) Remembering to follow appropriate hand hygiene practices can be supported by composing a rhyme or a rap. b) A relatable short film can provide a more effective and multi-layered account of a peer experience than an ordinary discussion.

- *Example 3.* Promoting the participation and cultural wellbeing of health service customers. Models for long-term cooperation can be planned together with local art schools. Activities such as guest performances, open rehearsals, workshops, and exhibitions will be organised on the health service organisation's premises.

- *Example 4*. Integrating a holistic view of people into the treatment: a) The personnel becomes better acquainted with a customer or a patient and learns more about their cultural background and cultural needs. That can be accomplished, for example, by making use of an exercise, such as the 'Tree of Life,' that allows the individual to recount their life experiences to others. b) Topics in further personnel training should include the role of cultural diversity and multiplicity in people's lives ('intersectionality') and their value from the perspective of professional care. The stereotypical categorisation of people (e.g., 'the elderly') should be avoided, and people's individual preferences and self-reflection in selecting cultural services and contents emphasised.

- *Example 5*. Reinforcing art therapies' status: a) An art therapist, a communal artist, and a nurse can form a working group in a hospice unit. The treating physicians evaluate the art therapy's suitability to the patients' care path on a case-by-case basis. b) How various art therapies can be employed, and the health benefits related to them, are discussed in physician training. The physicians are trained to assess art therapy's help for the patient in addition to, or in place of, other treatments.

- *Example 6*. Establishing regular artist-in-residence programs. The health service organisation negotiates with an art service provider (e.g., hospital clowns, dance ambassadors, literary artists). It formulates an agreement concerning the collaboration's annual goals, the concrete measures related to that, and the available resources.

- *Example 7*. Adopting the principle of extended percent-for-art in health services: a) Patients are provided with an opportunity to engage in participatory art activities along with the regular care services. That will be accomplished by allocating a discretionary proportion of the health service organisation's budget to art and cultural activities to improve the patients' cultural wellbeing. b) Cultural and artistic activities are integrated into the organisation's daily and weekly routines.

- *Example 8*. Recognising the role of art in the health service organisation's operations from the perspective of occupational health and work-based learning. a) The personnel can form a choir, for example, which provides variety to their everyday tasks and reinforces their sense of solidarity. b) A forum theatre can be used as a form of experiential learning in the critical assessment of personnel and patient reports.



## Cultural contexts of health and wellbeing and the ecosystem of cultural wellbeing

The Lancet Commission has emphasised the role of cultural diversity in people's behaviours and how they articulate health-related issues. Consequently, health should not be considered only in terms of measures that use standardised data related to clinical care, illness, and the patient, but also in light of local knowledge and culture-specific concepts (Napier et al. 2014). The cultural contexts of health are here understood in terms of how value systems, traditions, and beliefs can positively or negatively affect people's health and the existing clinical practices (Fietje & Stein 2017). Ignoring these perspectives can lead to a situation where questions related to the patient's health are considered and clinical practices planned, almost exclusively from the standpoint of physical wellbeing.

The perspective of cultural wellbeing should be recognised in the general development of the health service system. As a term, 'cultural wellbeing' has several meanings that pertain to how culture is part of people's lives and how it affects their health and wellbeing and clinical practices. Cultural wellbeing is often used about an individual's own experience of how "culture and art increase their wellbeing or are related to it" (Lilja-Viherlampi & Rosenlöf 2019, 21). On the other hand, the question is about a phenomenon where culture and art convey meanings related to health and wellbeing in society and thus influence both the individual and the community (id.). People's cultural wellbeing can be improved by providing everyone with opportunities to engage in artistic and cultural activities throughout their lifespan. Occasionally, cultural wellbeing can also refer to the culture and healthcare sectors: the inter-sector cooperation in the arts and cultural activities that promotes health and wellbeing (In Finnish context HYTE).

The health service system should acknowledge at the outset that, regardless of their age, physical condition, or living environment, each individual is a cultural, creative, self-expressive, and communicative being: someone who experiences culture and actively particular cultural customs and has specific needs related to that. The way these needs are met can either positively or negatively impact an individual's health and wellbeing. Reinforcing the individual's cultural wellbeing is based on their relationship with culture and art, as well as their cultural capital, which is accumulated throughout the life span. The possibility of participating in the arts and culture, developing oneself and one's community through them, and expressing oneself freely are basic rights (Lehikoinen & Rautiainen 2016). They are also essential components of a good quality of life and life-long learning. Indeed, people are grounded in their everyday lives and environment by art and culture.

