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Cover Page Footnote

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Laurie Sadowski, *Wilfrid Laurier University*, sado4180@mylaurier.ca

Abstract

Background: Though there are similarities to music therapy, the field of community music in healthcare, while in its infancy, is steadily growing. **Objective:** This case study explored how semi-formal, active music-making can play a role in illness and recovery and provide patients with a sense of voice, connection, and community, and the efficacy of community music programming in a hospital. **Methods:** Six participants began and three participants completed a 6-week music class learning the ukulele. Interpretative Phenomenological Analysis (IPA) was used as a method for data analysis from semi-structured pre-questionnaires, transcribed classes, transcribed post-interviews, and weekly questionnaires from both the participants and the facilitator. **Results:** Emergent and recurrent themes central to the participants' experiences were discovered: (1) Music as a connector, (2) Music within us external to cancer, (3) Musical experiences interrupted by cancer, (4) Music creates empowerment. Subthemes and individual experiences are also explored. **Conclusions:** Implications for future research and music's role in improving the Patient Experience in hospital settings are discussed.

Keywords

Community music, patient experience, cancer, musicking, patient-centered care, patient engagement, qualitative methods, quality of life

Introduction

When the therapeutic value of music is understood and appreciated, it will be considered as necessary in the treatment of disease as air, water, and food.” – Eva Augusta Vescelius ^{1(p376)}. Even more than a century after Vescelius, a musician who understood the healing power of music, founded the National Society of Musical Therapeutics, the value of music in healthcare settings is still growing in understanding and appreciation. The increasing number of societies, conferences, journals, and academic programs supports the merit of music and health activities. Many of these centre on music therapy or music medicine, while community music, also tied to health and wellness, is under-recognized for its value and underutilized in healthcare settings

Definitions

The growth of using community music in healthcare settings is dependent on understanding the different ways music and health currently interact. Music therapy (MT) emphasizes the therapeutic relationship between certified music therapists and their clients, focusing on positive psychological or physiological benefits using active or passive approaches.² Music medicine (MM), linked to MT, but disengaged from community music (CM), allows healthcare professionals to administer a passive musical interaction to patients, such as playing recorded music

during medical procedures, measuring outcomes through physiological changes.³

Defining CM lacks the clarity of MT or MM. This, however, does not lessen its worthiness of a rich field of study, but instead, enhances it. Veblen⁴ calls CM a “tapestry”, one that is “multifaceted” and “fluid”.^(p1) It provides equal opportunities by musicians for non-musicians for active and creative participation in music can occur anywhere, with the root of intention to increase access outside of conventional music settings and provide creative expression in an active environment.^{5(p31),6(p53)}

Considerable discussion is growing between CM and its link with health and MT. To help address this link, discourse surrounding community music therapy (CoMT) and health musicking has greatly increased in the last 15 years. – The term *musicking* was coined by Christopher Small, suggesting that music is a process (verb), not an object (noun).²⁰ While these topics are far too extensive to detail in this paper, the following overview provides an understanding of the state of the field.

Many researchers were among the first to detail MT's convergence with CM.⁷⁻¹¹ More recently, Stige, Ansdell, Elefant, and Pavlicevic¹² defined CoMT as “a broad perspective exploring relationships between the individual, community, and society in relation to music and health”.^(pp15-16) Ansdell and DeNora¹³ and Stige and Aarø¹⁴ specify the facilitation of CoMT is by a trained music therapist.

Stige¹⁵ coined the term *health musicking*, which has been explored in relation to both MT and CoMT.^{16,14} Bonde's¹⁷ deeper analysis describes health musicking as "any use of music experiences to regulate emotional or relational states or to promote well-being, be it therapeutic or not, professionally assisted or self-made".^(p121) MT and CM also link with music education and everyday uses of music,¹⁸ which further blurs MT's boundaries. However, it is in exploring these boundaries that will allow professionals to grow in their respective fields.

