Person-centred Music-making as a Cultural Change Agent for Compassionate Healthcare: Through the Lens of Experiential Workplace Learning

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Biography

Krista de Wit is a senior researcher specialising in the field of music in healthcare in the research group Music in Context of Hanze University Applied Sciences Groningen. She works as a teacher-researcher at Prince Claus Conservatoire, where she educates conservatoire students about age-inclusive music pedagogy, supervises practice-based research projects, and trains students to work in the healthcare sector. Krista is a violinist of Foundation MiMiC Music, which provides person-centred Meaningful Music in Healthcare-projects in Dutch hospitals and other forms of person-centred music projects in partnership with Dutch older adult care organisations.

Abstract

To meet the care needs of the rapidly ageing patient populations, the cultivation of a compassionate patient-centred healthcare culture has become central in the value-based healthcare discourse. A participatory music practice, 'Meaningful Music in Healthcare' employs a person-centred approach to music-making in Dutch hospitals. A grounded theory analysis on ethnographically collected data suggests that music-making serves as a social change agent

and cultural resource for catalysing compassionate contact between healthcare professionals and patients. Processes of experiential growth and shared values in music-making and healthcare help to enrich care relationships and allow the emotional dimension of nurses' professional performance to be explored.

Keywords

Person-centred music-making, patient-centred care, compassion, experiential learning

Introduction: A need for cultivating a compassionate culture in healthcare

As the world's population continues to age at a radical rate, ageing has become one of the most urgent challenges impacting healthcare sectors globally (WHO, 2015; United Nations, 2015; Lases, 2017). It intensifies the need for specialised care plans for older patients (Kubendran et al., 2016). While the ageing-related demands continue to grow, healthcare has long struggled with a critical shortage of workforce (Benner, 1984; Bittman, Bruhn, Stevens, Westengard, & Umbach, 2003). In the Netherlands, there is an expected shortage of nurses up to 100 000-125 000 already by 2022 (Ministry of Health, Welfare, and Sport, 2017). Keeping competent and motivated healthcare professionals in the workforce is, thus, urgent (Ten Hoeve, 2018).

The pressure to deliver excellent care for ageing patient populations under economically-driven management models has created a treatment-focused, *task-centred* healthcare culture opposite to *relationship-focused care* (Kitwood, 1997; Zeisel, 2010; Bunkers, 2010; Youngson, 2012). A strictly task-centred culture is harmful to patients' experiences of care and damaging for healthcare professionals' occupational well-being (Happell et al., 2013). A lack of inter-

personal contact with patients contributes to work absenteeism and job turnover (Happell et al., 2013; Lases, 2017) because task-centredness limits focus on the humane aspects of care (Youngson, 2012). Humane care requires responsive interactions (Van Heijst, 2005), and when missing, *emotional fatigue* among the workforce may increase (Ricard, 2013; Lases, 2017). Emotional fatigue occurs when exhausted healthcare professionals no longer feel "engaged with [the patients'] care needs" (Ross, Tod & Clark, 2015, p. 1224), leading to a loss of feelings of accomplishment at work and increased insensitivity towards others (Ricard, 2013). Engaging with patients in meaningful interactions is an essential part of cultivating *patient-centred*[1] care, where humane contact is prioritised (Van Heijst, 2005). This way, healthcare professionals can identify as "caring human being[s] first" and as clinical experts second, which supports their occupational thriving (Youngson, 2012, p. 92).

Patient-centred care builds upon compassion towards the personhood and unique needs of patients (Youngson, 2012). Compassion is "central to how people perceive their care" (Cummings & Bennett, 2012, p. 13). As such, compassion is one of the *'six C's'* underpinning patient-centred care: *care, compassion, competence, communication, courage, and commitment* (Cummings & Bennett, 2012). Compassionate care asks for genuine *presence* (Bunkers, 2010, Ross et al., 2014). Youngson (2012) explains that when fully present, "connection with others is dramatically enhanced. [...]. This is the state in which compassion and loving-kindness occur" (p. 60). Presence in care is connected to altruistic motivation to relate to others with emotional availability and dedication (Baart, 2001; Van Heijst, 2005). 'Presence care' is not about *doing for* but *being with* someone, "although one does not exclude the other" (Benner, 1984, p. 57). Subsequently, *fellow humanity* can grow in the care relationship (Van Heijst, 2005). Furthermore, compassion cultivation is connected to *sympathetic joy* (Scarlet, Altmeyer, Knier & Harpin, 2017). Sympathetic joy is "a practice of generosity, and giving isn't just about doing someone a favour—it makes us feel better" (p. 30). Sympathetic joy increases job sat-

isfaction in healthcare and supports care relationships because "[. . .] nurses express pleasure when seeing patients happy, and when they succeed in obtaining medical care or regain their health" (Jormsri et al., 2005, p. 588).

