

ARTICLE

How music-for-health practitioners' decision-making processes inform their practice in paediatric hospitals

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ABSTRACT

This qualitative research study investigated how music-for-health practitioners make sense of decision-making in the context of paediatric hospital wards in the UK. Whilst existing studies have explored the skills practitioners develop and how these relate to outcomes and benefits of music for health, this article describes specifically the process of decision-making and how practitioners drew on previously attained skills. Four music-for-health practitioners, all of whom work in paediatric hospital wards in the UK, were interviewed regarding their experiences of making decisions. The interviews were semi-structured. Data were analysed using thematic analysis and the following themes emerged: (i) Building the foundations; (ii) Taking note and taking in; (iii) Performance conditions; and (iv) Forms of communication. The research is addressed to music-for-health practitioners at the beginning of their careers, offering ways to understand the process of decision making. It might also support more experienced practitioners to understand and reflect on their professional decision-making processes and to have an evidence base to use when training new practitioners. With its focus on the paediatric hospital, this article also has possible multi-disciplinary relevance in helping doctors, nurses and other staff better understand music-for-health practice.

KEYWORDS

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INTRODUCTION

Decision-making is crucial to musical participation. Qualities required of performing musicians include expertise, analysis and intuition (Bangert et al., 2014) on the one hand and judgement and self-critique (Chaffin & Imreh, 2001) on the other. Practice forms a substantial part of musicians' preparation, as they decide what to play and how to play it, such as what tempo to take and which markings to observe, if reading from a score (Howat, 1995). Musicians' decisions can also be based on how recordings sound, to replicate a style or create a new interpretation. Performers might sometimes decide to counter something they did previously, by constantly analysing their practice and the choices they make (Chaffin & Imreh, 2001). These decisions are described as intuitive and cognitive processes (Bangert et al., 2013) with some musicians favouring unconscious decisions and others taking a more rigorous approach and consciously analysing their choices, as they prepare for concerts and other performances. Improvisation also requires multiple musical decisions. These are often spontaneous, such as responding to other musicians, maintaining the musical feel, or being led by one's initiative to create something new (Wilson & MacDonald, 2015).

Decision-making is no less important for musicians working in healthcare settings. Here, they face the challenge of making not only musical decisions, but also ones that relate to the wellbeing of participants, whether consciously or otherwise. Throughout history, music has been used to improve health and wellbeing; this continues in many ways today (MacDonald et al., 2012). It is used in multiple healthcare settings, including dementia care, mental health support and within community music projects (Sunderland et al., 2018). Music's value for health lies in that it is emotional, ubiquitous, engaging, distracting, physical, ambiguous, social and communicative, and affects behaviours and identities (MacDonald et al., 2012, pp. 5-6). 'Music for health' in the UK uses these characteristics and affordances in promoting wellbeing, through attending to people's social, emotional and physical needs, often when they are dealing with ill health. Whilst the term 'music for health' is not universal, and usages differ between countries, the scope of music for health and wellbeing is vast, and can be seen in a variety of settings, including hospitals.

Music in hospitals in the UK comes in different forms, with the three following instances highlighted by Trondalen and Bonde (2011). First, music medicine aims to improve a patient's wellbeing through the use of pre-recorded music, often during medical interventions and rehabilitation. Second, music therapy is based on the relationships between the music, the patient and the therapist. It concentrates on inter-personal and inter-musical relationships, normally using improvised music that is most often created and altered to fit the purpose by the therapist. Therapeutic music is the third form, and this includes work carried out by music-for-health practitioners, whose "function within the hospital can be to ease suffering, alter mood or support progression to recovery" (Hawley, 2018, p. 10). It is difficult to provide a definition of music for health in the UK, as "there are indeed a range of musicians working within 'health'" (Hawley, 2018, p. 9), with differing professional backgrounds and qualifications. However, music-for-health work is undertaken by "musicians who receive a very specific training in approaches to practice in hospital and healthcare settings" (Hawley, 2018, p. 9). In paediatric hospitals in the UK, music for health can be organised by services such as the Play Department (Great Ormond Street Hospital, 2018) and the Therapeutic and Specialised Play Service

(Manchester University NHS Foundation Trust, 2020) or by hospitals' arts teams such as Artfelt Sheffield (Artfelt, 2020) and Breathe AHR (Breathe AHR, 2020).