Nevertheless, does making music in a hospital setting require skilled music therapists and classification as MT? Aigen¹⁹ suggests broadening CoMT's spectrum, which seems to coincide with the concept of health musicking, to include four main areas of practice: (1) traditional MT, (2) CoMT, (3) therapeutic CM, and (4) CM. It is (3), therapeutic CM, where the project described in this paper finds relevance, using Aigen's description as a basis: "musicians who are not professional music therapists, but working in health-related contexts that music therapists traditionally inhabit, such as hospitals and hospices".^(p121)

This paper provides a detailed look into the lived experience of participants using CM principles in a hospital. This approach prioritized (a) creating a positive musical experience (b) in a non-traditional setting (c) using active participation (d) with an accessible, safe environment. Both Aigen's "therapeutic CM" or Bonde's "health musicking" can extend the CM definition for an understanding of this and future research using CM in a healthcare setting.

Focus of This Article

This current project explored the use of a CM-based intervention in a cancer centre at an Ontario hospital. At present, a guiding principle in many cancer centres, particularly in Canada, the United States, and the United Kingdom, is the Patient Experience, defined as "the sum of all interactions, shaped by an organization's culture, that influence patient perceptions across the continuum of care".^{21(p1)} In other words, patients' experiences directly affect quality improvement measures.^{22(p12)} The cancer centre for this project has a significant interest in enhancing the Patient Experience. In the past year, multiple projects, including the development of a Patient Family Advisory Council, have underscored this interest the cancer centre's current mandate of meeting the needs of all patients before, during, and after the cancer experience.

Patient-centered and whole person healthcare methods separate the presence of disease (signs and symptoms) from the illness (feelings, ideas, personal experience).^{23(p41),24} An important component of treating the whole person is that "the fact of a disease being

incurable does not preclude an intervention having a beneficial effect on a patient's experience of illness".^{25(p178)} Having music within a Patient Experience program can assist in fulfilling areas of patient engagement, education, technology, caregiver and patient support, and improved equity, all priorities of this and existing cancer centres' goals (as outlined in Cancer Care Ontario).^{22(p27)} Music classes can engage patients, songwriting can grow medical students' knowledge, mobile apps can ease at-home coping, caregivers and patients can come together in a choir, and music-making can improve psychosocial oncology. These suggestions do not account for previous music and cancer research, which includes a wide variety of outcome measures and specialty areas. Music has been used to decrease anxiety,²⁶⁻³⁰ enrich quality of life,³¹⁻³³ improve sound environment,³⁴⁻³⁶ lessen side effects,³⁷⁻³⁸ improve mood,³⁹⁻⁴⁰ decrease need for anxiolytic drugs,⁴¹ and improve pain management.⁴² This is not an exhaustive list; there are numerous systematic literature reviews of music and cancer.⁴³⁻⁴⁶ While these studies are valuable, many use MT and measure physiological and psychological outcomes. Programs that do employ CM principles are growing, and rightly so: it can complement therapeutic approach to offer rich data in improving the Patient Experience through engaging patients from a humanist perspective.

Accordingly, this project is phenomenological-based in both method framework and analysis. This reflects Van Manen's⁴⁷ reflective, iterative, inductive approach exploring the lived experience, uniting the idea that since human beings are complex, so is their experiences.^{48(p321)} By espousing Interpretative Phenomenological Analysis (IPA), this project goes beyond current presented data and aims to explore qualitative, personal lived experiences of music in a hospital setting. IPA examines "how people make sense of their major life experiences",^{49(p1)} focusing on all parts of the lived experience of reality and what the researcher can discover. This double-hermeneutic—the researcher attempting to make sense of what the participant is attempting to make sense is happening to them—immerses the researcher directly into the experience in order to understand the experience of the participants to explore their physical, emotional, and intellectual self.⁵⁰

The phenomenological method and IPA highlight the use of CM in a cancer centre and its viability in enhancing the Patient Experience. Through a six-week ukulele class, data was obtained through field notes, questionnaires, and interviews, addressing the following research question and objectives: (1) Can semi-formal, active music-making play a role in illness and recovery? (2) How will music-making provide cancer patients with a new way to view themselves during their illness? (3) Will an accessible musical experience result in effective community music programming? (4) How can we increase patients' social

and personal well-being, and provide them with a sense of voice, connection, and community?

