Orchestras in Health and Well Being

2026 National Conference

SARAH HOOVER: Good afternoon. My name is Sarah Hoover, and I am so honored to be here with you today, from another side of the city, at Peabody in Baltimore. I couldn't be more excited to have these wonderful people with me and to be able to share a lot of the work that we've been doing at Peabody with a group of folks who are curious about this work. So I'm going to go ahead, and can you all hear me okay? I'm trying to get the—yep, okay, great, thanks. I'm going to go ahead and get started here.

So, just a little bit about me. Before I came to do what I'm here to talk about today, I was a concert singer, recital singer, did a lot of chamber music and oratorio. I then got a DMA. I was also a teacher of singing, a studio teacher. I also taught music courses more broadly. I founded 501(c)(3), a community music festival, which is still going, called the Oyster Bay Music Festival. I came to Peabody in 2015, and I established our community-based learning programs. I began a long-term partnership with Hopkins Medicine faculty and staff to create four music programs within the Johns Hopkins medical establishment. I wrote a book, which was published in 2021, called Music as Care. The research that I did for that book all informed the development of our programs at Johns Hopkins. I've been very involved with developing curriculum and training pathways for both our conservatory students, but also music professionals.

[00:02:00]

Most recently, I have had the honor of working with Penny with a group from the National Organization for Arts in Health on a three-year workforce development initiative, and the paper that has resulted from that work, which is called "Advancing Practice in Arts in Health." So if you're interested in how artists can be trained and supported and how we can develop career development pathways for them, that would be a good resource for you.

So, okay, just a little humor for a second, because every speaker has to have something funny up at the beginning of their talk. This was the first time I made it into the New York Times. This was 2013 when, in my community music festival, we had somebody come and help carve instruments out of vegetables, and then we had our aspiring professional musicians play them. So we had a vegetable orchestra. So that's the first time I made it into the New York Times. This is the second time. This was an article that was published in 2025 in February about our music programs at Johns Hopkins Hospital. So you could say a lot has changed, but what I really want to tell you is that both of those activities were really about exploring new habitats and new ways of being an artist outside of the concert hall. Both of those have been explorations of how artists, especially musicians, can understand their

value and their relevance in context outside of the traditional classical music habitats. So, briefly, I run—

[00:04:01]

There are a lot of other things I run, but I'm not going to talk about those today, but for our Johns Hopkins music programs, there are two full-time staff, and we have more or less five part-time people, depending on how you count them. And we have an artistic staff of 19 student and professional part-time musicians. And our primary partners—I just want to put this out in front of the talk because the partnerships are so key to the development of this work. I wanted you to know what partnerships have informed our work. So we work very closely with the Office of Patient Experience, which is focused on literally making patient and guest experience more positive within the healthcare environment. We work with the Office of Well-Being, which is an internal Hopkins staff initiative to try to help support and retain staff and boost morale. We work with the Office of Spiritual Care, which is the chaplains who see patients all over the hospital. We have a partnership with the music therapists who work for something at Hopkins called the Center for Music and Medicine.

Our chief partners—nothing that we have done is possible without them. So I wanted to honor them, but also just let you know who they are. Before I get into today's presentation, I wanted also just to acknowledge the very fine work that was published last year in The Catalyst Guides, which focuses on our orchestras in health and wellness. I want to thank Karen for all the work that she and the other folks did on this really excellent resource. And from it emerged a number of themes which, if you read the Guides, you would be familiar with. But I wanted just to acknowledge that from my seat, as somebody who's been building work and training in this area, that all of these themes resonate for me in our context.

[00:06:10]

So the things that are on your minds are also on our minds at Peabody and Hopkins as well. So what are we going to talk about today? We're going to talk about the practical realities of designing and delivering music programs in health and well-being settings. We are going to talk about capacity, but especially hopefully helping you identify where your orchestra has the capacity to make a meaningful difference. We are absolutely going to talk about working safely and responsibly within healthcare environments with vulnerable individuals. We are going to talk about making sure that the musicians have the skills, knowledge, and clearly defined roles that they need in order to ensure that safety and well-being.

I've already mentioned partnerships, but we will also talk about creating strong interdisciplinary partnerships. And we will also talk about what training and supervisory methods and evaluation models are important for doing this work effectively. So first—I'm

sorry. I'm one of these people who, when I talk, I have to tell you what I'm going to say, then I have to say it, and I have to—sorry. It's just, I don't know. It's the teacher in me. So first, we're going to situate ourselves within the field of arts and health. Then we're going to talk about how music is integrated into healthcare. Then we're going to talk about how artistry can deepen and expand in doing this work. We're going to talk about the responsibility of assuming a duty of care, and then about developing empathy and connection, and finally about building collaborations and partnerships.

[00:08:00]

So we're going to situate ourselves first in the field of arts and health. You'll notice that there are a lot of sub-headings on this, and that's because this intersectional developing field is growing faster than any of our hair is growing, and so there are so many things going on, and the terms keep proliferating. It's exciting, and it's also confusing. We really would do well, and a number of us are going to be working on this in the near future, to try to see if we can coalesce around certain terminology, so that we don't divide and diffuse our ability to advocate for this work.