Professional distance, detachment from engaging with patients for the sake of protecting oneself from strong emotions, limits presence in care (Youngson, 2012). Distancing is used for coping with, e.g., empathetic responses to patients' suffering or *feeling with* the suffering of others (Ricard, 2013; Bloom, 2016). It can create an emotionally unresponsive workforce (Van Heijst, 2005). Compassion, on the other hand, takes an active form of altruistic motivation to *relieve suffering* without requiring to feel it (Ricard, 2013; Bloom, 2106). Therefore, cultivating compassion benefits healthcare, as it supports acts of kindness in care delivery and a sense of meaningfulness and accomplishment, which help to fight back emotional fatigue in the workforce (Gilbert & Choden, 2013; Ricard, 2013; Compton & Hoffman, 2013; Ascenso et al. 2016).

Participatory music-making as a social change agent in healthcare

In recent decades, live music practices have gained ground in various healthcare contexts (Oakland, 2012; Daykin et al., 2017). Especially *participatory* practices have emerged as cultural means of supporting meaningful social relationships and well-being in healthcare (Creech, 2018; Creech, Hallam, Varvarigou, McQueen, 2014; Fancourt & Finn, 2019). Participatory music-making considers musical participation or *musical doing* (see Turino, 2008; Matarasso, 2019) as a *social change agent* (Ansdell, 2014; Dunphy, 2018), which can catalyse connectivity, fellowship, and positive emotionality among participants (Finnegan, 2012; Hesmondhalgh, 2013). Lilja-Viherlampi (2012) explains that in healthcare, participatory music-making builds upon reciprocity, and thus, music is brought with enhanced social sensitivity. The music-making aims to promote a "non-hierarchical connection between patient and musician in contrast to the

hierarchical relationship between patient and clinician or therapist" (Oakland, 2012, p. 3). Vijinski, Hirst, and Goopy (2018) explain that "as a social phenomenon and yet both introspective and personal, music offers an extraordinary opportunity to place the person at the centre of caring strategies" (p. 5), which fits supporting patient-centred care. The French Musique et Santé-organisation explains that their musicians work towards the *humanisation of healthcare* by creating shared experiences of artistic discovery and dialogue, which can nurture "a climate of trust between hospitalised people, families, and healthcare staff" (Bouteloup, 2010, pp. 2-4).

A growing body of research suggests that healthcare professionals benefit from engaging in participatory music-making in their workplace (Bittman et al., 2003; Brooks, Bradt, Eyre, Hunt & Dileo, 2010; Smilde, Page & Alheit, 2014; Smilde, Heineman, De Wit, Dons & Alheit, 2019; De Wit, 2020). Musical participation is associated with, e.g., stress reduction, improved mood, and increased contact with patients (Daykin, 2012; Happell et al., 2013; Repar & Reid, 2014; Petrucci, 2018; De Wit, 2020). However, live music practices are largely yet to be provided as continuing cultural services in healthcare (Preti & Welch, 2012; Chadder, 2019).

Meaningful Music in Healthcare

> Two patients [...] a man and a woman share a room. The musicians, clarinettist Jonas, cellist Roy, and flautist Madelief are visiting them now for the first time. Nurse Merel is present and stays in the room for the music-making. [...] clarinettist Jonas explains that the musicians could make a special piece for the participants; a landscape. He asks the patients where they would like the music to take them. The patients want to hear a piece about a sea and a beach. Nurse Merel adds that she would like to hear a landscape about winter sports. Jonas answers that the musicians will begin from the sea and the beach, and from there, go to a snowy place of winter sports. Everyone agrees with smiles and chuckles. The piece begins with a motive

> of triplets imitating the waves of the sea. The motive grows into a warm cello solo, followed by a soft solo on the flute. Then, the musicians start to play motives imitating the motion of a skier sliding down a snowy hill. When the music comes to an end, the man comments: 'The first part was clearly a sea.' Nurse Merel laughs: 'There was a slope, too!' Afterwards, the musicians play 'I want to break free' by Queen as a request of the patients. Then, the musicians begin to make their way to continue their visits in other rooms. They finish the session, and while they are on their way out of the room, nurse Merel and the female patient [...] go on talking about the improvisation about the two landscapes. (Reconstructed from fieldnotes in De Wit 2020, p. 151)

This article focuses on a participatory music practice in the north of the Netherlands, Meaningful Music in Healthcare (MiMiC), which employs a *person-centred* approach to music-making with predominantly older adult hospital patients. Person-centred music-making in MiMiC builds upon collective musical processes between patients, healthcare professionals, and musicians (Smilde et al., 2014, 2019; De Wit, 2020), as described in the episode above. Hence, person-centred music-making can work as a social change agent by catalysing new social and emotional contact or deepening existing care relationships.