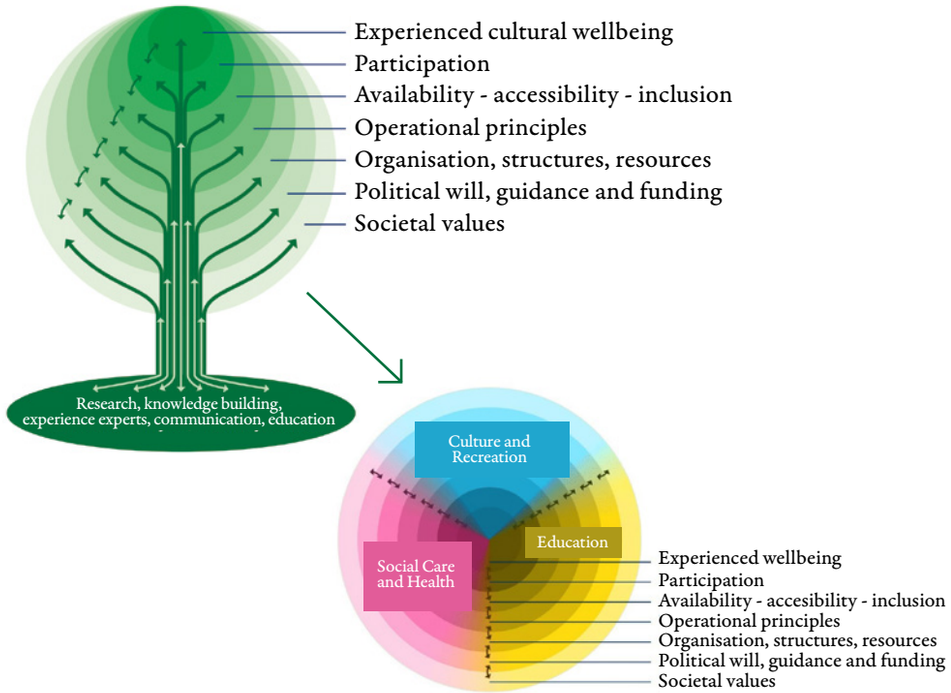


***Figure 1. Ecosystem of Cultural Wellbeing***

According to the ecosystem of cultural wellbeing (see Figure 1), it is possible to reinforce the sense of cultural wellbeing of all population groups. It can be done by investing in the availability, accessibility, and engagement of art and cultural services and integrating these services into the practices of health and social service institutions and educational organisations. That will become possible once the information about the effects of art and culture on people's health and wellbeing starts to affect our social values, political decision-making, funding, and operating cultures in various sectors. Reinforcing cultural wellbeing will thus become an acknowledged part of the organisations and their evaluation. Similarly, the practical experiences gained in people's opportunities to participate in the arts and culture, their actual participation, and their cultural wellbeing reinforce the existing body of research and knowledge accumulation within the field. Furthermore, by engaging in well-coordinated multidisciplinary collaborations between the culture, education, and health and social service sectors, it is possible to ensure that people's relationship with culture and the arts continues to develop from early childhood to adulthood and the later years in life.



