

## ARTICLE

# Healthcare musicians and musico-emotional work: An in-depth case study within the context of end-of-life care

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### 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,  
healthcare,  
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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 & Solbrenke, 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 & Sköldbberg, 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): Context <sup>1</sup>	Sex: Age <sup>2</sup>	Education, Programme	Professional position
A: 1, 2, 3a	F: 55-60	M.Mus, Music Education (Healthcare musician <sup>3</sup> )	Lecturer of Music (Voice, string instruments)
B: 2, 3a	M: 55-60	M.Mus, Classical Music (Healthcare musician <sup>3</sup> )	Orchestra musician Healthcare musician (French horn, percussions)
C: 1, 3c	F: 40-45	M.Mus, Folk Music (Healthcare musician <sup>3</sup> )	Vocal musician Pedagogue (Voice, Finnish kantele)
D: 3a, 3c	F: 55-60	Church Music <sup>4</sup> , Vocal Arts <sup>4</sup>	Healthcare musician (Voice, piano, percussions)
E: 3b	F: 35-40	M.Mus, Music Education (Care musician <sup>3</sup> )	Music teacher (Voice, guitar, wind instruments)
F: 3b, 3c	F: 45-50	M.Mus, Church Music (Community musician <sup>3</sup> )	Parish community musician (Voice, piano, guitar)

**Table 1:** Description of participants

<sup>1</sup> 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.

<sup>2</sup> Female, Male, Other.

<sup>3</sup> In-service training and/or degree in healthcare music, care music, or community music.

<sup>4</sup> 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' mastery 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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## Ελληνική περίληψη | Greek abstract

# Οι μουσικοί της υγείας και το μουσικο-συναισθηματικό έργο: Μία εις βάθος μελέτη περίπτωσης μέσα στο πλαίσιο της φροντίδας στο τέλος της ζωής

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## ΠΕΡΙΛΗΨΗ

Ο σκοπός αυτής της λεπτομερούς μελέτης περίπτωσης είναι η διερεύνηση του έργου των μουσικών στη φροντίδα στο τέλος της ζωής. Σε αυτήν τη μελέτη, μουσικός της υγείας [healthcare musician] θεωρείται ένας επαγγελματίας που κατέχει ακαδημαϊκό τίτλο σπουδών μουσικής και ενδο-υπηρεσιακή εκπαίδευση εντός εργασιακών πλαισίων μουσικής και υγείας. Πέρα από τη συνεργασία με υγειονομικό προσωπικό, συχνά συνεργάζονται με μουσικοθεραπευτές για την προσφορά ενοποιητικών υπηρεσιών υγείας για την καλύτερη φροντίδα των ασθενών. Στη μελέτη πραγματοποιήθηκαν συνεντεύξεις με έξι μουσικούς με εργασιακή εμπειρία σε πλαίσια φροντίδας ατόμων στο τέλος της ζωής. Οι αναστοχασμοί τους ως προς την κοινωνική διάσταση της δουλειάς τους αναλύθηκαν μέσα από το αναδυόμενο θεωρητικό πρίσμα του συναισθηματικού έργου. Αυτό οδήγησε στην ταυτοποίηση τριών θεματικών πέρα από την αμιγώς επαγγελματική διάσταση της μουσικής εκτέλεσης, οι οποίες συσχετίζονται με το συναισθηματικό έργο της φροντίδας στο τέλος της ζωής. Επιπρόσθετα, οι συναισθηματικές διαδικασίες που προέκυψαν, που ήταν εκ φύσεως βαθιά κοινωνικές, νοηματοδοτήθηκαν ως μουσικο-συναισθηματικό έργο. Αυτή η επικεντρωμένη στον άλλον εργασία συμβαδίζει με την έρευνα στο πεδίο της μουσικοθεραπείας και αποτελεί βασικό τμήμα του μουσικοθεραπευτικού έργου με άτομα στο τέλος της ζωής. Συμπερασματικά, παρατίθενται σκέψεις σχετικά με τις ομοιότητες μεταξύ μουσικοθεραπευτών και μουσικών, καθώς και με το διεπαγγελματικό δυναμικό της συνεργασίας τους.

## ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

συναισθηματικό έργο, φροντίδα υγείας, μουσικοί, μουσικοθεραπεία, φροντίδα στο τέλος της ζωής