

[MUSIC IN HOSPITAL article]

DO YOU DO QUEEN?

Mike White, Director of Projects at the Centre for Arts and Humanities in Health and Medicine (CAHHM) at Durham University writes about a music project in intensive care units in the North East

I recently accompanied two musicians – a cellist and a jazz singer – into the intensive care unit (ICU) of a North East hospital. For several months the musicians have been providing a discreet music service on request for ICU staff, patients and their relatives. The initiative has been jointly supported by the hospital and by Common Knowledge, an arts in health development programme for Tyne and Wear Health Action Zone.

Some hospital staff had initially been understandably nervous about such a bold intervention, that it might distract or disrupt care, or might even require communal participation (which for some seems a fate worse than death). Additional assurances were given to the hospital's Ethics Committee that there would be no breach of confidentiality, particularly in the journals the musicians have been keeping to reflect upon their project as part of the evaluation being conducted through CAHHM.

Tabitha, the cellist, rang me an hour before the ICU session to confirm it would take place. Due to the sensitive nature of the location and the circumstances of the moment, less than half the sessions can take place as planned and must be re-scheduled. So perhaps in future this pilot project, rather than being session based, should look to become a hospital residency with the ICU having first call on the musicians.

Tabitha and Margaret meet me at 5pm and take me through to ICU. They are proudly bemused by their identity badges that proclaim 'NHS Musician'. We are greeted by the unit's nurse manager. She by now seems quite relaxed in having the musicians' regular 'recovery service' brought into the unit. She tells me how one of the nurses has been really excited by this project and is writing about the therapeutic uses of music as part of his degree course in critical care nursing.

This is the time of changing work shifts in ICU. Today is less busy than usual. Present are seven nurses, four doctors, a domestic, and four patients only one of whom is conscious. Tabitha unpacks her cello and uses an orthopaedic stool as a makeshift music stand. I shrink into a chair, suddenly nervous. Margaret stands in

the middle of the floor. “Start me off” she says, “what should I sing?” I suggest “something by Frankie, but mellow”. And she’s away singing a cappella *It’s One for My Baby, and One More for the Road*.

Then Tabitha plays two Bach airs, Margaret joining her on the second one popularly known as the Hamlet cigar tune. (Somewhat ironic I realise later given the North East has the highest cancer rates in England. This hospital is also in a district with just about the worst coronary rate in the country.) They sing and play at a level just above room noise. And in the pauses between tunes, the chamber music of intensive care asserts itself like subdued Stockhausen – a constant hiss of gas cylinders, the occasional monitor bleep, and the clinical babble of staff quietly conferring. Everything here is as it should be - intense.

But the mood becomes more relaxed. The conscious female patient blinks recognition at the end of each number. Staff are preparing to move her to the High Dependency Unit next door. Tabitha tells me that at their last session all six beds were occupied. One old guy clapped feebly at the end of each piece, later confessing “You don’t know the good that’s done me. See, I’m a musician too.” A heartfelt response as this is not a place for sentiment. At their very first session the musicians were asked by a family to play last requests for a dying relative.

Margaret encourages the staff to make their own requests. So we get *La Vie en Rose* and a medley of *Sound of Music*. Two relatives come in to attend an unconscious elderly man in a corner bed, while Tabitha is playing an Irish melody. The nurse manager enquires if they’d like the music to stop as they’re clearly upset. No, they say, but ask if it could be more upbeat. Tabitha obliges. The musicians are constantly judging the appropriateness of what they are doing, responsive to the medical teamwork and trauma going on around them. Every bit of this ‘performance’ is in a very real sense on the edge.

Visiting hours begin. A last song from Margaret “Shall I do *Every Time We Say Goodbye?*” Her mouth opens, then she checks herself, abashed. “No, definitely not... *Wonderful World?*”, and she’s off again.

Afterwards during tea break in the staff room, Margaret says last week a young male patient asked her to “do some Queen”. “The only one I could think of was *We Will Rock You.*” “Better than *Another One Bites the Dust?*”, quips a male nurse evincing the kind of humour you need to retain the sanity required of the job. And I imagine that, her singing “*you got blood on yer face, yer big disgrace... we will, we will rock you?*”, transforming a macho anthem into a lullaby.

How do you put a value on work like this, identify its cost benefits? Some ICU staff have anecdotally noted a reduction in blood pressure in coma patients that has

coincided with these music sessions. This could be the basis of a longer-term research programme if we can raise resources and get Ethics Committee approval. But the essence of the intervention is already here in that it is about sensitising and alleviating the clinical environment through the potential pleasures of music in itself for people in distress, some in crisis. It is probably the most extreme circumstances you could place the arts in, short of a war zone. I am awed by the pluck and sensitivity of the musicians in taking on work as challenging as this.

The Chelsea and Westminster Hospital is currently undertaking in-depth evaluation of the benefits of arts in healthcare. Early findings revealed that music had a higher satisfaction rating than visual art among hospital staff, patients and visitors. The study has gone on to frame and explore more difficult questions around clinical outcomes, with intermediate indicators emerging that music reduces anxiety. But an evidence base for the effectiveness of arts in health could have a narrowing effect, simply using rather than developing the art form in its context, unless we can also achieve a broader understanding of quality in the clinical environment. Both the musicians and the music have their own unique subtlety if the engagement is approached in the right way. Therapeutic effects are embedded in the process and outcomes are a resonance of this. It is in this area, I believe, that hospital arts and community based arts in health could develop interesting exchange of research and practice. Therein I wonder if it might still be possible to evolve a unifying theory of arts in health. To have effective political influence we probably need one.