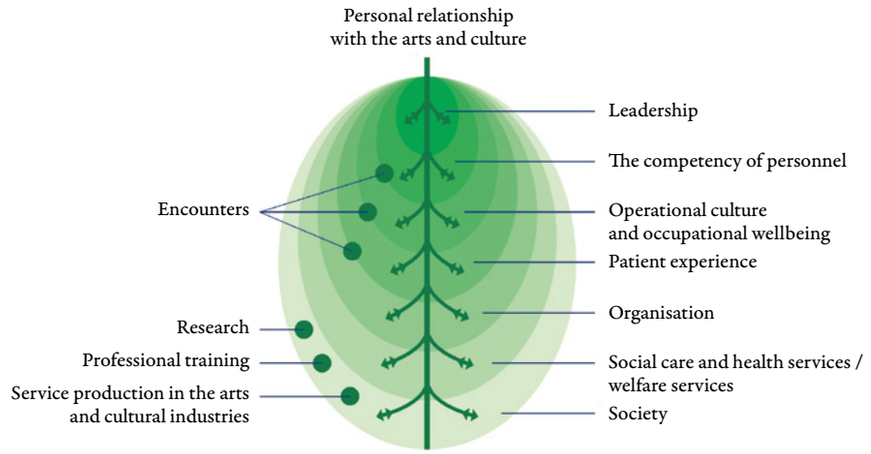


***Figure 2. Cultural Wellbeing in HEWE Ecosystem in Social Care and Health Services.***

## Cultural wellbeing in the HEWE ecosystem

The ecosystem of health and wellbeing (HEWE) concerns all sectors. Here, however, we will only focus on one part of the ecosystem – the dynamic network between the various agents in the health and social service sector. Such a network "produces services and distributes tasks, responsibilities, and decision-making power – [so that] all the participating agents work in cooperation, share the same goals, and carry out the required tasks according to the division of labour and responsibilities that have been agreed upon" (Vepsäläinen et al. 2017, 14). The adoption of cultural wellbeing principles can affect the HEWE ecosystem in different ways, from administration and personnel's expertise to the service organisation's operating culture, occupational health, and patient experiences (see Figure 2). Reinforcing one's connection to art and culture forms a central part of the ecosystem. The customers' (including the patients') personal connection to art and culture can be supported by making art and culture better accessible in the health and social services and reinforcing the role of art therapies. The personnel's relationship with art and culture will also be supported by paying attention to the concept of cultural wellbeing in the professional training provided by educational institutions in the health and social service sectors, leadership, operating culture, and occupational wellbeing.

## The inclusion of the arts in health services and hospitals promotes the wellbeing of both the patients and the personnel

Multidisciplinary cooperation between health service organisations and art and cultural organisations will increase cultural wellbeing in society. According to the scoping review commissioned by the World Health Organization (Fancourt & Finn 2019), the arts can be used for many purposes: e.g., to influence the social factors of health, to promote children's development, to encourage behaviours that have a positive impact on health, to prevent illnesses, and to support care work. Moreover, art can benefit people recovering from mental health problems, it can support acute care, and it can help treat non-infectious diseases. Art can also support people suffering from neurological disorders and be part of palliative care (ibid.). When art and culture are taken increasingly into account in providing health services, the resulting care work will also be more ethical than before. Understanding the cultural contexts of health helps people consider patients as individuals whose lives, wellbeing, and health are substantially determined by culture. By paying attention to the patients' cultural needs, it is possible to promote their wellbeing at a time of crisis or illness. Simultaneously, an increased understanding of art and culture's opportunities in advancing people's health and wellbeing provides support to a more holistic approach to the development of people-centred care. Once the organisation-based, hierarchical operating models that health service organisations currently adopt are replaced by people-centred and increasingly equity-driven solutions, this will also increase transparency in the health service organisations' operations and communication culture. That will also diversify the value basis of the health service organisations and services to support mutual trust, making the organisations more resilient the arts and culture enjoy an autonomous status in a civilised society. Still, in the extended discourse of wellbeing, they also play a legitimate role in the health and social service sectors. As we now live in a time following the expansion of the welfare societies, all investments in the arts, art education, and culture should not only be regarded as cultural investments; instead, they are also proactive investments in people's health and social care. They are investments in a good life, wellbeing, inclusive principles, and the alleviation of cultural tensions. These ideas can even be extended to the health service organisations' innovation capital and the sustainable growth of intangible value creation.