So those are a lot of the terms, but not all of them, that are currently being used for this work. I am going to draw upon the definition of the field of arts and health, found in the 2017 white paper, which you see here, which was a seminal white paper written by the National Organization for Arts and Health, a professional organization like this one. And the definition is "a maturing field dedicated to using the power of the arts to enhance health and well-being in diverse institutional and community contexts." That still is a defensible general definition of the field, and just to let you know also that it leans heavily upon the WHO's definition of health altogether, which is not merely the absence of disease, but "a state of complete physical, mental, and social well-being." So that is the kind of health towards which we strive.

So you may be aware of all three of these books, or certainly I think you're probably aware of Renee Fleming on the far right there. Renee Fleming's work with Francis Collins and the NIH's Sound Health Initiative has been really foundational to the development of research in the field.

[00:10:02]

Renee takes this work very seriously and put together a very strong book, a collection of essays by different experts, perspectives on music and the mind. My colleague at Hopkins, Susan Magsamen, and her co-writer Ivy Ross, wrote a very readable book, a high-level book on the power of art on the brain, really leaning into neuroscience. And the book I'd really like to recommend to you is the one in the middle. It just got published by Daisy Fancourt, who is

the leading researcher in the field of arts and health right now. She's at University College London. This is written for a general audience, and it synthesizes and distills and explains in common parlance the body of research backing the efficacy of the arts in health and well-being across multiple different contexts. So we're hearing a lot about this. There's a lot of momentum internationally. There has been quite a bit of expansion of both public awareness and funding sources, both in the philanthropic foundation area and also in science funding—but we know how that is kind of precarious right now. The advancement of the research base, we've really moved forward with some higher-powered studies. Daisy Fancourt's 2019 WHO report on what the evidence base is for the arts in health and well-being is one of the most downloaded WHO reports to date, a very strong scientific synthesis of the research.

[00:12:04]

The field of arts and health is, as we speak, professionalizing. Penny and I both sit on the Artists' Workforce Development Committee. We're deeply involved in creating codes of ethics, standards of practice, scope of practice, core professional competencies, all of the infrastructure for a very significant training platform and also moving towards certification for artists.

Arts prescribing. How many of you have heard of arts prescribing? Okay, that's actually pretty respectable. Good for you. Arts prescribing is very—If we're giving a talk on what's really new on the horizon, that would be the talk I would be giving you. Google arts prescribing. Look up Social Prescribing, USA. They're a reputable resource. Look up NJPAC, which is doing a lot of really interesting work in arts prescribing right now. The University of Florida's Center for Arts and Medicine is also doing some really powerful work. So essentially, it's being able to prescribe creative activity, nature activity, for social health and for management of chronic health conditions, and getting a script from your healthcare provider for these specific activities. Maryland is the next state to adopt social prescribing. It's happening in real time here. Yes, here. I couldn't remember if I'd gone to DC for a minute. Sorry. I'm in Baltimore. And then there is lots of energy right now around expanded training programs and resources for equipping artists in this area.

[00:14:02]

I already mentioned this paper before. The point of this paper is, in some ways, like the Catalyst Guides, to elevate and create visibility around the work of expert practitioners who are already doing this work, to really help distill down what excellence in this work already looks like, because we have those practitioners out there. It also intends to create developmental pathways for artists who are both new to the field and also advancing to look at what career architecture should look like in this field. So it provides a case statement, frameworks, and action steps for developing all of these things.

I'm going to be really brief about the evidence base, but I just want you to know that it is growing stronger every day on many different domains of health—social, emotional, cognitive, physical, and spiritual. In physical health, we have research that really changes the perception of pain and reduces the need for pain medication. It has efficacy in neurodevelopmental and neurodegenerative disorders, in addressing sleep issues, mobility and movement issues, balance and coordination issues, and also it has efficacy in palliative care. In mental health, we have the ability to address depression, anxiety, stress reduction, trauma, bereavement, dementia, cognition, attention, and motivation. But I think the biggest one that I want you all to think about is really what it does for social health. You may remember that our last Surgeon General, Vivek Murthy, wrote a beautiful essay on loneliness and social isolation. This is one of the chief health crises of our time. So anything that we can do through the arts to address loneliness and social isolation, as well as community cohesion, all of which are upstream drivers for more positive health outcomes.

[00:16:07]

Healthcare can influence staff retention, staff morale, patient experience, overall cost and length of hospital stays, all of which is music to the ears of hospital leadership. It can also help—I'm going to underline this one by coming in closer—it can help elevate their satisfaction scores, which go into their hospital rankings. So anything you can do to help them improve their rankings, they love.

In public health, increasingly, the arts are being used as a tool for health promotion, health education, and also to address the social drivers of health. A lot of stuff is going on. Okay, but when we talk specifically about music in healthcare, which is where I'm going to spend the bulk of my time with you all today, first, it would probably be no surprise to you that we can sort this activity into receptive experiences and participatory experiences. So on the receptive side, this is obviously the ability to experience art without actually participating in it oneself. So this could be attending concerts, events, or presentations, or listening to recorded or online music. And you all have a role to play in all of those things because you already do all of those things, right? You have the access to those sorts of things.

The other way that music can be experienced is by a musician who comes either room-to-room or on-unit or in a lobby space. So on the participatory side, when we're talking about active engagement or hands-on involvement, we're talking about music-making, either oneself, by oneself or with others.