Methodology

Overview

The present project investigated the experience of cancer outpatients currently undergoing chemotherapy taking part in a ukulele class at a hospital in Ontario. The Research Ethics Board at Wilfrid Laurier University and the hospital where the project took place both provided ethical approval. At the time of the project, the researcher was not a hospital employee, a Patient Education Specialist (Advance Practice Nurse) served as the Locally Responsible Investigator and reviewed all protocol.

The ukulele class used CM principles, focusing on the experience of learning music in an accessible manner. The goal was to investigate the participants' experiences and test the viability of similar future programming, with expectations of providing some form of respite from illness.

The primary facilitator (hereafter referred to as "facilitator") is a professional musician and recreationist specializing in music at a long-term care centre. He approached the class using the goals outlined by the researcher, and worked with the researcher in creating a handbook for the participants' use. The researcher assisted with facilitation, though not serving as the facilitator to allow for taking part or writing field notes.

The program consisted of six weekly, 90-minute classes in a meeting room after hours in the cancer centre. The sessions were semi-structured, with flexibility as a response to the participants' preferences, and focused on music-making and group interaction. Sessions involved learning the parts of the ukulele, tablature, and songs, both from the handbook and by rote. The participants could keep the handbook, and given a ukulele for use in class and at home for the duration of the program.

Participants

Recruitment involved a convenience sample from outpatients waiting for or receiving chemotherapy. The researcher approached patients and posted an invitation at the front desk. Eligibility included English-speaking patients currently receiving chemotherapy able to attend all sessions (barring unforeseen circumstances). Recruitment concluded within two days. Six participants were recruited, a number requested by the facilitator to provide participants with a fulfilling, connected experience, and supported by Thomas and Pollio's⁵¹ recommendation of six to 12 participants and Creswell's⁵² suggestion of "as many as 10"^(p26) individuals for similar research methods.

The group included four women and two men, ages 53 to 78. All participants signed a consent form, which included project information and purpose, declaration of consent, potential benefits and risks, confidentiality (including the use of pseudonyms in all analysis and publications), and contact information. Participation was on a voluntary basis and patients could withdraw from the project at any time.

Data Collection

After signed consent, the researcher asked participants a variety of closed and open-ended questions about their current relationship with music and goals for taking part. Participants also filled out weekly questionnaires, exploring positive and challenging moments in their learning process. The researcher took field notes during each class, which included comments on body language and facial expressions, and what to listen for when transcribing. Each week, the facilitator debriefed with the researcher, and provided a detailed follow-up questionnaire with observations. After the final class, one-on-one, semi-structured post-interviews occurred between the researcher and each participant. All post-interviews lasted approximately 60 minutes, ending when material repeated itself and no new information was obtained. Audio recorded classes and post-interviews were fully transcribed, and pseudonyms were used in all materials.

Three participants withdrew from the project. One did not attend any sessions, a second participant withdrew after the first class, and a third participant withdrew after the third class. The latter two participants agreed to have their completed questionnaires included in the data material. Table 1 summarizes the total of data collection materials from the participants. Other materials included the facilitator's questionnaires and all transcriptions and field notes.

Data Analysis Aims and Approach

The phenomenological method and IPA allowed for a detailed exploration of the participants' experiences. Using Smith and Osborn's⁵³ recommendations for data analysis, the first stage involved listening to the recordings and reading the transcriptions, field notes, and questionnaires multiple times, annotating points of interest. The next stage was to re-read all materials, documenting emergent themes, and then listing emergent themes for each participant. This included extracting quotations and context from the materials. The next stage looked for recurrent themes, clustering them on a single list and seeking overarching, main themes. All emergent themes from the participants were categorized into main themes, even if these themes only occurred in an individual participant. Lastly, the researcher reviewed findings with the Patient Education Specialist for accuracy.