In the MiMiC practice, person-centred music-making takes place on a hospital ward during week-long projects. Three professional musicians make music with and for patients and nurses in patients' rooms and nurses' breakroom. The musical approaches include person-centred improvisations created for or with participants and arranged repertoire of diverse genres (Smilde et al., 2019), as shown in the episode above. Musicians may ask the participants to describe, e.g., a landscape, a colour, or a theme, which can be translated into an improvised piece of music (Smilde et al., 2019). Improvisations may be conducted by participants, or interpreted based on participants' shared stories of life or nurses' outspoken wishes for their patients. These

forms of person-centred improvisations are, thus, underpinned by a musical dialogue between patients, healthcare professionals, and musicians[2] (Smilde et al., 2019).

Research approach

This article explores cultivating a compassionate healthcare culture through healthcare professionals' experiential learning of person-centred music-making in the MiMiC practice. The article is based on the findings of a doctoral dissertation, where MiMiC was one of two empirical studies (see De Wit, 2020). The research questions were:

1. What kind of knowing is transferred from interactive music sessions into daily healthcare practices in elderly care and hospital settings?

2. What resources and social changes can music sessions generate for nurses and caregivers' daily routines, and what kind of an impact can they have on the culture of their work environment?

The doctoral study was connected to a research project into the development of the MiMiC practice in 2015-2017 (see Smilde et al., 2019), which was carried out as a collaboration between the research group Lifelong Learning in Music[3] and the research group of the Department of Surgery of the University Medical Center Groningen (UMCG) [4]. The data was collected on three surgical hospital wards, Traumatology, Oncological Surgery, as well as Vascular and Hepatobiliary Surgery at the UMCG. During five MiMiC-projects, the collected set of data included 26 participant observations, four group discussions, and 18 episodic expert interviews with healthcare professionals.

The data collection took place in the workplace of the participants with intended minimal intrusion to their work shifts. The sample was inclusive of healthcare professionals holding diverse job functions: nurses, nurses in training, specialised and coordinating nurses, care assistants, nutritionists, doctor-in-training, physiotherapist, social worker. The sample was sig-

Timeframe and department	Data collection
Date: 24 - 30 October 2016 Vascular and Hepatobiliary Surgery	Seven participant observations, one group discussion (four participants), four episodic interviews with narrative passages (four interviewees)
Date: 28 November - 4 December 2016 Oncological Surgery	Seven participant observations, one group discussion (five participants), four episodic interviews with narrative passages (four interviewees)
Date: 27 February - 4 March 2017 Traumatology	Six participant observations, one group discussion (three participants), five episodic interviews with narrative passages (five interviewees
Date: 8 - 13 May 2017 Vascular and Hepatobiliary Surgery	Six participant observations, one group discussion (two participants), four episodic interviews with narrative passages (four interviewees)
Date: 27- 30 July 2017 Vascular and Hepatobiliary Surgery	One additional episodic interview with narrative passages (one interviewee) on 29 July 2017

Table 1. Overview of data collection (see also De Wit, 2020, p. 79).

nificantly gendered by overwhelmingly female-dominated participants, reflecting the notable gender imbalance in healthcare (see also Zhang & Liu, 2016).

The research data was collected using an ethnographically-informed approach, as the aim was to describe and interpret processes of development from the participants' point-of-view in their working context. Participant observation, as the first method of data collection in this research, derives from classical ethnography (Atkinson & Hammersley, 2007; Bisschop Boele 2013). It entails a systematic description of behaviours, actions, and interactions in social situations (Kawulich, 2005). The data is captured by writing ethnographic fieldnotes (Emerson, Fretz & Shaw, 2011), which are further interpreted into observation reports.

Episodic expert interviews were employed for drawing out participants' expertise into the analysis. Episodic interviewing has a semi-structured scheme, and it invites interviewees to recall their experiences of episodes of social situations (Flick, 2004). Additionally, to gain insights into healthcare professionals' collective sense-making of the musical experiences, group discussion was used as a third data collection method (see also Bohnsack 2004). Data triangulation (see Olsen, 2004) was used to check the connections and concepts arising from the data analysis, to gain validation to the interpretations of the findings.

The data were analysed using a grounded theory approach (see Charmaz, 2006). The grounded theory process employs coding, memo-writing, theoretical sampling, and constant comparison of data (Saldana, 2009; Ramalho et al., 2015). By employing an *abductive* approach to grounded theory analysis, the researcher considers several possible explanations for the data reflexively during the research process (Charmaz, 2006; Robson & McCartan, 2016), until arriving at "the most plausible interpretation of the observed data" (Charmaz, 2006, p. 186). In the process of analysing, codes and code families are generated from *initial* and *focused* coding of data (Krüger, 2008; Untamala, 2014). The code families, finally, lead to *core categories* or clusters of central concepts underpinning a middle-range theory applicable to practice (Charmaz, 2006, 2008). From 837 initial codes, focused coding produced eight consistent code families, which were later organised under three core categories: *Participation, Experience, Learning benefits* (see De Wit, 2020).