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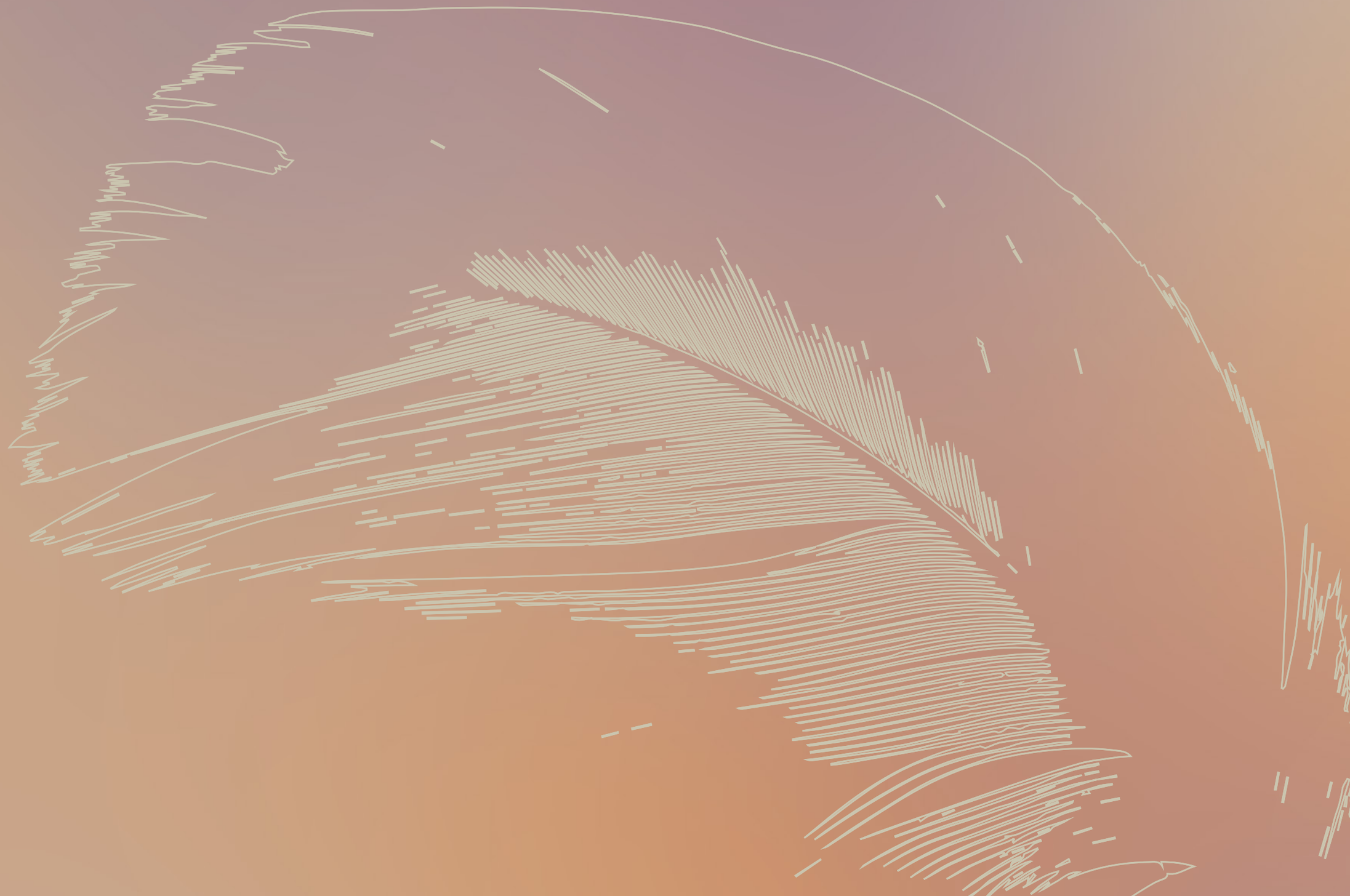

APPENDIX 1.
Statement of the Research Ethics Committee
and research permits.



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**Helsinki**
**February 15, 2018**
**Lauri Väkevä**

# Statement of the Research Ethics Committee

Taru-Anneli Koivisto has requested a statement from the Research Ethics Committee of the University of the Arts Helsinki regarding the ethicality of her research project.

On the basis of the statement request and the included information of project, the Research Ethics Committee finds that the researcher is engaged to follow ethically sustainable study methods and procedures in her project. According to the Committee, the project can be granted the research permit on the basis of ethical review.

However, the Committee suggests that the researcher pay attention to the following:

- The information sheet (appendix 1 of the request) should be as understandable as possible. The purpose of the study should be clearly stated in the beginning.

- The informed consent sheet (appendix 2 of the request) should be more precise. It should state as clearly as possible what the person is participating in the study. Instead of "agreement" ("sopimus") it should be labeled "consent form" ("suostumus").

- The guardians of minors participating in the study should be informed and their consent should be asked.

- Because of the nature of the study, the researcher should check whether she needs a statement from the ethical committee of the participating hospital or hospital district as well.

- If the condition of a personal data register is fulfilled, the researcher should fill the form for notice of personal data register for the Office of the Data Protection Ombudsman (Tietosuojavaltuutetun toimisto).