Table 1. Participant Information

Pseudonym	Length of participation	Data collected
Heidi	Did not attend	Pre-questionnaire (PQ)
Greg	Week 1	PQ, Week 1 questionnaire
Lucy	Weeks 1 to 3	PQ, Week 1 to 3 questionnaires
Marie	Weeks 1 to 6 **	PQ, Week 1 to 6 questionnaires, post-interview
Jenn	Weeks 1 to 6**	PQ, Week 1 to 6 questionnaires, post-interview
Moyer	Weeks 1 to 6**	PQ, Week 1 to 6 questionnaires, post-interview

Note. ** Indicates participant completed the project

Table 2. Main Themes and Subthemes

Main Theme	Subthemes
Music as a connector	Connection in personal relationships Connection in social relationships Connection between the participants and the facilitator Connection to the environment
Music within us external to cancer	Music becomes a part of the participants Internalizing the sound of the instrument Difficulties in the learning process (not related to cancer) Positive emotions when playing the music or listening to music Music can provide companionship
Music experience interrupted by cancer	Cancer directly impacting the experience Cancer indirectly impacting the experience Increased empathy for others
Music as empowerment	Participants had the choice to take part and learn something new Increased level of confidence

Results

Four main themes with multiple subthemes emerged from the data (Table 2). These themes and subthemes are detailed below, with selected quotes to further illustrate the data.

Theme 1: Music as a connector

Connection in personal relationships. Each participant expressed during class, in the questionnaires, and in the interview, that taking part gave them a topic of discussion with family and friends outside of their illness.

- Greg: “My son plays the guitar. I want [learn the ukulele] to be able to jam with him.”
- Moyer: “I can’t wait to tell the boys I was learning *Mary Had a Baby*.”
- Jenn: “I even had my husband play a few [songs] with me.”
- Moyer: “[My kids] thought it was cool. [...] They said, [...] Dad, you could have showed us two notes.”
- Jenn: “If I play this, the notes here, will [my granddaughter] be able to play the same thing on the guitar?”

In week 4, Jenn’s granddaughter joined the class, which boosted confidence levels and enthusiasm in the group, as they vied to show the granddaughter their abilities.

Connection in social relationships. Participants had the shared experience of cancer, but they also shared the experience of collectively learning something new, which drew them to taking part. The connection between the participants was immediate, despite meeting for the first time in sessions. There was camaraderie and laughter, and concern and empathy for each other’s health.

- Marie: “I’ll learn anything if it involves other people. [...] I want to connect with others who have similar experiences.”
- Jenn: “[I miss] socializing and getting out. I need to do things. I can’t stay at home.”
- Marie: “How can you not have fun when you have someone like Moyer involved?”

Socializing was especially important for Jenn. She frequently asked the others about their lives (both related to and outside of cancer), and revealed in later weeks that her social outlets drastically minimized after diagnosis.

Connection between the participants and facilitator. The connection between the participants and facilitator was cyclic. They connected in multiple ways, calling him “motivating”, “enthusiastic”, “relatable”, “funny”, and “encouraging”, and followed his advice for engaging with the ukulele at home, such as leaving it on the couch to play during television commercials. Jenn, specifically, felt drawn to his kindness, saying in her post interview: “He’s a super guy. His parents should be very proud of him.”

In turn, the facilitator frequently mentioned his connection with the participants, both on a musical level during class, and on a personal level through talking about his own cancer experience. All participants said in post-interviews that they felt connected to him by his own cancer experience.

Connection to the environment. A pre-questionnaire question included: “How do you currently view the hospital?” A hypothesis of participants having a below-average experience came from anecdotal reports from patients and community members, as well as a comprehensive news investigation supporting the need for improvement in this and other hospitals.⁵⁴

Despite this, participants felt positive about their experience, but also expressed that taking part in the music class enhanced their current care, and music can improve the patient experience and the hospital environment.