Theoretical framework emerging from Grounded Theory analysis

Through the reflexive processes of grounded theory construction, the findings were conceptualised within John Dewey's (1859-1952) philosophical pragmatism, which focuses on learning in environments that foster *experiencing* and participation (Westerlund, 2004; Renshaw, 2009). Philosophical pragmatism builds experiential learning upon two chief principles of experiencing: interaction and continuity (Dewey, 1916, 1938). It means that experiential learning takes place in a *continuum* of experiences, and thus, experiences are cumulatively and sequentially organised within interactive transactions with the learning environment (Dewey, 1938). Hence, what is learned becomes "an instrument of understanding and dealing effectively with the situations which follow" (Dewey, 1938, p. 44). Dewey (1938) refers to the accumulation of knowing as *growth* (p. 36). Reflection is essential for experiential learning processes, as there is an initial tension between what is already known and what remains uncertain, which must

be resolved (Dewey, 1916). Hesitation and doubt upon new, unusual experiences are relevant concepts in care professionals' experiential learning, as healthcare professionals are trained to follow fixed protocols of maximal risk reduction (see Youngson, 2012 in De Wit, 2020).

Furthermore, healthcare professionals are known to have specialised professional identities through the accumulation of professional expertise, social interactions, and contextual influences in the workplace (Ten Hoeve, 2018). Professional identities become collectively shared through generalised *values and beliefs*, including *sets of assumptions*, which guide the behaviours and actions of professional performance (Benner, 1984; Ten Hoeve, 2018). Goffman (1959) proposes that all social interactions are *performances* in which individuals aim to control the impression they give off to others, e.g., about the nursing profession, by *impression management*. Giving off a *false impression* by acting *out of character* of, e.g., what is expected of a nurse's professional behaviour, is avoided (Goffman, 1959). A *front* of the performance conveys the norms of professional performance, and it can be protected through means of professional distance, e.g., when facing emotionally impactful situations (Goffman, 1959).

Finally, Lave and Wenger's (1991) situated learning theory provides concepts for placing the learning processes into the workplace context. Research into workplace learning is concerned with supporting work engagement and promoting positive changes in the working culture (Fenwick, 2010). Lave and Wenger's (1991) situated learning theory proposes that learning happens through *negotiating meaning* in a *community of practice*[5]. Members of a community of practice are described as *old-timers and newcomers* based on where they are in the process of moving towards growing membership in the community of practice (Lave & Wenger, 1991; Wenger, 1998).

Analysis and findings

The findings on person-centred music-making as a social change-agent for compassionate care through healthcare professionals' experiential learning can be organised into three categories: 1. Experienced impact on care delivery, 2. Experienced developments in collegial relationships and collaboration with musicians, 3. Experienced developments in working culture and professional performance. All examples of raw data have been previously published in the doctoral dissertation by De Wit (2020) and partly in the published research into the developed MiMiC-practice by Smilde et al. (2019).

1- Experienced impact on care delivery

Participation in the MiMiC music sessions is fundamental for healthcare professionals to gain opportunities to experience person-centred music-making. A nurse reflects in an interview: "Yes, it really is something where you need to be present to really understand it. . . to see that it really has an impact." However, in line with Dewey's (1916) notion of hesitation when facing a new experience, some healthcare professionals express doubt about live music on the ward. A nurse-in-training describes:

> At the beginning, I thought something like: 'What is this? What do we have here now?' Suddenly a whole bunch of people came with big instruments in the hallway. It made me take my time to just look from afar at first, like a cat looking from a tree.

Taking professional distance due to initial hesitation can be decreased with collegial support from *'old-timers'* (see Lave & Wenger, 1991), meaning colleagues who are further along with their familiarisation with the music-making. A coordinating nurse explains:

> There are those who completely keep their distance and are happy when the music

> is over. Then, I will go and talk to them, because I try to emphasise how important it is for the patients and that one also sees a real effect. Then they go along with it.

Becoming familiar with and seeing value in the music practice for the care is a process that challenges healthcare professionals to connect their *task-focused* care acts with *relationship-centred* musical interactions. A nurse describes being concerned about how she would be perceived as a nurse if she would participate in music-making with her patients:

> Eventually, it was funny, because first I thought: 'I just look and see how the patients react.' But it was such fun inside the room, so I thought: 'I will join... I find it a bit... I must remain professional, but I think that I must first wait for a bit, and then, when I see that things are going well, I can join [the session].' Just to stay professional with the patient... One must see that one can still give care... I think that if I go along singing a song, then I am in a way keeping the care in the background. For me, the most important thing of the day is the care. If that is going well, then I can also do things 'for myself'. And that the patients feel good in music, then I can think like: 'Okay, then I can join along.' Because then I am giving care to them, and then I can combine the music and the care.