Music-for-health practitioners can draw on their experience making musical decisions and transfer this to their practice in health settings. However, such practitioners have to understand how such processes operate in contrasting environments, such as hospitals. The aim of this paper is therefore to explore the decisions that music-for-health practitioners make when working on the wards of paediatric hospitals. The results will be useful for music-for-health practitioners at the beginning of their careers to help them understand the concept of decision-making in this setting and to apply the findings to their own work. It also aims to support more experienced practitioners to understand and reflect on their personal decision-making processes, and to have an evidence base to use when training new practitioners. With its focus on the paediatric hospital, this article also has possible multi-disciplinary relevance in helping doctors, nurses and other staff to better understand music-for-health practice.

LITERATURE REVIEW

Research into the role of the arts in improving health and wellbeing is substantial, with benefits relating, broadly speaking, either to prevention and health promotion, or the management and treatment of ill health (Fancourt & Finn, 2019). Looking specifically at children in hospitals, live music interventions have helped "to reduce anxiety and pain and improve mood and compliance with medical procedures" (Fancourt & Finn, 2019, p. 34). In these ways, music in hospitals supports the needs of patients and their families, running alongside the work and goals of clinical staff, with music therapists and music-for-health practitioners working not only in bays, treatment rooms and by the bedside in the wards (Edwards & Kennelly, 2016), but also in clinics, waiting rooms and public spaces (Preti & Welch, 2012a). Aiding clinical work in the hospital was noted by Wood et al. (2016) as a way to ensure the growth of music therapy services in the NHS. Complementing the primary focus of care within the medical model is not the sole aim in this field however, with benefits emerging for the general wellbeing of patients, hospital staff and families alike (Youth Music, 2017). In one instance (Music in Hospitals and Care, 2018), benefits included reducing the stress and anxiety of patients with dementia, whilst increasing the welfare of the staff and family around them. Hallberg and Silvermann (2015) recorded the views of staff about their experiences of music in hospitals and noted only positive effects, such as aiding non-medical procedures, relaxing patients and creating a calming atmosphere, without being overpowering. In areas of patient wellbeing, music in hospitals has been noted to enhance quality of life in paediatric palliative care (Sheridan & McFerran, 2004) and as a way of aiding the emotional and psychological state of the patients (Avers et al., 2007). Turning specifically to paediatrics, in another study (Reid, 2016), adolescents with life-limiting cancer experienced music making as an opportunity for normalcy, to experience laughter and fun, especially in interacting with their peers. Musical participation afforded them "the opportunity to keep living whilst receiving palliative care" (Reid, 2016, p. 74).

Youth Music (2017) found music in healthcare to have social, personal, musical and workforce outcomes, whilst supporting the wider needs of the hospital. Using the lens of community music, Harrop-Allin et al. (2017) reflected on the experiences of patients, staff and families during a project

to bring fourth-year music students into a hospital. They found that “live music performances may be able to humanise hospital spaces, enabling different modes of musical engagements that confer agency and control to patients, their carers, and nurses” (p. 56). Patients have been observed to gain confidence through playing music, finding a way to communicate through sounds and instruments (Wetherick, 2014) and become relaxed in the hospital environment, with nurses commenting on reduced anxiety and calmer patients (Preti & Welch, 2012a). Many hospital staff referred to the benefits of multi-disciplinary working as “the opportunity to share learning with those of either the same or different disciplines, developing different ways of thinking about how music and healthcare interact and work together” (Youth Music, 2017, p. 10). Music making in this instance created community within an emotionally challenging environment. These multiple outcomes are interesting in relation to the experiences of practitioners and how working in hospitals affects their practice and more specifically their decision-making.

Hawley (2018), in a case study of her own practice in a paediatric hospital setting, explored the process and factors of long-term residencies. She noted that, through promoting interaction and opportunities for expression, such programmes are beneficial for patients and musicians, who experienced reduced anxiety and a deepening of creative and reflective practice, respectively. Hawley (2018) reported that patients find their own voice through music, with musicians listening to them, responding to their actions and ultimately creating compositions. Furthermore, musicians challenge themselves with memorised and improvised repertoire, the creation of new music and the subtlety of making changes to suit the individual. Together, through regular interactions, all these elements of practice are developed over time.

For many musicians, music for health has become a valid career path. Transferable skills are essential when developing from musician to music-for-health practitioner (Hawley, 2014). Petersson and Nyström (2011) investigated how musicians train to be music therapists, discovering that they learn through conversion, openness, reflection and practice. Their study, even though focusing on music therapy, shows how trainees build from one skill to the next during the training process, and this might be relevant for understanding how music-for-health practitioners reflect on their training. Although Petersson and Nyström’s study is particularly useful for understanding how musicians draw on their previous musical skills and their use of reflection, it does not investigate how the musicians react to a patient’s needs, including what they read from the individual and the setting or how this affects the decisions they make.