[00:18:10]

We're talking about perhaps taking classes—there's a very interesting program in Chicago called Snow City Arts, which actually does music and art classes in an in-patient, long-term

pediatric hospital—or participating in workshops or collaborative composition. I want to just indicate that with both receptive and participatory music engagements there is research to support their positive impacts on health and well-being. The effects are stronger on the participatory side.

Okay, here are a whole bunch of examples of music in hospitals. You might want to take a screenshot of this one, just because this is kind of a random hodgepodge of things that could touch the kind of work that you do. But also, if you're doing work that is more organized and more long-term than this, just to say, you will be navigating around these kinds of activities. There's so much more I could say there. But there are potential collaborations there with your teams as well.

So in my book, this is the way I framed what a continuum of musical engagement looks like. So if you start on the left side and you move towards the right, you can see that on the bottom, there's an arrow indicating what type of skill and training is needed to facilitate or to engage in that activity. So it becomes progressively a more specialized practice as we move across.

[00:20:01]

And as you think about your own context, you can think about where the resources are that I already have. Do I have music therapists that I can partner with? Do I have experienced teaching artists who are already doing this sort of work? If so, I can extend pretty far to the right. But if what I have is mainly a core of performing musicians and maybe music educators and maybe community groups that are affiliated with my orchestra, community music groups, you'll want to be looking more on the left side of this. What I want to underscore about this continuum is that the contexts also go from less intimate to more intimate, so public space versus private room. That makes all the difference. All kinds of things that are not possible to do bedside with a musician who doesn't know anything about being bedside are possible in a lobby, because a lobby is a public space where people are free to go. If they don't like it, they can leave. But by the time you get to a patient room, it's a very different setup.

The other situation is that generally speaking, the people on the left-hand side are much less vulnerable and probably less sick than the people who are moving around in the lobbies. They might come in the lobby to enter, but then they are up in there where they're being cared for. Versus the other side where patients, everybody, family members—everybody is more vulnerable in that context. So we have to figure out ways that we can hold that vulnerability.

Okay, so just a brief drive-by. You know all this, I think, but I'm just going to, for the purposes

of being systematic about this, reiterate. If we're talking about music presentation, these are usually scheduled, publicized, drop-in kinds of things with a very informal format. They're usually placed in very visible, high-impact public spaces, usually at entrances. The audience might sit somewhere if there are a few seats around, but usually they just stop and stand for a little bit and then keep on going on their way.

[00:22:11]

They may be healthcare providers who only hear the 30 seconds that they hear as they're walking by, but you'd be surprised by what kind of impact that could actually make on them. Generally, these sorts of presentations feature a wide range of genres and styles of repertoire, so you can be as inclusive of the people who are within that environment. Small ensembles do better than very large, massed ensembles because the spaces are usually pretty tight, and the sound can be overwhelming. We would put the larger ensembles in a purpose-built theater kind of setting within a hospital or outside. And this may be a place where there's some holiday music, or other seasonal music. Environmental music is actually a practice we take very seriously at Peabody. And we've created a document, which I think I tried to link into our documents called "The Music for Wild Guidelines for Musicians." If not, we'll make sure we get that somehow to you. It's online, and it's just our best attempt to try to frame how you think about bringing music into a public space in a hospital.

The music is calibrated not to interfere with people's work that might be taking place in that public space or conversations or anything else that is taking place. And the acoustics are often super loud—air handling systems which got really jacked up during COVID and stayed jacked up, or beeps, elevators, security sounds, all that kind of stuff. They're designed to enhance experience in public and semi-public spaces. They're usually discoverable. They're like surprises. It's a little bit like busking, right? You turn a corner. We have this one place where you go up the escalator, and there's a little balcony up there that nobody ever sees.

[00:24:05]

And we put a singer on top of that. People just go like this, because they first can't figure out where it's coming from. It's like a beautiful surprise. Again, a range of styles and timbres are particularly important here, and a much more intimate number of performers. But environmental music can become responsive. On the far right you see the violinist there all alone, playing. And then people start to come into the space, and the violinist has picked up her head, and she has her eyes on those people, and she's starting to figure out how she can connect with those people.

Then we move towards responsive music. Our bedside music program really fits in this niche. So this is on-unit and bedside services, again a range of genres and instruments and

styles to be able to again meet the musical cultures of the people within the hospital setting as best we can. Short visits, very personalized, and always by obtaining consent. They can be interactive with both patients and staffs. We do a lot of supporting of staff through this program. And there is a high attention to safety, infection control, and privacy considerations here.

Finally, we go all the way to the far end, which is inclusive of music therapy but also of really specialized music practices where the musician actually steps back, and the two become co-creators of whatever the music is. I strongly encourage you to Google this video. It is one of the most heartrendingly beautiful things I've ever seen. It's from the University of Florida. Jamal Davis is waiting for a heart transplant. And Ricky Kendall is one of the bedside musicians.

[00:26:02]

And Ricky is in this facilitating Jamal's performance. Jamal can sing. It's outstanding. It's just beautiful. So in that way, it really is highly collaborative, and you're handing the reins more to the person in the room. You probably know that there are a bunch of very specialized micro-therapeutic musics. This is the list of all of them. They each have their own training and certification mechanisms, and they do very specific things with music. Their certification qualifies them to do the practice that is associated with their form of—so make sure, if you're going to hire one of these folks, that you understand not only their credentials, which are very sound, but also what their practice is, because that may or may not be something that fits with your identity as an organization.