Here Goffman's (1959) notion of managing a professional impression is relevant. The realisation that a nurse can *remain professional* while *combining* the care with musical agency is a crucial first step towards a new awareness of opportunities to display care in participatory musical situations. A coordinating nurse reflects on developments towards relationship-centred care that can follow from musical participation:

> It can provide an opening, like 'How does it make you feel?' 'What's going on?' 'Is there anything I can do for you?' 'Or should we just sit here together?' Patients

> are here only for a very short time, really. Some of them are here for two or three weeks. And that is relatively short because during that period they are very ill and have no energy to talk extensively about that kind of thing. But the music, it brings emotions to the surface. And it also helps us to deal with things.

Here, the socio-emotional dimensions of participatory music-making as a social catalyst seem relevant (see also Turino, 2008; Matarasso, 2019). The fragment above shows reflected-upon awareness of the emotional openings facilitated by the music-making, which may serve the development of compassionate care. A nurse explains further in an interview: "You are able to talk to each other easier, and I think that it is a huge benefit." In Dewey's (1938) terms, the experienced opening of contact with patients can become an instrument of understanding in daily care. A nurse reflects upon this aspect in a group discussion: "I also find that once you have been there, the patient also connects with you about other things faster too. He has made a connection with you in that moment."

After becoming aware of person-centred music-making supporting patient-centred contact, healthcare professionals may begin to initiate musical interaction pro-actively as a means of displaying compassionate care to patients and colleagues. Organising musical birthday surprises for patients and colleagues with the musicians, making a special wish for a patient through the music, or allowing musicians to play for patients during clinical treatments to divert them from discomfort are among observed actions taken by nurses (see Smilde et al., 2019; De Wit, 2020). A doctor-in-training describes:

> [. . .] it is also really beautiful if you can say in the patient's presence: 'I really wish you the best', or 'I really hope that you will be well.' And that there can then be a piece of music again. Yes, I find that just really beautiful.

The increased agency in initiating musical interaction with patients and colleagues is in line

with Lave and Wenger's (1991) concept of the process of growing membership in a community of practice. Furthermore, wishing someone well through a musical piece can be seen as a new opportunity for compassionate care in action.

2- Experienced developments in collegial relationships and collaboration with musicians

Through shared musical experiencing, healthcare professionals appear to experience developments in their collegial relationships. A nurse reflects:

> You are just all equal, you are doing it together. And I think that is what the music does; you become aware of each other's vulnerable sides because everyone joins in. [. . .] I also noticed this in the breakroom, because everyone, indeed, deals with [emotions] differently.

Equality and social-emotional connectedness are values both in participatory music-making (see Turino, 2008; Matarasso, 2019) and patient-centred care (see Youngson, 2012; Lases, 2017). Thus, reflecting upon colleagues' emotional responses to music with compassion can be considered feeding into the cultivation of a relationship-focused care culture. Additionally, through shared musical experiencing, healthcare professionals can begin to consider musicians as cultural allies for achieving patient-centred care. A coordinating nurse explains:

> And even if as nurses, we don't have the time to join the patients while they're listening [to the music], you do think: 'Who's at the patient's bedside?' And that is a really good thing as well. [. . .] the patient indicates what he or she wants to hear and then, [the musicians] make up something on the spot. So, at that moment, the patient is the leader. The patient says: 'Jump', and the musicians ask: 'How high?' That also gives a sense of leadership; that [the patients] are 'running the show', and

> I think that it is very good for them. They finally get to decide something. That is, I think, the greatest advantage of the improvisations, that at that moment, the patient is in charge; that they get to choose.

This reflection shows explicitly patient-centred care principles being reinforced through the music-making. It appears that musicians can help to reinstate the balance of control and autonomy in the patient's experience of hospitalisation, which is central for achieving patient-centred care (see also Youngson, 2012). Moreover, the reflection above exemplifies how nurses can begin to value person-centred music-making as a contributor to the patient's social well-being when nurses' job resources for contact with patients are limited.

3- Experienced developments in working culture and professional performance

Moments of enhanced connectivity

The reflected-upon experiencing in the MiMiC-practice seems to touch upon a deeper level of compassionate care beyond utilising music as a catalyst for contact in the care delivery. It resonates with the concept of *fellow humanity* (see Van Heijst, 2005). A nurse reflects in a group discussion:

> You get something more to share, you could say. Except for 'You are a patient, or you are a nurse', but at that moment we are all people who are talking about music. [...] Something besides the hospital, the illness, the pain. I found it nice that one gets just a bit more of a human relationship instead of 'nurses and doctors.' [...] You begin the conversation about the music and not immediately about the condition.