Helsinki, February 15, 2018

**Lauri Väkevä**, PhD
Vice-Rector
Professor
Chair of the Research Ethics Committee of the University of the Arts Helsinki
[contact information]

# RESEARCH PERMIT

## GRANTING OF RESEARCH PERMIT

Based on the application for research permit that has been received on 24.4.2018, the Social Services and Health Care Board of the City of Espoo/Ketterä Result Area of Development grants a research permit with the following terms.

Applicant/contact person: Taru Koivisto

Study topic/title: The (Un)Settled Space of Music Practitioners in the Finnish Healthcare System

The one or those carrying out the research must not use the information collected to cause harm to patients or their close ones. Neither must they share collected personal information with a third party, but maintain confidentiality. In addition, the Lawyer presents the following conditions: The applicant must ensure that it is clarified whether the right of representation of legal representatives includes the right to consent to participation in the study. If the person has no legal representative, the applicant must ensure that the capacity of the person to properly consent to participation is evaluated. The results of the study must be presented in a way that does not allow identification of a specific person or family. Moreover, regulations concerning research registers included in the Personal Data Act and other legislation must be followed. This granting of research permit does not oblige the research subjects to participate in the study. The researcher must always negotiate separately with each organization studied concerning participation in the study. The process of the research must not interfere with the work of the research subjects.

We require that the researcher/contact person sends the final research report to the email address of the Social Services and Health Care Development Unit sotet_tutkimusluvat@espoo.fi.

Espoo 8.5.2018

Tuula Heinänen
Development Director
Social Services and Health Care
City of Espoo



# DECISION ON RESEARCH PERMIT

18.6.2018
Taru Koivisto
taru.koivisto@uniarts.fi

## RESEARCH PERMIT FOR THESIS 5/2018

Professor, Consultant Taneli Raivio has, as a form decision, granted a research permit for the following thesis work:
The (Un)Settled Space of Music Practitioners in the Finnish Healthcare System

Applicant: Taru Koivisto
Degree: Doctor of Music
Time period: 1.10.2018-31.12.2018

Person in charge at HUS: Music Therapist Hanna Hakomäki

The administrator of the research register is to be informed when the research is concluded. If an extension of the time period is necessary, a free-form application for this can be submitted.

Marjaana Peussa
Helsinki University Hospital Department of Children and Adolescents
Research and Education
[contact information]
Hospital District of Helsinki and Uusimaa
Children and Adolescents. Research and Education
P.O. Box. 281
00029 HUS
www.hus.fi

# APPENDIX 2.
# Example of an information letter and informed consent form for the empirical part of the study.

## Information letter to guardians 9.5.2018

Dear guardian,

Your child has received care at the _____ (name of the ward) of the [children's hospital].
Based on the care and its associated tasks we contact you for the purposes of research. The HUS has granted a permit for conducting non-medical research aiming at the production of a thesis that is part of a dissertation at the MuTri Doctoral School of the University of the Arts Helsinki. The purpose of the study is to investigate the work of hospital musicians in a hospital environment. The study is part of the ArtsEqual research initiative coordinated by the University of the Arts Helsinki and supported by the Academy of Finland.

The study is conducted by M.Mus, music therapist Taru Koivisto. The purpose of the study is to assess and investigate the work of music professionals (musician-music educators) in a multi-professional environment and to describe the opportunities and challenges associated with combining the hospital environment with the arts.

We invite you and your child to participate in this study, and we will now give more detailed information about how to participate. The interviews and observations needed for the study will be carried out at the _____ (name of the ward) of the [children's hospital] during the autumn of 2018.

During the research process, music interventions at the ward will be observed and study participants interviewed, including in total 2 patient-clients, 2 close ones, 2-3 staff members and 1-2 hospital musicians. We ask you to allow 30-60 minutes for the interview. All information collected from you and/or the child under your care will be handled confidentially without associating it with names or other information about your identity. Participation in this study is completely voluntary. Participating or not will not affect current or future care received at the [children's hospital]



More information about the research project can be found at www.artsequal.fi.

Researcher: Taru Koivisto, M.Mus, music therapist, doctoral researcher
Organization: Sibelius Academy of the University of the Arts Helsinki
[contact information]

Signature and date:

_____

Heidi Westerlund, Professor, Director of the ArtsEqual research initiative
[contact information]

## Information about the ArtsEqual research initiative and consent form for participation [date]

The present doctoral research project is part of the multidisciplinary ArtsEqual research initiative coordinated by the University of the Arts Helsinki. The aim of ArtsEqual is to study how the arts and arts education may increase equality and wellbeing in Finland in the 2020s. ArtsEqual considers the arts and arts education as a basic service that everyone is equally entitled to. The research is conducted during the period 2015–2021.