- Marie: “Coming in for a different reason, and doing something fun simply makes the hospital a less scary place in general.”
- Jenn: “[Having music] is a neat program to have. [...] They should have more programs for people because you’re feeling bad. People are feeling bad. They need something that is upbeat. Some happiness.”
- Moyer: “I’m going to take [the ukulele to inpatient treatment] with me.”
- Marie: “If there are ways of opening up communities that feel natural and fun and related to the hospital, because you realize you’re there because you’re getting treatment of some kind, then that takes away people’s fear.”

As the staff at the cancer centre became knowledgeable about the project, the interest in incorporating music in other ways grew. Numerous staff members asked about developing a ukulele class for staff members, many attended a presentation of the projects’ results, and the position of Arts in Medicine Coordinator was created to facilitate further programming at the centre.

Theme 2: Music within us external to cancer

Music becomes a part of the participants. Before the project, four participants had no musical experience (outside of

listening to music), and two previously sang in choirs (but could not read music). It emerged during the first session that one latter participant, Marie, regularly played guitar many years ago, but did not realize how much she remembered until she started playing the ukulele.

Regardless of their level of musicianship, music became a part of all participants—seemingly without them knowing. Musical terminology was frequently used, such as when counting beats (“So you go 1, 2 and 3, 4, 5, 6... And then you start up again?”), learning chords (“The C chord is just putting that finger right there.”), finding hand positions (“Bar that [chord] down there.”), transitioning (“You just have to move down one, from the G to the C.”), showing others techniques (“For that [chord]? You’d go like this and it’s right there.”), or transposing (“If I transpose it, I can do it anywhere.”) Words and phrases like chords, frets, riffs, beats, downstrokes, and strum came naturally, even without formally learning the definitions.

Internalizing the sound of the instrument. Participants also regularly commented their growing awareness of the ukulele in daily life.

- Jenn: “You know, it was funny. Do you ever watch that show where people are going looking for houses? They were in Hawaii. And you know what they were playing in the background? The ukulele! And it was so funny, it was like, oh! Look what they’re playing.”
- Moyer: “I was watching the golf channel. [...] There was a guy with the ukulele and he was just going like that [*motioning playing*]. I was watching him move his hands. C [chord]... And then he was playing F [chord].”
- Marie: “[The biggest outcome of this is] just awareness of the ukulele. I had no idea it was Hawaiian, I didn’t know the music associated with it. I didn’t know the songs associated with it. I love learning new things of any kind, so this was an, oh, an area that I never had a clue about. So mostly just learning about something new that is good and fun.”

Difficulties in the learning process (not related to cancer). The musical experience was not without difficulty for all participants. When Greg withdrew in the first week, he lamented the “slow process” and that he was “not learning fast enough”. He explained this happened previously on the guitar: “My lack of patience probably was the cause of me giving up [after three lessons].”

Marie’s unfamiliarity with many of the songs also resulted in difficulty. The songs included Christmas carols and from well-known musicians, such as the Beatles, Bob

Table 3. Weekly Progression in Confidence, Ability, and Positive Outlook Among Participants

Week(s)	Quote demonstrating progression
1 to 2	<p>“My biggest problem is getting the beat.”</p> <p>“Where the heck do you put your fingers for these different notes?”</p> <p>“I’m too heavy fingered, I guess.”</p>
3 to 5	<p>“Oh, what a difference, eh? Wow!”</p> <p>“I’ve got my foot going.”</p> <p>“I’m excited, though. It’s just so nice.”</p> <p>“That’s helping. One, two, three, up. The “and”. The “and” helps.”</p> <p>“I get it now. That’s easier.”</p>
6	<p>“Thank you very much. This was a better class.”</p> <p>“I don’t think I want to stop.”</p> <p>“Oh, yeah. It did. It did [bring me happiness].”</p>

Dylan, Johnny Cash, and Simon & Garfunkel. Though still enthusiastic, she commented on this weekly. To help, the facilitator learned some of her preferred songs, teaching them to her during one-on-one moments each week.