The awareness of the humane care values emerging through the musical interactions supports the understanding of participatory person-centred music-making as a social change agent

in the hospital care. Here, the notion of healthcare professionals acting as "caring human beings first" (see Youngson, 2012, p. 92) manifests in practice. Furthermore, the recalled moments of fellow humanity through music-making seem to bring about a sense of fulfilment and joy, as described by nurses in a group discussion:

> Nurse 1: *You are with your patient. You can observe what [music] evokes in your patient, but it is also for yourself; you listen, and you can act upon it. If someone gets emotional, then you can do something about it, you can respond to it. I find it wonderful.*
>
> Nurse 2: *It gives me joy.*

The described responsiveness and acts of kindness resonate with the definition of compassion (see Ricard, 2013), which, in the last statement, "it gives me joy" also links to the concept of *sympathetic joy* (Jormsri et al., 2005). Sympathetic joy, the rejoicing for the well-being of others (Jormsri et al., 2005) can serve as an emotional resource for the occupational thriving of healthcare professionals (Jormsri et al., 2005; Scarlett et al., 2017). In many situations, the experienced sympathetic joy is connected to the artistic processes of person-centred improvisations, which are made specifically for patients in the moment. A coordinating nurse details in an interview:

> As I said, it's very nice to hear [the improvisation]. [...] especially also to see the patients' faces: 'How do those people enjoy themselves?' And I think that is fulfilling for the healthcare professionals, you could say.

Similarly, receiving recognition as a care professional through person-centred music-making can evoke personal fulfilment and satisfaction at work. A nurse reflects:

> It was quite fun, too, because [the musicians] made an improvisation about what kind of a nurse I am. And the patient replied with one word: 'enthusiastic.' And then, they improvised around that word. I could not help laughing, because I recognised it immediately. The piece was so fitting and so much like the word [the patient] had chosen. And [the patient] was looking at me like: 'how is she going to react?' But I liked it immensely because I really recognised how I am like that sometimes. [...] It brought me happiness. I loved it that it became a piece of us two together. And that [the musicians] brought me closer to that patient. And naturally, it is so special that a piece is made just for you.

The reflections on the experienced social-emotional contributions person-centred music-making can bring to the care relationships, namely catalysed contact, sympathetic joy, and job satisfaction, are also seen as factors for creating social change in the healthcare culture. A social worker proposes:

> Having live music regularly would really soften up [a ward]. Especially a surgical ward, [where] the workload is so heavy. [...] It also brings you back into the moment. And maybe by being in the moment, you go out of the autopilot mode of simply continuing with what you were doing. [...] But with the musicians, you are actively listening, and then, you are in the 'here and now'.

This account aligns with Youngson's (2012) call for taking time for *presence-care*: "It's a paradox: if you don't have enough time to care, slow down, stop rushing, and pay more attention" (p. 17).

Reconsidered professional stances

The participatory musical processes of the MiMiC-practice can provide new insights into the patients' personhood, which otherwise might not surface in daily care. In one account, the

relationship between a patient and his nurse was strained, as the patient had behaved coldly towards the nurses. He did, however, respond warmly to the musicians' approaches to person-centred improvisation about things that were dear to him, namely, his life at the farm he missed. The coordinating nurse, who observed the music-making, reflected later:

> I think [the music sessions bring] more understanding of each other. I think that is the most important thing. For example, when a patient is really grumpy and closed up during his stay in the hospital. Then sometimes you think: 'Must it be like this?' But if you then hear the history behind it, which comes out through the music, then you often hear stories of the patient, and you think: 'Yes, I can put it in perspective; why this happens like this.' [...] The man was just homesick for his farm. He just missed his cattle. And that emerged now, [through] the music. And before then, he did not speak about it. Then, he was just only angry and grumpy and cursing, and so on. [...] That is what I have learnt. We often approach it like: 'It is probably someone's character'. But that is not always it. Just look: If you have experienced something terrible, or if you are really homesick, then you can also react quite differently. Then you are different from who you usually are. I also notice it within myself.

The new social understanding through the emerging insights into the patient's personhood through music-making can inform healthcare professionals about how to relate to their patients with compassion, as reflected above: "I can put it in perspective." Furthermore, the new understanding can stimulate critical reflection and reconsideration on the taken-for-granted assumptions about patients by nurses, as pointed out above: "We often approach it like: 'It is probably someone's character'. But that is not always it." Benner (1984) and Ten Hoeve (2018) note that collective sets of assumptions guide nurses' behaviours and decision-making in care, but as the

interview data above suggests, certain assumptions about patients may be flawed. Thus, the new catalysed contact with patients through person-centred music-making may facilitate a new compassionate stance towards the patient.

Intimacy and emotional vulnerability

Intimacy is a shared characterisation of person-centred music-making by various healthcare professionals. A nurse describes in an interview: "The room feels smaller, you get closer to each other." Another nurse adds: "Very intimate. [...] It evokes something in a person." In the intimacy of live music-making, healthcare professionals may be confronted by emotional vulnerability through becoming touched by the music and witnessing patients' emotional responses to the music. To keep the professional front intact (see Goffman, 1959) in front of the patient, some healthcare professionals feel the need to practice impression management by distancing themselves from the situation. A coordinating nurse describes:

> Then you step outside for a moment and distance yourself. And then, the feeling goes away and you think: 'Okay, I'm fine now.' It is just that little moment where you think: 'Yes I am feeling something, too. Yes.' I think that that's allowed. As long as you don't weigh it on your patients.