Music therapy, I'm sure you know about. We do a lot of work as non-music therapists to clarify the distinction between what we do and what music therapists do. It gets really confusing. People just lump it all under an umbrella of music therapy, but we're not, because we don't have the training, we don't have the licensure, we don't have the credential. And mainly that training is in counseling. We are not counselors. We do not hold space for emotional processing. So we're moving towards an arts and health practitioner certified through NOAH. And this looks like—what might this look like? This looks like a proposed scope of practice where we move from less vulnerable at the bottom and move towards more vulnerable at the top, and less need for a credential, to more need for a credential.

[00:28:07]

You can read the paper to find out more about that. Also just a quick acknowledgement that there's lots of music for well-being beyond healthcare settings. And these are three different examples of it. So what does expanded artistry look like? These are the skills that a musician usually walks in with. Artistic excellence, technique, repertoire, playing by memory

and hopefully by ear as well. But then there are additional musical skills that are really key here: To be able to be very flexible with the musical structure, to break it down, songwriting, all the kinds of improvisatory work. And then the ability on the spot to adapt tempo dynamics and timbre are all critically important. But more than that, the other really key skills are interpersonal, empathy being first and foremost among them. The ability to remain present, to position music not as the main event but as support. To be able to be self-aware and to maintain proper boundaries. To read the room in a variety of different ways. These are essential. And I will tell you they can be trained. It's easier to find somebody who naturally does this, but they can be trained.

So I just wanted to highlight for you that we actually do decibel meter readings all the time to make sure that we're staying within—that's the NIOSH sound level meter app that you see there. And we use that, just to make sure that we're not playing too loudly. These are some beautiful quotes from some of our artists who are doing this work professionally, and what it gives them. I'm sure you are aware of the artists. If you have artists that are working in this area, it can be tremendously personally rewarding for them.

[00:30:00]

Another one, it's moving beyond music being an athletic feat and really getting into a space where somebody has said they want you there to make music and allowing that to be true and to break down that performer-audience barrier. We train this. I'm actually in the middle of my training week, so I will be leaving here to go right back to our training. If you're ever interested in our week-long intensive, it's called the Power of Music in Healthcare. The duty of care. It's so important that we understand what patient and staff experience is. This is a little info graphic made at Johns Hopkins. These are the chief emotions that patients reflected back in this particular gathering, and this is staff. So everybody's having a hard time.

And it's also a highly regulated environment. You've got infection control and safety that you must deal with. You've got patient privacy and HIPAA concerns that you must address. And then the hospital has its own regulations and requirements in terms of how you dress. You can't take tips. That kind of thing, right? So you have to understand the regulatory environment within which you're working. "Do no harm" is a principle that we all must adhere to. So we're trying to both do no harm by promoting the well-being of patients, families and healthcare staff through our music, but we're also trying to avoid unnecessary harm by reducing or eliminating the negative impact. So what does this look like? In our world, it looks like making sure that you secure consent and that you allow patients and listeners to drive whatever music it is that they want to hear.

[00:32:07]

You focus conversation on music and the musical experience, that you are highly responsive to listeners' verbal and non-verbal responses, that you seek support when you need it from somebody who knows things that you don't know, and that you bring closure to the experience however you can. So empathy and connection—it's really important that you are very clear about what your goals in this work are. What are you there to do? We're clear that we're there to provide positive distraction, entertainment, creative engagement, and social connection. We're not there to change your blood pressure. We're not there to give you your meds. We're not there to help you figure out where the security guard is. We're there for these purposes. So then you build your program around what those goals are. It's really important that you're clear about what you're there to do. We also build it around the ethical principles established by NOAH. And these are the eight critically important ethical principles, most of which actually derive directly from the medical establishment.

This is just a quote about the importance of the artist-in-residence to be present with those. We don't enter with therapeutic objectives. We engage as one human being meeting another and offering opportunities for the other person to express and/or enjoy themselves. And with doing that, we create opportunities for healing. I also want to underscore in this environment as much as a musician might be used to being a soloist, it's not soloist work. No one works alone in this environment. It's highly regulated.

[00:34:01]

There is complex coordination of different roles and tasks. Everyone is identified by their role, and the musician has to have a role as well. There are all kinds of people you can collaborate with, who can make the work easier, who can share some of the load in terms of making sure that you're meeting people in the appropriate way. These are all relationships—I can't underscore the importance of partnering with the security guards. They're so incredibly helpful. But there are all kinds of different ways and people that you might consider establishing relationships with in order to build a practice.

So the other thing you really need to think about is where and when the musician can be more autonomous, as opposed to more guided, escorted collaborating with a healthcare professional. It depends on the level of their contextual knowledge and skills. It depends on the individual's ability to maintain boundaries and operate within scope of role. Just saying, a lot of musicians jump into this work with a big heart and a big, lofty desire to serve and be helpful and get themselves in way over their heads just by trying to be nice. That does not work out well in this environment. How high is the level of medical acuity in this situation? If so, the musician is likely to be less autonomous. Try to put the musicians in a context where they can operate safely and thrive, rather than putting them in areas that are too

complicated for them. Is there a supervisory model? Is there a way to supervise them? Who is doing that supervision to make sure that everything is going okay? And then think about what responsibilities are put on the back of the individual artist, the practitioner in this work, and what are really the responsibilities of the program itself to frame?