Preti and Welch (2013) used thematic analysis to investigate the reasons musicians go into music-for-health work and how they subsequently view their professional identity and develop skills within this field. Participants in their study commented on the ability to “decode” a situation (Preti & Welch, 2013, p. 369) and react spontaneously during an interaction, drawing on skills such as non-verbal communication and flexibility within a planned session, and attributes such as confidence. All of these abilities and attributes helped practitioners guide the interaction, each time being more confident as they learn from the past. However, Preti and Welch (2013) did not research this process of decoding, be it of a situation, a patient’s personal demeanour or the practitioner’s feelings as part of the decision-making process.

A critical level of decision-making was apparent in Loth’s study (2017) of work with a mother and triplets for music therapy sessions. Loth commented on the constant shift of emotions in the room,

the challenges of deciding which child to focus on and the complexity of the mother-child relationships. This study is a useful first-person reflection on the feelings and experiences of the music therapist and the necessity of using these experiences to make future decisions. It gives a small insight into the challenges of making decisions in a very fluid environment. Whereas Loth focused on regular therapeutic sessions with the same group, the current article researches these decisions in the larger environment of a paediatric hospital ward.

Decisions come from the ability to choose, and perhaps the most important choice in music-for-health work is the patient's decision whether to engage with music at all. Sheridan and McFerran (2004) researched how music therapists read body language and other non-verbal cues to determine if a child in palliative care wants to engage with music. The researchers found that, when children did engage, the process was child-centred; that is, the therapist listened and responded, offering choices based on the child's behaviour. This then developed into interpreting the child's musical preferences with the therapist tailoring the session accordingly and enhancing the child's quality of life as they developed a sense of responsibility and autonomy in creating their personal session. This article looked at decision making from the point of view of the reactions and choices of the child in palliative care, particularly regarding quality of life. Whilst Sheridan and McFerran (2004) explored this in relation to music therapists, the current article investigates the patient-led nature of decisions that music-for-health practitioners make in their practice, whilst also considering the wider hospital, staff members and family. Finally, Kern (2011) has investigated the processes of decision-making for evidence-based practice (EBP) in music therapy. She identified individual client factors, clinical expertise and the best available research evidence as the main elements of EBP. Whilst her focus (early childhood music therapy) relates to this study, her purpose was to examine existing models of evidence-based medicine and apply these theoretically to music therapy.

Therefore, the present article differs from the above-mentioned studies in exploring the process of the decisions made prior to, during and after musical interactions with patients and how practitioners decide which skills to draw on and tools to use. It does so within the specific context of paediatric hospital wards in the UK. This research explored how practitioners make sense of their decision-making process, focusing on the knowledge required to make these in-the-moment decisions. The research question for this study was: How do music-for-health practitioners make sense of their decision-making whilst interacting with patients in paediatric hospital wards?

PROCEDURE

As a qualitative study, this research aimed to explore decision making for music-for-health practitioners. A qualitative approach allows us to "explore the complex set of factors surrounding the central phenomenon and present the varied perspectives or meaning that participants hold" (Creswell, 2011, p. 129). The descriptive and in-depth nature of the data made for a rich account of the phenomenon, as understood by the participants and researcher (Merriam, 2002).

Four music-for-health practitioners were recruited purposively because they had experience working on paediatric hospital wards. Participants chose to remain anonymous in the research outputs, therefore they were given pseudonyms (see Table 1).

Participant	Pseudonym	Total years of experience
1	Sophie	13
2	Reuben	10
3	Fiona	7
4	Claire	1

Table 1: Research participants' pseudonyms and total years of experience

The participants' work ranged from playing music in the general ward space and play rooms, to four-bed bays and isolation rooms. Wards differed depending on the needs of the patients. All participants had varied experience of working on specific wards, such as the intensive care unit, long-term ventilation ward and burns unit, as well as less specialised wards.

Research participants were interviewed individually by phone. A semi-structured interview allowed them to explore their understanding and experience of decision-making with the interviewer (see Appendix for interview questions). Fourteen prepared questions gave opportunities for the researcher to prompt and participants to extend responses, as appropriate. Interviews lasted approximately 30-40 minutes and yielded a rich, yet manageable, data set.