Despite these difficulties, there was a clear line of progression in the confidence, abilities, and positive outlook in all participants. Table 3 demonstrates this growth.

Positive emotions when playing the music or listening to music. All participants who completed the project had a positive relationship with music before and after the classes. In the pre-questionnaires, they expressed their current relationship with music (“music gives me energy”; “I love music, it’s on all the time”). In the post-interviews, all participants said they would be continuing their musical experience in various ways. Throughout the weeks, they described their practicing at home with words such as “enthusiasm”, “cool”, “chills”, “absorbing”, “reminders”, “awesome”, “reinvigorated”, and “feeling at home”.

The participants also indicated music allowed for relaxation, giving them the ability to focus on the self in the midst of illness. Moyer’s growth in understanding this connection was especially significant:

I think it’s cool. And I couldn’t believe that—and other people have said that music relaxes you and calms you down and stuff, and I didn’t think, yeah, okay, sure. It was a little frustrating, but you know, if you just play certain things... It is. It is relaxing. It’s kind of cool. I wish I could have got better. But I’m not going to quit.

Music can provide companionship. While companionship can come from relationships, music can provide personal companionship, especially in a time of illness. Learning the instrument gave the participants something pleasurable

to focus on, as an indirect way to cope with their illness, and serving as self-entertainment.

In the first class, the facilitator suggested leaving the instrument out at home to provide more incentive to play. Moyer frequently mentioned this in class, demonstrating to the others his at-home arrangement. “It’s right there. It’s like this. Right beside my chair.” Marie said hers stayed on the coffee table as a “conversation piece”.

The participants prioritized this need for companionship. They rearranged schedules and asked for phone call reminders before class, and wanted classes rescheduled for their previous commitments. They also expressed adding to the research itself was important. As their lives changed in substantial ways, including leaving employment, moving from another country, spending less time socializing, and relying on spouses or children for assistance and support, the combination of an accessible class with an equally accessible instrument at home seemed to provide reprieve for their new life situation.

Theme 3: Musical experience interrupted by cancer
Cancer directly impacting the experience. Lucy struggled with her health leading up to her withdrawal from the project at week 3. Though she played consistently at home, it was frustrating for her not to feel able to participate fully, wanting to leave moments of wellness to prepare for Christmas. She asked to be included in future research, and “really wish[ed] this opportunity had been at a quieter time of year.”

Chemotherapy side effects also directly affected some patients. Fatigue and nausea were common, though infrequent, but pain impacted mobility and aggravated other symptoms, and treatment delays increased stress and discouragement. In the final two weeks, Marie wore hand braces to ease her pain, making it “hard to do anything with [her] hands at all.”

Cancer indirectly impacting the experience. Cancer indirectly impacted the musical experience when it caused issues with the participants' self-identity and emotions. While this did not directly affect their attendance, it likely influenced their mood, which may have altered their experiences.

There were also brief mentions of mourning diagnoses. Jenn was forthright, calling the experience a "rollercoaster". She continued:

I'm not saying I haven't had [sad] days because, sure, and you question, 'why did I get cancer? Why did my world come to a stop? I was working, why, why, why did?' [...] And, of course, you're going to have good days, too. So, you gotta try to pick up the good days and get rid of those bad days.

She explained she was looking forward to finishing treatment so she could carve herself a new life, even if modified.

Marie's experience involved moving from another country to receive treatment. "My life changed dramatically because I had to move here in the first place. It's definitely been a strain [...]. So that part of it has been difficult. So that's a big change." She also noted the stress from external pressure to finish treatment. "It just feels to me that people are a little less patient because I'm not longer a patient. They ask, 'Why aren't you here yet? Going back yet?'"

Moyer observed that pressure to socialize caused stress, finding that his friends' concern for his health resulted in wanting to spend more time with him. "All of my buddies call me... [...] All this nonsense with the hospital and everything else they all think I'm going to die or something, I don't know."