[00:36:05]

A lot of the work needs to be done at the program level. So in summary, I would just like to say that in this work, rather than being the main show, the artists are part of a care team which looks a lot more like this. So that's a whiz through a lot of topics involved in this area. That's my email if you have questions and want to follow up with me. I'm going to now transition to my seat over here, and we're going to have some panel discussion with these lovely people.

[APPLAUSE]

I am looking forward to resting my voice for a while and letting these people speak. And what I would like to start with is just asking—starting with Penny and coming down the line—how did you come to this intersectional work after 40-something years with the Pittsburgh Symphony Orchestra?

PENNY BRILL: Partway through my years playing with the Pittsburgh Symphony, I played viola, and I was doing a lot of playing for smaller groups in the community, but when I turned 50 and was wondering, "Okay, what do you want to do next with your career?" That's when I got diagnosed with cancer, breast cancer. And I went through chemo and some other things. But I thought, "Well, okay, here's an opportunity to find out how music might support the diagnosis phase, the anxiety that goes along with that, pain reduction, things like that. And then during treatment and then in recovery, what kinds of music did I find most helpful, and did it make a difference?

[00:38:01]

And of course it did. Already I'd been connecting with different types of music therapists in the community. Duquesne had a music therapy program, but also I'd run into someone who did guided imagery with music, and we did an imagery session before. It was actually the Helen Bonny method. She was a violinist, a professional violinist who created a sequence for using music to resolve certain fears that you might have before surgery. And someone—this tells you how long ago it was—dropped cassette tapes at my house in order to be able to listen to music before and during surgery, and then I happened to be interested in Indian music, Shakti yoga, and various types of Indian music. I listened to that in recovery because it gradually speeds up and re-energizes you if you're listening to it.

So then people were wondering, "Well, how are you recovering so fast and not needing as much pain medication?"—things like that, which happened to be true that time and doesn't necessarily mean that everybody gets that kind of benefit. But someone else who was diagnosed right after me tried this, and she recovered even better. So I thought, "Why don't we have music in the—especially since this is Magee Women's Hospital. Why aren't they using music to help support—I mean, self-chosen music, preferential music that the patient picked—why aren't they using music, if people want it, to help support their experience with medical treatments?" And so I started being sort of persistent, relentless, I guess you would use that word.

HOOVER: One could say that.

[00:40:01]

BRILL: So the Healthy Lifestyle Program, the UPMC Head, who is a researcher on measuring types of stress, he helped pay for a music therapist to go in once a week with me to the Transplant Unit in Montefiore Hospital. So once a week for nine months, we were there, and I was helping to support what she was doing, but what it also taught me is how many skills the music therapist has, and the ability to immediately identify what might be the most effective way of using music for each of these patients, which gave me infinite respect for the types of knowledge that you need to have. But it also got a lot of attention in papers and in magazines and TV and stuff like that. So two foundations funded music therapy positions in the hospitals. One of the problems is that there aren't enough—

HOOVER: Penny, you have so many stories to tell. Can you save some of them for the next question?

BRILL: Yes, okay. But at any rate, the thing is, then the orchestra could work with that music therapist safely in the hospital, and that was the whole point of that. Now, it's a completely different environment, but I'm amazed, actually, in the 10 years between when I started doing this and now, how much you've learned, how much the whole field has learned, so that people don't have to invent this stuff from nothing. So I'm really grateful for that.

HOOVER: Yes, thank you so much. Jotaro, what about you?

JOTARO NAKANO: Hello. My name is Jotaro Nakano. I am a conductor. I actually met Sarah when I started my doctorate at the Peabody Conservatory. This was during the pandemic.

[00:42:02]

And you can remember a couple years ago when we were all there during this brittle time in our lives. In our zeitgeist, we were having many conversations about the value of the arts. At

the same time, we were having conversations about doctor burnout. And meanwhile, a lot of the hospitals were closing their doors so that you couldn't visit your patients. A lot of concert halls were closing, and concerts were being canceled. In that kind of environment, there was this opportunity. I served as the Arts and Health Fellow at the time at the Johns Hopkins Hospital to really think critically about how we can bring musicians to the patients, to the doctors and nurses and staff. And what kind of opportunities or what kind of need might there be, despite this very difficult environment? And so that was a hugely transformative experience for me at that time. And later on, actually, it was just kind of perfect timing.

[00:43:05]

But a few years ago, I became the Music Director of an orchestra in Boston called the Longwood Symphony Orchestra. The Longwood Symphony Orchestra is, well, if you know Boston, Longwood is the medical area of Boston, where all of the great hospitals of Boston are all situated right there. There is the Children's Hospital, Boston Children's Hospital, Dana-Farber Cancer Institute. There's the Brigham and Women's Hospital. There's Harvard Medical School there. It's just a very concentrated area around healthcare. It's an orchestra that was founded in the '80s, full of doctors and researchers who have firmly planted their identity right at this intersection of the arts and health. If you know about this emerging and quickly growing field, it was not like that back in the '80s when the orchestra was born.

So at that time, it was a hugely innovative orchestra. And we continue to build on that legacy by partnering with all kinds of hospitals and medical nonprofits. And that's where I'm able to now continue this work today.

HOOVER: Thank you. Julie, what about you?