Interviews were audio-recorded and transcribed verbatim. Transcripts were analysed using thematic analysis (Braun & Clark, 2006), a flexible method that relies on an interpretivist approach, identifying meaningful elements of the data. Transcripts were studied iteratively and coded before proposing themes and sub-themes. The data set was analysed and coded as a whole and inductively, that is without any prior theoretical assumptions. To reduce bias, the researchers took a reflective approach and discussed the analytical process collaboratively. The study was granted ethical approval by the Royal Northern College of Music Research Ethics Committee (27/06/2018) and all participants gave their informed consent.

RESULTS AND DISCUSSION

Through analysing the data, the following themes and sub-themes emerged (see Table 2). These will be discussed below, using representative quotes from participants.

Themes	Sub-themes
Building the foundations	<ul style="list-style-type: none"> Valuing musical skills and knowledge Experience working in hospitals
Taking note and taking in	<ul style="list-style-type: none"> Reading the moment Reflection
Performance conditions	<ul style="list-style-type: none"> Clinical setting Spontaneity and intent
Forms of communication	<ul style="list-style-type: none"> Musical presentation and choices Interpersonal interaction

Table 2: Themes and sub-themes

Building the foundations

All the music-for-health practitioners spoke about having to be prepared to make a variety of decisions, and for each participant this preparation took several forms. The preparation undertaken, before any in-the-moment decisions need to be made, acts as a foundation to support the choices the practitioner makes throughout a session. Preparation also means making decisions in advance, whether in relation to the music or decisions based on previous experience.

Valuing musical skills and knowledge

Participants transferred performance skills, such as being proficient on their instrument, being aware of audiences and the ability to play with others, into the ward environment. Fiona said, "I firmly believe that in order to do this job effectively you have to know your instrument back to front and not have to think about it." In addition, Reuben noted, "knowledge of playing in front of audiences is a good prep for doing this work. I think that the more gigs that you've done, you learn a little bit more to read an audience." In both cases, we see the conversion of artistic to therapeutic knowledge, as noted by Petersson and Nyström (2011), in their study of developing music therapists. In this case, it is not only general musical knowledge that enables decision making, but also instrumental competency and performance experience.

The choice of music plays a key role in musical preparation. Practitioners commented on the necessity of knowing a bank of high-quality repertoire thoroughly, being passionate about the music they played and choosing music that could be adapted. Sophie stated, "We've got like a canon of repertoire that we use as starting points and... we feel really comfortable with that repertoire so... we know how we can then play with it and extend it." Practitioners said this enabled them to make decisions quickly, converting their musical experiences outside the healthcare setting into something relevant and useful within the decision-making process in the hospital. Participants placed value on the quality of musical knowledge and skills, as a basis for successful interactions in the hospital. Regarding the related field of music therapy, Hanser (2016) found a similar emphasis placed on the quality of music making. She quotes music therapist Mary Adamek: "High level musicianship paired with strong therapeutic skills creates a foundation for effective music therapy interventions leading to positive outcomes" (p. 856).

Experience working in hospitals

Making decisions requires drawing on previous experience. "Building experience" appeared frequently throughout the data, regarding how naturally practitioners made decisions and how at ease they felt in the environment, learning from previous hospital work. Sophie observed: "It's kind of an action research, you go in, you experience and then that informs the way you prepare for the next session."

Interviewing practitioners with varied levels of experience revealed interesting differences in their initial decision-making process. The difference in confidence in their practice between Sophie and Claire (most experienced to least) was apparent. Sophie described her detailed decision-making process when entering an interaction, talking of observing the "feel of the ward" and getting a sense of what is appropriate. On the other hand, Claire was guided by the experience of the hospital staff who knew the patients better, due to her apprehensions of getting something wrong. This suggests

that music-for-health practitioners become more confident at making their own decisions over time and are, like music therapy students, “learning through practice” (Petersson & Nyström, 2011, p. 9). The more experience music-for-health practitioners have, the more confident they become (Preti & Welch, 2013). For example, one participant described how she learnt to prepare herself mentally, emotionally and practically:

It actually starts from even going back to when you arrive at the hospital... thinking about what kind of mood you are in, so that... you leave everything behind and your... mind is clear and open. So, even that process of preparation I think is very important, how you enter the environment of the hospital... Then it gives you time to get ready, get the instrument ready... all that kind of clearness, that ritual of preparation I think it's all part of this process of being ready.
(Sophie)

Taking note and taking in

Information from observation was significant for the practitioners' decision-making process, not only whilst interactions took place, but also in their reflections after the sessions. In these ways, they absorbed what happened and used this to move forward in their practice.