Roles also changed at home for all participants, primarily in the form of needing a caregiver for appointments, tending to catheters, and adjusting responsibilities. All participants had very independent lives before diagnosis, making this considerably new for each of them.

Increased empathy for others. This relates to the social connection described in Theme 1. Their connection in having cancer resulted in strong empathy for each other, evidenced in situations such as Lucy's withdrawal and a delay during Moyer's treatment.

In the post-interview, all participants expressed future plans to use music-making to give back to others. Marie surmised she would offer a class to students as an elective, Moyer asked about taking part in a CM experience, in or outside of the hospital, and Jenn wanted to "get good

enough" so she "could do something like [play music] at a hospital." They also requested to take part in future music-related studies.

Theme 4: Music creates empowerment

Participants had the choice to take part and learn something new. During pre-questionnaires, a goal of all participants was to learn something new. Frustration in the learning process was inevitable. After the first class, Jenn called the researcher, uncertain on her abilities, and, after encouraged to try one more class, was much happier with her experience. "When you first start something, you take it so serious, and you're thinking, *I have to play this, I have to learn this*, and you're putting too much pressure on yourself." Knowing—and being reassured—that there was no pressure made the process much easier for her to tackle.

A distinct shift in Week 3 coincides with Table 3's overview of the patients' progression through the weeks. Participants began self-learning, co-facilitating, and sharing their at-home successes. They were impressed with their abilities, and showing musicianship.

- Jenn: "We don't even know [those chords]. How can we learn that? Oh! Cause from there!"
- Moyer: "I learned a trick for the G. Like this."
- Marie: "I like the feel of it. I can remember the chords."
- Moyer: "I was showing her what you were doing... I was doing this. Look. Listen."
- Jenn: "Well, I guess [I am a musician]. I'm practicing."
- Moyer: "I would start playing. It was nothing, no song or nothing, all I had was C. I wasn't trying to get the G. I was just playing simple stuff. And it was kinda cool. I had something and I knew what to do with it."

Picking up the instrument and knowing "what to do with it" made the process enjoyable, rather than stressful.

Increased level of confidence. Having the choice to do something relaxing, trusting in their abilities, freeing their mind, and building their confidence were all associated with their musical experience during their cancer treatment. During and after treatment, cancer patients often feel as if they have lost a sense of self-identity.⁵⁵⁻⁵⁶ This class gave them a choice of something to do that, although related to their cancer experience, was disparate from making a life-changing decision in their treatment.

When asked about their biggest outcome of taking part, both Moyer and Jenn described this increase in confidence and knowing they could do something.

- Moyer: “The biggest thing is that I tackled it and that I can actually play a musical instrument.”
- Jenn: “More confidence. More confidence. Confidence in doing something different.”

Similarly, it pleased Marie to be reminded her knowledge of the guitar, saying, “it would take very little to relearn the progression of chords.” She also acknowledged she would likely start playing again.

Discussion

Principle Findings

These four themes demonstrated the role of CM in a healthcare facility. Music became a part of the participants, giving them a sense of connection and empowerment. Using a CM approach provided a therapeutic outcome for the participants, without requiring MT techniques. The participants’ experiences also allow for understanding in how music plays a role in illness.

Strengths, Limitations, and Retrospects

Combining various forms of data and using a phenomenological approach proved to be a strength of this project, resulting in rich accounts of the human experience. Ongoing discussion with the facilitator and Patient Education Specialist also reinforced analyses made.

While the decrease in sample size is a clear limitation of the project, the rich data from the participants’ experiences encourages repeating the project. The small sample, however, may have been a catalyst in the patients’ ability for a fully immersive experience, and a large group may have hindered the data. Future research will endeavor to have protocol to prevent less than six participants, and repeating the project multiple times will provide a larger overall sample size. A possible method in preventing withdrawals—such as Greg’s after Week 1—would be an invitation to still take part musically, but without the ukulele.