JULIE NOLAN: Hi. My name is Julie Nolan, and I'm with the Annapolis Symphony. That's a smaller orchestra about an hour south from here. And I was working with—we developed a program to make music accessible through an academy nine years ago. And so I was working with the academy and for the orchestra, writing grants for the orchestra. And my daughter happened to be at Peabody. She was part of the program that they had going, and it was spring break. She said to me, "Mom, I don't want to miss my time. I'm going to go up there." And I, as a mom, was like, "It's spring break. Can you just stay home? I haven't seen you much." But then she was determined, and I said, "Fine, I'll go with you. We'll have lunch." And I just sat down to do some work, and in watching her, I was amazed by the impact a musician at the hospital was having on people who were going by. And I learned that people were booking their chemo appointments so they could stop and see the musicians.

And it was just such a positive distraction. It brought a sense of community. This was just post-COVID. And it brought such a sense of community that I went back to our orchestra and thought, "What can we do?" And that's how we started. We started out very slowly, and we're still small, so it's slow. But it's exciting, the impact you can have, just in a small way, outside of the concert hall.

[00:46:04]

We were reaching people who were at their most vulnerable points and helping a staff that's exhausted and tired. You know, they're always excited to see you. There are children who are taken to the hospital, and nobody quite knows what to do with them. And suddenly someone's playing "Beauty and the Beast" for them, and the little girl is dancing. So it's just been a wonderful experience for us as an orchestra to be out there in the community and to be able to offer this.

HOOVER: Thank you so much. I'm going to go right back to you, Julie, if you don't mind. I know you've started small, but you're building your program. How have you and the organization leveraged partnerships and collaborations within your community?

NOLAN: Well, that's been another exciting part of this that has sort of developed. We are at the hospital, but we also this year started working at a shelter. We originally started also at the Mental Health and Addiction Center, which is run by the hospital. And particularly for the last three years with those, we've gotten to know the staff. Especially post-COVID, it was really hard to fill our concert hall, so we started with offering tickets to our events, and our musicians enjoyed that aspect of it. Whoever the musician was, we would tell them, "Call the box office and say your name, and you can have a spot." So we were kind of amazed by a review we got from a nurse at the addiction center saying, "These people are going through such a terrible time, and for an hour, they get to talk about music, to think about something else, and to be very positive when they talk about attending a concert."

[00:48:12]

And we would say, "We have ten spots." We would open more for people if they were interested, because we don't always get them. But it's nice that they're offered it. And some have taken us up on it. There are different partnerships as we go. With the hospital, we have a pilot program right now that has put music in the hallway at the oncology and the cardiology units. And the hospital really likes us there. And so the development people at the hospital are working with us, too, to see about donors, because sometimes we share donors that are very positive about this aspect. So it helps a small orchestra like us be able to fund it.

HOOVER: Thank you. Penny, I'm going to go back to you. You've been doing this for a long time, and you indicated that things have changed since you started. How has your thinking about this work changed over time? And I guess even more to the point, what do you know now that you wish you'd known when you started? In terms of how we think about folks who might be starting programs, what lessons have you learned?

BRILL: Well, it's actually interesting because there has been so much knowledge that's been gained by—you know, when we were working on this project to create a framework for training that I have to say even from the beginning of when we started to work together on Code of Ethics and then this framework, I feel like I knew this much, and now we are all much more informed because we're working as teams.

[00:50:04]

And the team is somebody who's working in a hospital as a nurse. Someone's a supervisor in a music program. Someone just experiences in the Arts and Health from all different aspects of the field. That has made the learning process faster and more thorough, and the discussions have been very rich as far as improving what we come up with for solutions for some of the issues that come up. So to some extent, for me, the biggest learning has been working in these groups to come up with suggestions for what this field should look like. And that's phenomenal improvement, but I have to say that Daisy Fancourt coming out with—

HOOVER: Art Cure.

BRILL: Yes, this because she's so good with data. If you want to have a program where the interactions can be measured so that you can get grants, because it shows measurable improvement by doing a program, she knows how to do that. I used to say that she was capable of nailing Jello to the wall. I mean, she can do these interactive things that have been harder to capture. She can do that. Her team has been able to do that. It's incredibly valuable in addition to her level of clarity in what she says in this book, but it helps us a lot with—

Because one of the arguments was you can't measure these things, so how are you supposed to get grants for that? And this solves that problem. This is an incredible contribution to arts and health being able to be funded. So anyway, that's my answer.

HOOVER: I just want to underscore that one of the richest things about doing this work is actually the opportunity to collaborate with people who have different knowledge bases

than you. It's really invigorating to have that opportunity. So Jotaro, you just got a doctoral degree. Congratulations.

[APPLAUSE]

And you wrote a thesis—okay, here we go—"Emerging Opportunities for Health and Wellness-Informed Programming for Large-Scale Music Organizations." This sounds like something for you all. What did you learn?