## How is the ArtsEqual research conducted at the [geriatric hospital] / [children's hospital]?

The collection of research data at [geriatric/eldercare hospital] / [children's hospital] focuses on the work of music educators and musicians (referred to as hospital musicians) conducting hospital visits. While at the hospital, the musician-music educator collaborates with the staff to promote the wellbeing of patients and their close ones. The work involves various opportunities and challenges that the research strives to assess and develop.

## Background of the research

The purpose of the ArtsEqual research group Arts in Health, Welfare and Care is to investigate new services relating to the arts and arts education that are being implemented in the social services and healthcare sector. The research utilises insights about the relationships between art, health and wellbeing yielded by recent scholarship within medical research and studies on adolescents, the elderly and people with disabilities. Many studies have indicated that staying creative and culturally active increases an individual's subjective experience of wellbeing, quality of life, health, social capital, positive view of living and even life expectancy, regardless of the individual's illnesses and other problems. There is also strong evidence that art has positive effects on rehabilitation, taking care of patients, mental health work, and work among patients with dementia, adolescents and people with disabilities. International policy documents emphasize the significance of art, arts education, art-based creativity and cultural skills for learning, wellbeing, health and sustainable growth (Westerlund et al., 2016).



## How is the research conducted?

Research data on music interventions in hospitals are collected at [geriatric hospital] / [children's hospital] through observing and interviewing patients, their close ones, staff and hospital musicians.

Data are collected by:
Researcher: Taru-Anneli Koivisto, M.Mus., Music therapist, Doctoral researcher
Organization: Sibelius Academy of the University of the Arts Helsinki
[Contact information]

Data are collected through:

- Monitoring and observing music interventions carried out by the musicians of [band] and [orchestra].
- Interviews with patients, their close ones, staff, and members of [band] and [orchestra].

Staff members and hospital musicians are interviewed individually for 45-60 minutes.

The interviews and focus groups are recorded and stored, following which they are transliterated, made anonymous and analyzed qualitatively. After the transliteration, the recordings from the interviews are erased. Excerpts from the interviews may be used in research articles and communication. The researcher will take field notes to facilitate observation.

# Consent form for participation in ArtsEqual research [date]

The present data collection is conducted as part of the research initiative **The Arts as Public Service: Strategic Steps towards Equality (ArtsEqual).**

ArtsEqual is a multidisciplinary research initiative coordinated by the University of the Arts Helsinki. The aim of ArtsEqual is to study how the arts and arts education may increase equality and wellbeing in Finland in the 2020s. The study considers the arts and arts education as a basic service that everyone is equally entitled to. The research initiative is conducted during the period 2015–2021. ArtsEqual is a joint research initiative of the University of the Arts Helsinki, CUPORE, the Lappeenranta University of Technology, the University of Turku and the Finnish Institute of Occupational Health. ArtsEqual has received funding from the Academy of Finland's Strategic Research Council. The research director of ArtsEqual is Professor Heidi Westerlund of the Sibelius Academy of the University of the Arts Helsinki [contact information].

Data are collected through interviews and observations.

Data are collected by
Researcher: Taru Koivisto (doctoral researcher)
Organization: Sibelius Academy of the University of the Arts Helsinki
[contact information]

The data collected during ArtsEqual is used primarily for the purposes of the research initiative. The data will be stored at the Finnish Social Science Data Archive, where they can be accessed by domestic and foreign researchers according to the terms of use of the archive. The archive provides access to data only for the purposes of scientific research and education.

Interview and observation data will be anonymized. Data from the interviews and observations may be used in scholarly publications, education and communication of research findings, for example in conference presentations and on the ArtsEqual research initiative website (www.artsequal.fi).

I have received, read, and understood the separate letter and information sheet about the study. The letter has provided me with sufficient information about the ArtsEqual research initiative and its associated data collection, processing and access, both regarding myself and my child. The information contained in the letter has also been communicated to me orally, and I have received satisfactory replies to all my questions about the study.

This information was provided by: Taru-Anneli Koivisto Date: .....2018.