Reading the moment

One term frequently used was to “read the room”, the ability to take in the moment and decide how to respond musically. Reuben said, “I think a lot of it is almost a sense of reading the room... and then you try to spot individuals within that setting.” Preti and Welch (2013) discussed “the constant attention musicians needed to ‘decode’ an emotional situation and ‘translate’ it into music” (Preti & Welch, 2013, p. 370). This process includes reading body language, sensing changes in emotion, and being aware of physical and verbal cues. Body language was particularly relevant for the participants. Sophie mentioned looking for small body movements: “they might turn their head slightly towards the music, they might open their eyes. They might start to move a hand or a foot.” In Reuben's case, he talked of more emotive body responses, such as patients who made eye contact and those “who will not give eye contact or hide behind newspapers or phones... [or] somebody who looks a bit upset or turns their back on you.” This level of awareness allowed him to interact with everyone accordingly and sensitively, perhaps drawing the more subdued patient into the interaction through the enthusiasm of the other. The ability to read body language has long been recognised as a key factor when communicating in all professions (Slovenko, 1998). This is essential in an environment, such as a paediatric ward, where many of the patients are non-verbal. Not only is this key for initially reading a situation, but also to continue communication during an interaction, by observing emotions, gestures and the sounds patients make (Hawley, 2018). Sophie explained:

On approaching the bedside, really trying to see, is there a child who is maybe on their own or isolated or maybe looking bored that might be ready for some musical interaction? Does anybody in a bay look at us immediately and look curious?

Practitioners then determined whether music was appropriate at that time, whilst being aware of each individual in the room. These cues were not always positive, and Reuben mentioned how it was equally important to be aware of the people who did not want music. Similarly, Sheridan and McFerran (2004), even though focusing on music therapy, discussed similar opportunities of choice and control, where patients were given the option to engage with music or not. The practitioners spoke about processing this information to decide how to react and move forward with the interaction.

Reflection

Reflective observation allows practitioners to understand their current practice and improve for the future. All participants highlighted the importance of reflection, especially for making future decisions, having a support network and processing their experiences. Claire explained, "learning from the past to inform the future, it just makes every decision so much quicker." Reflection allows practitioners to examine their practice, note successes, learn from observation and create a basis for making future decisions. This corresponds to Petersson and Nyström's (2011) theme of learning through reflection. Sophie said, "to think about your practice, to think about why something worked, why it didn't work, how you felt at that time, how you engaged with other people, is definitely important in improving your work." Fiona described a cyclical connection between reflection and action as follows: "it's all very well and good sort of sitting and thinking about things for a long time but then, it's almost like you have to practice making decisions based on your previous reflections on the spur of the moment."

Reflection on self is another important aspect of this theme. Preti and Welch (2012b) researched the challenges musicians face in the emotional and stressful environment of a hospital, in particular the "risk of burnout and related causes" (p. 652). Their participants talked of physical exhaustion and emotional fatigue and how it impacted their work. The negative implications for musicians working in hospitals, such as the "burden of caring" (Edwards, 2016, p. 850) experienced by music therapists, should be understood and tackled. Self-care is self-evidently important; "it makes sense that in order to help others we must first help ourselves" (Radey & Figley, 2007, p. 210). In this study, Sophie mentioned allowing herself time before working in the hospital to get in the correct frame of mind. In addition, Fiona stated:

Quite often I will just slip off to a play room or just wander down the corridor between interactions so that I can just have a little bit of head space, so you don't feel like you're just constantly running... and that's the only way really that I've managed to feel like I stay in the moment for each interaction.

Understanding self-preservation appears to be of utmost importance within this work. Many of the participants in the study by Preti and Welch (2012b) talked of having a break from hospital work for self-care. Being aware of one's emotions and the need to react accordingly runs parallel to being congruent in one's practice. There is a balance between emotional self-awareness and the need to be transparent with the patients (Greenberg & Geller, 2001).

Performance conditions

Even within a hospital setting, the practitioners were all aware of themselves as performers. The space they were in became a performance space. However, an awareness of the setting helped guide the decisions of the practitioner, determining what was appropriate.

Clinical setting

The paediatric hospital is an unpredictable and difficult environment for family, patients and staff (Edwards & Kennelly, 2016). This was noted by all practitioners; the complexity of the setting needed acknowledging in order to make appropriate musical and interpersonal decisions. The musicians learned their place within the hospital, as described by Sophie: “music is one element in the hospital... it might be quite a low priority element for the whole hospital, so... finding your place and that being strong there... can take time to develop.” To help find this place, participants found it helpful to observe and listen to the staff because music-for-health practitioners are often not informed of a patient’s situation before starting an interaction. Musicians also learn to transfer their skills (Hawley, 2014) to fit this unique performance space, where decisions are no longer only musical, but also based on the patients’ needs and the clinical surroundings (Hawley, 2018). Aiding a medical intervention, as mentioned by Fiona, might require the musicians to play relaxing or distracting music (Preti & Welch, 2012a), whereas entering a play room might mean performing something fun and engaging. For the practitioners in this study this meant understanding the unpredictable ward environment, taking note of the clinical situation and demeanour of staff. Sophie and Reuben both commented on observing the monitors for oxygen levels and heart rate, reacting to changes as part of their decision-making process.