NAKANO: Thank you for that. For this project, much like the Catalyst Guide, I took a deep dive into many orchestras of all budget sizes, going from Group 1 all the way to Group 7 orchestras who particularly do a lot of activity in the arts and health space. And I interviewed a lot of leaders, both artistic leadership and administrative leaders to understand what it takes organizationally to sustain these kinds of programs. Oftentimes, when I speak to hospitals, I get some feedback. Hospital administrators or music therapists, they say, "Oh, you know, years ago we used to have this music program, but I don't know what happened to that." And that's a very common sentiment that I find. One of the main findings that I have observed is that these programs that—while maybe many of your orchestras do have varying levels of Arts and Health programs, they're often sustained by usually one fierce leader within your organization. The sustainability of these programs is very difficult, so the orchestras that are able to sustain stronger, more robust programs are the ones that are able to more incorporate these values of health and wellness into your vision, into your values of your organization, into your missions.

[00:54:17]

And oftentimes, there is also this perception that maybe the big Group 1 orchestras with the biggest budgets might have the most robust and the biggest, most beautiful programs in the hospitals, but already we've discussed that you can do so much great work with very, very little investment monetarily. Sometimes even this work is sustained by volunteer efforts, even to organize. There are a lot of smaller, Group 5, 6, 7 orchestras that really bring a lot of value to the table here. There's a lot of opportunity, and I would say that there's a lot of opportunity or low-hanging fruit for you all.

HOOVER: Thank you for doing that important piece of work for the field. All of us can benefit from that. The heaviest question on my list is this one, and that's about the duty of care. I went through some of the aspects of that very quickly, but we need to make sure that our musicians are hired and trained in such a way so that we know that they're properly prepared and qualified. What, from your seat, is needed to make sure we have the right artists doing this work and that they're prepared? Who'd like to start? Julie?

[00:56:00]

NOLAN: From a smaller orchestra's standpoint, training can be hard, but I would highly recommend Dr. Hoover's class at Peabody. I attended it last year, and what we do is—we're a contract orchestra, so our Director of Artistic Operations has the big job of finding a musician for us to play. But what happens is often the people who really want to do this do it. And so right now, like in the pilot program, I will be there or the hospital person I'm working with—we share the job—to try to help the musician when they start and see if there are ways we can help them feel more comfortable or suggest music. And then the musicians kind of—a lot of what I've found is they enjoy upping their game each time. When they come, they're like, "Oh, the next time I come, I'm going to bring more pieces of this or that." And then there are a few that decide it's not for them, and that's fine.

So we kind of figure it out along the way together. But it's very key to know where to be. We try to position our musicians in places where you can close your door if you don't want to hear, so that we aren't intrusive in a more open environment. Because we aren't going room to room. We're not putting our musicians in that. So I think some education is good, but it doesn't take much to get this going and making an impact in your community.

HOOVER: Others?

BRILL: I think you also want to introduce musicians who are less experienced playing in hospital settings, either matched with someone who has more experience or have someone in the hospital who's comfortable guiding them and saying, "I think they need something that's quieter," or notice body language.

[00:58:03]

Make sure that if someone doesn't want to listen to something, they can leave, or they can shut their door. Just issues like that. The whole environment is so different from an orchestra environment that there's so much to learn that actually it really helps to have someone experienced with that setting guide you. And I really encourage that because there are so many inadvertent things you can do without realizing that it could cause a problem, especially infection controls. What I really appreciate, since so many people have been through this COVID thing, people have masks, people understand more about infection-spreading, that kind of thing.

So I have to say, before COVID, unfortunately, a lot of people didn't have a concept of germ control and things like that. And so that has actually helped us with the ability to think more about safety of the patients. The other thing that's so different about this than in an orchestra is it's patient-centered care. So if it looks like it's not right for the person, or

they've had enough, or it's too loud, that you immediately adjust. What I found—I played in a radiation oncology waiting area, and I'd ask people if there's something—I had actually a whole container of fake books, and they'd picked something that meant something to them. And I learned a lot from that about what meant a lot to different people and it wasn't—

We don't have the right music. Coming from an orchestra, we often don't have at all the right music. And just to recognize things like that, that we have no idea what people like until you ask, until you ask the people around them who are in that culture. There's a lot to learn that we actually all benefit from because we're finding out more about our community.

HOOVER: Yes, that's beautiful. Thank you. Jotaro, what about you?

[01:00:05]

NAKANO: Sure. To echo that sentiment about pairing an inexperienced musician with a very experienced musician, I would also like to add to that—I know we've already talked about this, but I would like to overemphasize the value of a potential collaboration with a music therapist.

Now, in the landscape and in the medical field, there aren't a lot of musical therapists. And whenever I go to a hospital, usually I find, when it's really bad, one music therapist that three hospitals share, or something like that. And then there are other environments, like in Boston, at Boston Children's Hospital, I was just speaking to them, and they were telling me about a whole team of music therapists that they have full time. It's a completely different kind of paradigm.

But I think music therapists are usually the ones that would be able to speak the language of a musician and speak the language of medicine, to be able to really guide you. While we're talking about these challenges and the do-no-harm commitment in this kind of work, I do get a sense, as a performing artist, that if you are a musician who has never done this kind of work, that you might hesitate because I don't want my music to harm my patients. And that may discourage you towards getting this kind of work. But I do want to encourage about this idea that once you understand the guardrails and the structure and the newness of the things that you need to learn, there is still so much room within this realm to be creative, to be artistic, and to be beautiful, and to contribute so much value into this space.

[01:02:09]

I think there are endless opportunities to collaborate and to be creative in program. And so I would definitely want to encourage you to learn about all of the things that are required to do this work well.