Background information about the participant

Gender: Male ☐ Female ☐ Other ☐
Year of birth:
Profession:
Education:
If necessary, I may be contacted for discussion
about an additional interview: YES ☐/ NO ☐ Date:

Signature:
Type or print name: Address:
Email:
Phone:

GDPR Compliant Document of the research (EU 2016/679) [Tutkimuksen tietosuojailmoitus], replacing the registry information created according to Personal Data Act (523/99 10 §) is available and updated here: https://taru12koivisto.wixsite.com/researcher/doctoral

# APPENDIX 3.
## Excerpts from interview transcriptions.

Transcription excerpt A. Healthcare musician.

R = researcher
HM = healthcare musician

[...]

R: In your opinion, what is required from someone working in a hospital or other environments? What would be good advice?
HM: Well, let's say that you really got to keep your horns up here. This is really extreme, it is an extremely good place to work. Here it's, this is sort of rewarding, at least it's been that for me so far. Much more rewarding than the final years in the orchestra, where I began to constantly have thoughts like if only nothing bad would happen, since you sort of decay physically. And you decay mentally as well. Your, your pressures grow all the time like crazy. This is something really shocking.
R: So is this work, in the end, more lenient?
HM: Well, it is. Of course, it is if you yourself are in control of the situation. Since you are in charge of what you do, you control it all by yourself.
R: Some people might say that it is precisely this kind of situations they cannot control.
HM: Yeah, this may, then, also be due to my inheritance. I'm also, you see I'm also specialised in working with people with intellectual disabilities, plus in special work relating to palliative care, since other musicians do not work with palliative care assignments. This, in turn, may be because I provided palliative care for my father and mother. It feels fully natural to me.
R: In your experience, what is a palliative care assignment? That is, your palliative care assignment.
HM: Well, when carrying out my palliative care assignments, I would not just go to the middle of the ward and play music, like we just did.
R: Yeah.
HM: First of all, I need to think even more carefully about what I will play as the people there may no longer be around tomorrow. And I don't know, it may be a young person who has been in an accident and may be full of anger, or perhaps sorrow or any other feeling. Most of them are, however, older people who know



and hope in the same way as my parents. Mother had hopes that oh no now. That she had to suffer, it was totally awful. That if (inaudible) the kind like... if there had been, had been euthanasia, she would certainly have requested it.
R: Yeah, yeah.
HM: But, well, it is this kind of situation, I go to the doorway, I play in the wide corridor so that the sound would reach individual rooms in the best possible way.
R: You play the [instrument]?
HM: I still play the [instrument]. Yeah, I would not, especially not there...
R: Ukulele.
HM: One cannot just start playing the Uilleann pipes or ukulele. And then there have happened things like, they are extre... that is the situations are somehow extremely wonderful and calm. Someone asks me to enter the room. Now there was a singer who asked me to visit. The singer was paralyzed from here [points with hand], and did not... and the singer said that your playing, even though I myself felt that I had totally messed up my playing and that I had never had such a bad day as far as I could remember. Usually I play accurately, but now I mixed up the rows, and something, something strange happens. And... But I still got that kind of response.

[...]

Transcription excerpt B. Patient in eldercare hospital.

R = researcher
P = patient

[...]

R: Have you got any particular feelings? You told [the hospital musician] something, can you tell me what that was about?
P: Well, I once, once had a situation where my wife came into the room along with that singer.
R: Yes.
P: I will always remember it... memory (inaudible) memory.
R: Yes
P: It was really wonderful. One can never say no to something like that
R: Yeah. Indeed
P: (inaudible)
R: Sure

P: (inaudible)
R: Right. What do you think was particularly good about that moment of music
P: (inaudible)
R: Yeah
P: (inaudible) built (inaudible)
R: Many have said the singer has a great voice.
P: (inaudible)
R: Yes. The singer began with the song On suuri sun rantas autius [traditional Finnish song: Great is the Desolation of Your Shore].
P: (inaudible) My wife and I sang it many times together (becomes emotionally moved)
R: Yes, true. And actually, I think there were three of them…
P: There were three …
R: …songs in minor key. And the last one was more cheerful…
P: Yes, it was.
R: …then. The singer was apparently able to choose those songs just…
P: And it was certainly not the first time.
R: Yes, true.
P: And can of course do things on the right spot…
R: Sure, yes.
P: …beautiful to hear
R: Yes.
P: Sorry.
R: No problem
P: (emotionally moved)
R: Hmm.
P: Shall we continue

[…]

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