All practitioners were asked about how they make in-the-moment decisions in the clinical setting. The word “clinical” proved to be of great interest, with practitioners stating that they were unqualified to make clinical decisions. Fiona responded, “I’m not clinically trained so I wouldn’t say I was making clinical decisions generally.” Even though “Clinical decision making is a balance of experience, awareness, knowledge and information gathering” (NHS Education for Scotland, 2013), and this definition could be used to describe music-for-health practitioners’ work, it must be acknowledged that musicians working in healthcare settings might not identify with this label. Some music therapists, such as Procter (2004), also actively use non-medical ways to organise and understand their work, which de-emphasise the clinical. In this regard, there is a strong resonance between music-for-health work and the ideals of Community Music Therapy (Stige & Aarø, 2012).

Spontaneity and intent

Intuitive, spontaneous and instinctive decisions play an important role when working in this unpredictable environment. Claire stated, “you never really know what’s gonna happen and every session is completely different, and it’s great but it’s crazy.” Instinctive decisions occurred as practitioners became more familiar in an environment. Claire added that “there are decisions that you don’t even realise that you’re making until you’ve made them... as it gets more instinctive you can kind of see if something isn’t going to work very well.” Sophie also commented on working with other musicians long-term:

I suppose through working together for a long period of time, most of the time... we might... feel a shift together that we need to slow down or change the mood... That kind of working together I think is like an unsaid decision-making.

The performance setting is a particularly unpredictable environment, where change is frequent; therefore, spontaneity is needed in making quick decisions. All participants mentioned this as part of their work; for example, reacting to a child by copying their movements and emotions was a spontaneous action that practitioners employed. Participants in Preti and Welch's (2013) study also discussed the ability to be flexible in order to meet patients' needs, especially when they are non-verbal. Flexibility ran throughout participants' responses in the present study, regarding their intentions and reactions, including the idea that there was not just one way to make a decision. There was respect for fellow practitioners who made different, but equally effective, choices:

Somebody else might go into a situation and maybe make a different decision and both outcomes might be equally effective... so it's not that your one way is the right way. (Sophie)

Practitioners all started with intentions, even if they diverted from their initial plan, as in studies of music therapy practice by Beer (2011) and Loth (2017). In this current study, Reuben spoke of musicians having a role to play in lightening the mood and creating a fun atmosphere, similar to the participants in Preti and Welch's (2013) study, who talked of needing a sense of humour and being entertaining. However, Fiona's intentions were the antithesis to this:

I feel very... strongly that the music is not there to cheer people up, it's there as a reflection of what's going on in that moment. And the mood can change, can be helped by music but at that time I'll always try and fit the music to the mood, not to impose the mood on top of what's happening.

This view echoes the Iso Principle (Bunt & Stige, 2014), which relies on initially matching the patient's mood before intervening to change their affect. Similarly, in Baker's (2013) study, music was composed with patients to convey the emotions of the moment. Fiona developed her view by stating, "My intention... is always to bring music to the space and to see what happens. But that's the only intention I ever have when I go... to work." For Fiona, this intention underlay all others and never changed, all further intentions related to context. In this sense, her approach proceeded from musical actions to goals, rather than the opposite. These two possible ways of connecting actions and goals are outlined and discussed by Beer (2011).

Forms of communication

Communication through music and through interpersonal interaction was frequently mentioned by the practitioners as fundamental to decision making.

Musical presentation and choices

In an environment where verbal communication is not always easy or possible, music provides a place where “people can share emotions, intentions and meanings” (Hargreaves et al., 2005, p. 1). With the music prepared and chosen in a way that was flexible and had variety, practitioners then altered it to suit the situation. Music was predominantly directed by the child, similar to the findings of music therapist North (2014) who noted, “we continually respond to an individual’s actions or vocalizations, no matter how small, seeking to give control over aspects of the music” (p. 780). This form of direction was noted by the participants in this study and took several forms: it could be through following the children’s emotional state, but equally following the physical movements or sounds they were making. It could also mean playing music that suited one child, but then having to alter it quickly to suit the needs of another. Fiona described such an interaction:

When I went into the room I had a piece of music which could have gone either way. I started off... at a moderate speed and quite a low level and then, immediately this boy ran up to me and so I sat down on the floor with him... he was just so excited to see the cello and the instruments, and so immediately in that little corner of that room the music came up... But then I’d noticed... there was another little boy who was on his own and was quite upset so, I then brought the music back down when I was leaving that corner and using the same music walked over to go and work with this boy, on a sort of different musical level.