HOOVER: I mean, that feels like a mic-drop moment right there. So we'll turn over the questions to you all at this point. Do we have questions? Oh, right here, up in the front. The mic is coming to you.

MALE QUESTIONER: Thanks, Karen. A phenomenal presentation. It feels to me that this type of musical expression is so much more in tune with the audience, and I'm wondering what our field can learn for our classics programs and masterworks programs about showing up as a musician in that context for our audience, because it seems to be so much more collaborative and impactful than, I think, what a lot of us feel sometimes on stage currently.

HOOVER: Wow, thank you so much for that comment. And I can see there are people, all of us, want to say something to that. I will say just really quickly, our artists are different artists after they start doing this work. The way they go back to their mainstage work is really different. So, I'll just throw that out. And, Jotaro, I think you wanted to say something.

NAKANO: Yeah, absolutely. I was more initiated into this work fairly recently. I was telling you about back in the pandemic. I could remember very clearly that once I observed this experience in the hospital, it made me really think back when I went back to the concert hall, "What's the point of this?"

[01:04:03]

And obviously, we're all here because we love classical music. We love orchestra music and all of that. But oftentimes, it feels like organizationally, administratively, these programs are housed within community engagement and education departments or programming, which already are usually—

Depending on the orchestra and organization, these can sometimes develop an antagonistic type of relationship between that and the masterworks sort of programming and the artistic staff in that realm. And once I had this kind of opportunity to take my very conservatory-trained, narrow-minded training into the hospital, it was eye-opening that these two ideals should not be so separated. When it's really bad, it really does feel like an orchestra does community service in a separate but equal kind of manner to the musical excellence. If we can think towards a new paradigm, where we integrate these ideals back into the concert hall, it really does—

I can see so many more possibilities in which we can now start programming our masterworks concerts with the lens of how we can attend to the wellness of our audiences and our musicians on stage. I think that's just my hope.

HOOVER: We've got one back there. Yes.

MIKE STEFFEN: Thank you. Mike Steffen from the Quad Cities. Sarah, do you or any of your panelists have any statistics that might relate to the use of music with a patient for return of memory?

[01:06:06]

HOOVER: There's a lot of research on music and dementia that's quite strong. And Daisy Fancourt has got some of that summarized in her book. There's also a wonderful resource that Berklee School of Music—it's in their Music and Health Institute. They have something called the "Music and Health Taxonomy." And it is a compilation of music therapy research that is searchable by medical condition or diagnosis. So you can type in "dementia," and it pulls up all of the major studies. And they've done a really good job of curating that list. So that might be a helpful resource in looking more deeply into the work. I'm sure you've seen the documentary or are aware of the documentary Alive Inside, which is an incredible look at music reconnecting people with memory and language who are in advanced dementia. So there's quite a body there.

Yes, we have a question here.

FEMALE QUESTIONER: Hello, thank you all for being here today. I'm a student at Spelman College, studying neuroscience and music. And I would like to ask, how do you see the future of technology impacting and evolving the field of music therapy?

[01:08:01]

HOOVER: Shall I take a stab at this?

BRILL: Go for it.

HOOVER: So first of all, disclaimer, I'm not a music therapist. So with that grain of salt, there's a lot of really interesting stuff that is starting to happen around brain imagery and transforming that into musical material. That's been going on for a while. There's a lot of interesting stuff happening around generative music that responds to different vitals in a person's body. So there's that kind of stuff that involves imagery and creativity coming out and also assisted with AI. That's one lane.

The other lane is how do we actually scale music therapy resources? Can we have apps? And there's been a lot of work to try to develop apps that people can use. Some of them are better than others, and I don't have them at the tip of my fingers right now, but some have been very positively received and have quite a bit of research behind them. Scaling them, there's not anything that comes to mind, other than that sort of obvious thing. The Calm app people and Spotify, they are tracking all of this music and mood stuff. They have huge datasets that we all should get our hands on and figure out what that can show us about what kind of music curation or music activities we could create.

So a lot of really interesting stuff to come in this area, and as with technology and a lot of other issues in the arts, some anxiety also about that and about replacement for the, you know—interest in scaling and pushing it out and making it more accessible and anxiety about quality of experience and quality of product and just what's going to happen to live music, right? It's both of those things.

[01:10:22]

BRILL: Well, since one of the concerns is that people aren't connected to other people in the community, one of the problems if you get too much into that, using an app for it, is that you actually—it might be much more productive, let's say someone with depression or actually even with dementia to do group activities because there's a kind of energy level of people who work in the same group, let's say doing drum circles together. I actually was just reading a study about drumming and people with dementia, and what you notice is their face acquires it. Their face expression comes alive again. Eye contact. They start talking with each other. They might have more intentional movements. You can see very dramatic changes, and you'd never know that from going through the apps. I mean, you get different information if you do it live. And it matters in a situation where people feel disconnected and isolated, to be doing these things in groups.

HOOVER: Thank you so much for saying that. If there's one parting comment I would like to offer is the research around social cohesion, loneliness, social isolation is so strong right now that if you could use that as a design principle in anything that you build, whether it's for people who are just disconnected or older people with dementia who are disconnected, but if you could factor in social connection and reducing loneliness, that would be a huge boon for our society and where we are right now, given everything.

I think we're at time. Thank you so much for being here today. Thank you.

[APPLAUSE]

[01:12:27]