The tension between allowing emotions to surface while striving to manage a professional impression can be challenging in musical situations. Yet, Benner (1984) reminds that caregiving is about being with the patient rather than *doing* something *for* them, and *'being with'* involves one's emotional self. Through reflection, it seems possible to find a way to cope with the tension between emotional expression and impression management. A coordinating nurse explains:

> We are people as well, of course, and we feel a lot about things, as well... And I think it is a good thing to acknowledge that. As I said before, one piece of music really moved me. And then you think, 'Why does this move me? Oh yes, that's

> why.' You are a human being. It's allowed. And sometimes it's like, 'Darn, does this have to be now?' But for me that's okay. [...] you can say to someone 'This is really difficult for me now.' Sometimes you talk about it, and things surface of which you think: 'How should I deal with this?' And then you can say 'Gosh, I don't really know how to respond right now. This is difficult for me, too.'

This final reflection suggests that through reflection and practicing self-compassion, healthcare professionals' involvement in the music sessions can evolve in a way that is not threatening their management of a professional impression. Rather, nurses may learn to self-regulate between professional performance and emotional vulnerability, as shown in the fragment above. This way, presence-care (see Van Heijst, 2005) can be achieved in musical situations. This last notion is important for maintaining the openness of the person-centred approach to music-making: both musicians and healthcare professionals engaging in emotionally intimate shared musical moments with patients as they emerge.

Conclusions

Participation in the MiMiC-music practice can catalyse new social contact between healthcare professionals and patients, providing opportunities for displaying compassionate, patient-centred care. The shared participatory musical experiences allow healthcare professionals to see new, often emotionally vulnerable, sides of their patients. The new knowing of patients' personhoods can help healthcare professionals to respond better to their needs. New insights seem to emerge particularly through the processes of person-centred improvisation which are often connected to the patients' biographies.

Furthermore, seeing new sides of patients allows healthcare professionals to examine their sets of assumptions about patients critically. Through reflection, the catalysed new knowing about patients can lead to the care relationship to develop. Similarly, healthcare professionals

may see new sides of their colleagues through witnessing their responses to music-making, which can evoke new social-emotional connectivity. These findings align with, e.g., Finnegan (2012), Hesmondhalgh (2013), and Matarasso (2019).

By gaining familiarity with person-centred music-making, healthcare professionals may begin to perceive its principles—presence, and respect for the patient's unique needs—as *shared values* in both musicians' and healthcare professionals' professional practice. In particular, musical processes focusing on supporting patients' agency and autonomy, such as asking patients to conduct the musicians or to initiate a theme for an improvisation, seem particularly resonating with the principles of patient-centred care (see also Kitwood, 1997; Youngson, 2012). Subsequently, when slowly becoming recognised as *cultural allies* for achieving patient-centred care, musicians' artistic interactions with patients can become seen as supporting compassionate care delivery, particularly when nurses have limited time to be present with their patients. These processes of *growth* (see Dewey, 1938) are underpinned by collaboration between healthcare professionals and professional musicians in an emerging community of practice (see Lave & Wenger, 1991).

Furthermore, the recognised shared values of person-centred music and patient-centred care become an important validation for the relevance of music sessions in hospital wards. As Dewey (1916) points out, hesitation and doubt are typical when faced with an unfamiliar learning situation. Yet, support from colleagues, who can be seen as *old-timers* (see Lave & Wenger, 1991) in the music practice, plays a crucial role in facilitating the growth of engagement among more doubtful colleagues. Such proactive display of support, in itself, can be considered as a manifestation of compassionate care (see Ricard, 2013).

Finally, as proposed, participatory music sessions build upon moments of focused presence in the moment, which resonates with the central values of patient-centred care (see Benner, 1984; Van Heijst, 2005). Presence in the music sessions allows healthcare professionals to

feel more socially intimate with their patients, which can evoke intense feelings of fulfilment and *sympathetic joy* (see Jormsri et al. 2005). Yet, these moments can pose a challenge for allowing oneself to become emotionally moved by the music-making. In some situations, keeping the *front* of the professional performance (see Goffman, 1959) intact by distancing oneself from one's emotional responses to music is considered necessary. However, being emotionally present in the music sessions does not equal empathic suffering (see Bloom, 2016), as the music-making is not focused on feeling the suffering of the other, but on *engaging* in the social and artistic processes *beyond* the physical condition. In such shared moments, opportunities for compassionate acts of care emerge.