Music is a tool to communicate with patients, especially through musical conversations: “Improvised musical interactions can help sustain communicative interactions without words” (Wetherick, 2014, p. 868). Petersson and Nyström (2011) stated that a thorough musical knowledge enables a conversion to therapeutic performance, especially with regard to improvisation. Practitioners in this study communicated through reacting to changes in the patient. Sophie suggested this may occur when “a child’s got quite excited quite quickly so we might think... we just need to bring everything back a little.” Practitioners found ways to reflect this change in their performance. They mentioned different methods for doing this, such as changing the key, melody, tempo, timbre and dynamics, sometimes using silence and ensuring the changes between musical styles were gradual, so the transition was smooth and the music mirrored the child’s actions and demeanour. Hawley (2018) described the variety of repertoire needed to aid the communication process and the knowledge of how to change the music and why. The need to have an extensive knowledge of how to communicate through music is essential.

Interpersonal interaction

Communication also occurred through personal interaction between practitioner and child. Similar to determining a musical change, practitioners reacted to a change in a child’s demeanour, interpreting their emotions by altering aspects such as their own body language, their position in the room or what they said. Thus, the patients’ needs were communicated and reflected through the interaction, as Reuben described:

If... I'd read that somebody was feeling very distressed I'd try and... dissolve away a little bit... move slowly backwards. Likewise, if somebody was reaching out, or if the readings look positive I would move forward.

Hawley (2018) wrote of "learning to read the signs of communication" (p.14), as it is important to note that communication is not only from the musician through their playing, but also from the patient reacting to the music. Many of the patients in a paediatric environment are non-verbal and Hawley described the importance of using facial expressions and body movements as a form of communication with a patient. Practitioners in this study mentioned the importance of approaching an interaction with care, also observing the use of verbal and non-verbal communication. Speaking to family and children at times was mentioned as being useful, as well as watching staff reactions and having eye contact with the child. Then, the role is to react to this information accordingly and communicate one's understanding of the situation. Sophie spoke of communication with a non-verbal child:

The boy and I had little kind of mouth popping conversations... very subtle sounds at the bedside and there was this point where we felt we really had a conversation and he was very aware of us.

Regarding starting interactions, Loth (2017) described the difficulties that can arise, especially when meeting patients for the first time. The practitioners in this study decided by what means they should approach the bedside and allowed space for the child to react and guide the interaction. Being guided by the child and creating a reciprocal communicative flow relates to Sheridan and McFerran's (2004) findings that choice and control in music therapy leads to empowerment and improved quality of life.

CONCLUSION

This study aimed to explore how music-for-health practitioners make sense of decision making whilst interacting with patients in paediatric hospitals. In responding to the research question, the results express an understanding of decision-making through the following themes: (i) Building the foundations; (ii) Taking note and taking in; (iii) Performance conditions; and (iv) Forms of communication. These elements of practice interconnected and ran in parallel, grounding the practitioners' decisions and allowing them to draw on their previous musical knowledge, skills and experience. Participants also found meaning in their reflective process and how they read the moment during an interaction. They also discussed spontaneity in their practice and how the decision-making process developed through experience. This process included different types of decisions: in-the-moment decisions as an instant reaction, intuitive decisions that developed through experience and reflective decisions that were informed by previous practice.

The results give a detailed picture of the multiple areas of decision-making required for music-for-health practitioners. Although the data collected in this study are rich, having more participants, especially those with fewer than five years of experience, would have resulted in a more representative

sample. An area for future research would be to compare the decision-making process of practitioners at the very start of their careers to practitioners with a wealth of experience. This could help to outline what areas of training need to be developed for new practitioners to begin the decision-making process that the more experienced practitioners undertake. Additionally, the points raised by practitioners regarding their understandings of the word “clinical” highlights a potential area for further discussion, namely the use of terminology in music-for-health work and how this might relate to notions of professional identity.