A second limitation stemmed from Marie’s recollection of her guitar abilities. As the weeks progressed and she quickly improved, there were two distinct ability levels in the class. The facilitator suggested that, in future studies, beginner students can start class earlier for additional practice.

Both a strength and limitation was having the classes over the Christmas holidays. Playing Christmas music provided a familiar form of musical engagement and, without

school, Jenn’s granddaughter could join a class. It was, however, part of the reason for Lucy’s withdrawal.

One retrospect would be to record details on declined invitations. The researcher made brief notes, however, specific notes could inform future studies. A second retrospect would be to collect further information from family members, caregivers, and staff on their interactions with the participant, though this would require numerous modifications in ethical approval and materials, and may be better suited for a new research question.

Recommendations

Phenomenological methodology is currently present in CM research and growing in MT research, however, few phenomenological studies explore CM in healthcare settings. This project has implications for supporting using music as a component of the Patient Experience and whole person healthcare, and the connection between music and wellness—while growing—remains undervalued in hospitals.

The musical impact for the participants extended outside of the classes. Weekly questionnaire data, as well as discussion in class, indicated all participants played the ukulele an average of three times per week, and over the weeks, feelings of relaxation and hopefulness increased, excitement and productivity were consistent, and frustration decreased.

This impact can reach past patients, and extend to caregivers and healthcare staff, by exploring musical experiences—either separately or combined—of all three groups. In her post-interview, Marie suggested having patients and staff together could increase the relationships between them. “Taking part [...] wouldn’t be based on anything. Not why you’re here. That relationship, between the patient/doctor—what does that become when you’re sitting in a music class together? It would move into a different kind of relationship.”

Future exploration can also improve the sense of community on many levels: between individuals, in specific parts of the cancer centre (e.g. the chemotherapy suite), in the cancer centre as a whole, within the hospital, and outside of the hospital. As the cancer centre and hospital become more efficient as a system, the Patient Experience needs to improve concurrently. Marie also commented on this after proposing the patient/doctor music class, inferring that better efficiency results in loss of relationships. “You know, maybe, by doing music together [...] that’s a way to improve it. I think that’s a great thing.”

Understanding the musical experience can also benefit educational practice. Having music electives in healthcare training—at the college/university level or as continuing

education for current staff—broadens the scope of knowledge and can increase the ways doctors empathize with patients, enrich communication modalities, and provide insight into individual differences or uniqueness.^{24,57} This will create a greater understanding for music's impact, allowing for the creation of dialogue and multiple disciplines working together in a fluid manner to enhance patient care.

Conclusion

Further investigation can identify how CM supports the Patient Experience. Longitudinal research will help find new avenues in progressively changing healthcare, and results of this research can inform the future of CM in both this particular hospital and other health contexts. This type of research is low cost, simple to execute, and can create positive change in multiple ways, particularly in the priorities of current cancer centres. These factors allow for an effective duplication for the project, resulting in a larger overall sample size from a clearly defined methodology and verify the validity of its worth in healthcare.

The findings from this project demonstrate that the positive experiences from a CM class for patients currently undergoing chemotherapy may conceivably be attributed to three main principles that unify the four themes: providing group social support, building a sense of connection and community, and giving patients a self-imposed option in their current care. These themes also revealed detailed information within subthemes, highlighting how using active music-making plays a role in illness and recovery, and can enhance the current Patient Experience.

After agreeing to take part in the project, the patients were thereafter referred to as “participants”. However, by the final week, the researcher, facilitator, and, most importantly, participants agreed: they could now also call themselves musicians.

Community music has a unique ability to present itself in multiple ways. This project prioritized creating a positive, accessible musical experience in the hospital using active participation, moving deeper into the principles of CM and linking to current research in CoMT and health musicking. As the convergence and research in CoMT, health musicking, MT, and CM continues to grow, the continuum of practice may further lack specific definitions. However, by connecting community musicians and leaders with healthcare facilities and/or utilizing musicianship of current healthcare staff, this valuable field of study can continue to grow and inform new ways of using music to improve the Patient Experience in hospital settings.

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