Being present asks the care professions to find ways to self-regulate between emotional vulnerability and impression management (see Ricard, 2013). Through reflection, a balance between emotional responsiveness and professional impression management can be found. Interview fragments, e.g., "Then I can combine the care with music" and "I allow myself to feel as long as I do not weigh my patients down with it," can be considered as accounts of such experiential learning. The subsequent small cultural changes in care can be viewed as a part of a broader discourse on the humanisation of healthcare (see also Bouteloup, 2010; Youngson, 2012).

Discussion

The findings add to the discourse of professional musicians responding to the challenges of ageing societies. With healthcare sectors operating under growing pressure and a mounting body of research suggesting that cultivating a compassionate culture of patient-centred care can positively contribute to the job resources of healthcare professionals, the small social changes catalysed by person-centred music-making on the quality of care should be recognised as cultural resources for supporting healthcare. When considering person-centred music practices as

a cultural ally for patient-centred care, the perspective of participatory arts supporting value-based healthcare can be introduced into policymaking discourses.

The findings on healthcare professionals' experiential learning through person-centred music-making should be considered a modest, nevertheless significant, supporting element of cultivating compassionate care culture rather than being painted as a solution to the multi-faceted problems creating emotional fatigue and detachment in the healthcare workforce. Regarding the processual nature of experiential learning, early familiarisation with participatory music-making can support healthcare professionals' overcoming of initial hesitation about live music in hospital wards more effectively. Additionally, the value-based connection between person-centred music and patient-centred care needs to be addressed in music and nursing education. In conservatoires, professional musicians need specialised training for delivering person-centred music to patients in various healthcare contexts and connecting with healthcare professionals (see also Smilde et al., 2019; De Wit, 2020).

Regarding further research, *sympathetic joy* (see Jormsri et al., 2005) evoked by musical interactions appears to contribute to personal feelings of fulfilment and satisfaction at work. Yet, sympathetic joy has not yet been sufficiently researched, although "it would seem like a pressing topic for those with an interest in other-regarding affect in general and altruism (benevolently other-regarding) emotions in particular" (Royzman & Rozin, 2006, p. 82). Sympathetic joy has been taken into account as a part of compassion cultivation in a new international research project *Professional Excellence in Meaningful Music in Healthcare (ProMiMiC).*[6] ProMiMiC (2019-2023) is a research project which explores interprofessional learning processes and collaboration between musicians and nurses, between musicians and music therapists, and the increase of compassionate skills of nurses within the live music practice Meaningful Music in Healthcare (MiMiC). The data collection in the four partner locations is ongoing, including mix-methods research into nurses' compassionate skills development in the MiMiC practice.

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Notes

[1]Patient-centred care has become a cornerstone of a value-based healthcare policy discourse for measuring healthcare quality (Youngson, 2012; Ryan, Kinghorn, Entwistle & Francis, 2014), as it stands as a cultural opposite for the "routinization, standardization and cost-cutting" of healthcare (Kitwood, 1997, p. 115)

[2]Given the need for tailor-made musical encounters, MiMiC-musicians are experienced improvisors, facilitators, ensemble players, and arrangers of compositions, which are played by heart. Suitable instruments for the MiMiC practice are portable ones, such as strings (violin, viola, cello, and double bass) and woodwinds (e.g. flute and clarinet). Dons, Pyykönen, and Hendriks (2017) specify: "The choice of instruments is very important. Ideally, there are one or two instruments with a bass range and one or two with a higher range for a more melodic role or a middle voice. It is important that the musicians as a trio are able to vary the timbre and harmony sufficiently" (p. 8)

[3]Research group Lifelong Learning in Music belongs to the Research Centre Arts & Society of Hanze University of Applied Sciences Groningen. The research group Lifelong Learning in Music aims to contribute to musicians' professional development and learning, so that they can learn to connect to various societal contexts and fulfil their roles as socially-engaged artistic and entrepreneurial professionals (Research group Lifelong Learning in Music, n.d.)

[4]The UMCG, which is one of the largest hospitals and medical employers in the Netherlands, has a particular clinical, educational, and scientific interest in healthy ageing (UMCG, 2010). Thus, it has focused on developing a patient-centred care approach for supporting the well-being of older patients (UMCG, 2010)

[5]A community of practice, which creates a social fabric of learning, consists of four elements: meaning (connected to experiencing life), practice (the social frameworks sustaining engagement), community (social belonging), and identity (learning processes of becoming) (Wenger, 1998, p. 5)

[6]ProMiMiC is led by the Research group Lifelong Learning in Music of Hanze University Groningen. Partners in the project are University Medical Center Groningen, Research group Nursing Diagnostics of Hanze University, Royal Conservatoire in The Hague, Haaglanden Medical Centre The Hague, University of Music Performing

Arts Vienna, Allgemeines Krankenhaus Vienna, Royal College of Music / Centre of Performance Science London, Chelsea and Westminster Hospital London, and Foundation Mimic Muziek. The project is co-financed through the RAAK-Pro programme of Regieorgaan SIA, part of the Dutch Research Council (NWO) (Research group Lifelong Learning in Music, n.d.).