Music for health is becoming an increasingly popular career path for freelance musicians (Petersson & Nyström, 2011) and this study has explored the process of decisions that can be transferred into practice for musicians who are making the transition into this work. It is hoped this might be particularly useful for practitioners at the beginning of their therapeutic careers and for experienced practitioners as a point of reflection. The emergent themes could be referred to in training new practitioners, to develop sensitivity to this aspect of practice from the outset, running alongside the work of Petersson and Nyström (2011), who explored the learning processes for early-career practitioners. This article may also have relevance to multi-disciplinary teams, allowing doctors, nurses and other hospital staff to understand decision-making processes in greater depth. In turn, this understanding may foster closer collaboration and better integration of music-for-health practitioners into healthcare settings.

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APPENDIX: INTERVIEW QUESTIONS

1. How long have you worked as a music-for-health practitioner?
2. How long have you done this work in hospitals?
3. How long have you worked with children in hospitals?
4. Could you tell me about a memorable experience interacting with a patient?
5. How do you make sense of the initial decision-making process?
<Prompt> For example, is there anything in particular you might look out for to guide your interaction?
6. (i) What sources of information do you use to make clinical decisions?
(ii) How do you integrate these sources of information?
7. What decisions do you make when first going into a musical interaction?
8. Are any of these more important than the other?
9. How does planning and preparation help make in-the-moment decisions?
10. What might prompt you to decide to change how you play and interact during a session?
11. To what extent does your prior musical knowledge help guide your decision-making?
12. How do you decide what music is appropriate for the setting?
13. How do you know which of your skills you need to draw on for particular interactions?
14. How does reflection on previous practice help you make in the moment decisions? (reflection in action)

Ελληνική περίληψη | Greek abstract

Πώς οι διαδικασίες λήψης αποφάσεων των επαγγελματιών μουσικής και υγείας ενημερώνει το έργο τους σε παιδιατρικά νοσοκομεία

Jessica Tomlinson & John Habron

ΠΕΡΙΛΗΨΗ

Η παρούσα ποιοτική έρευνα μελέτησε τον τρόπο με τον οποίο οι επαγγελματίες μουσικής και υγείας [music-for-health practitioners] κατανοούν τη διαδικασία λήψης αποφάσεων στο πλαίσιο των νοσοκομειακών παιδιατρικών κλινικών στο Ηνωμένο Βασίλειο. Παρόλο που προϋπάρχουσες μελέτες έχουν διερευνήσει τις δεξιότητες που αναπτύσσουν οι επαγγελματίες και πώς αυτές συσχετίζονται με τα αποτελέσματα και τα οφέλη της μουσικής για την υγεία, αυτό το άρθρο περιγράφει συγκεκριμένα τη διαδικασία λήψης αποφάσεων και το πώς οι επαγγελματίες αντλούσαν από ήδη κατακτημένες δεξιότητες. Τέσσερις επαγγελματίες μουσικής και υγείας, όλοι εκ των οποίων εργάζονται σε νοσοκομειακές παιδιατρικές κλινικές του Ηνωμένου Βασιλείου, τοποθετήθηκαν σχετικά με τις εμπειρίες τους στη λήψη αποφάσεων. Οι συνεντεύξεις ήταν ημι-δομημένες. Τα δεδομένα αναλύθηκαν θεματικά και προέκυψαν τα παρακάτω θέματα: (α) χτίζοντας τα θεμέλια, (β) παρακολούθηση και κατανόηση, (γ) συνθήκες της μουσικής εκτέλεσης, και (δ) τρόποι επικοινωνίας. Η μελέτη απευθύνεται σε επαγγελματίες μουσικής και υγείας που βρίσκονται στο ξεκίνημα της καριέρας

τους, προσφέροντας τρόπους να κατανοήσουν τη διαδικασία λήψης αποφάσεων. Μπορεί επίσης να φανεί χρήσιμη σε πιο έμπειρους επαγγελματίες ως προς το να κατανοήσουν και να αναστοχαστούν σχετικά με τις δικές τους επαγγελματικές διαδικασίες λήψης αποφάσεων και να έχουν μία τεκμηριωμένη βάση όταν εκπαιδεύουν νέους επαγγελματίες. Με επίκεντρο το πλαίσιο του παιδιατρικού νοσοκομείου, αυτό το άρθρο μπορεί ακόμη να έχει διεπιστημονικές προεκτάσεις στο να βοηθήσει το ιατρικό, νοσηλευτικό και άλλο προσωπικό να κατανοήσουν καλύτερα την πρακτική της μουσικής για την υγεία.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

λήψη αποφάσεων, παιδιατρικό νοσοκομείο, μουσική για την υγεία