

“...SING A SONG TO THE SICK AND TENSE...”

Within the boundaries of the healthcare institution, the sounds of illness become the only song that is heard unless the environment is programmed for healing.

by Susan F. Mazer and Dallas Smith

Two sets of smoky glass doors slide open automatically, widening onto a black corridor of sterile linoleum. The walls are nondescript, with overhead fluorescent lights and painted arrows on the floor. The sounds are a combination of crying, laughing, talking, machinery, beepers, Muzak, loudspeakers, all mixed together with an ominous silence. Upon entering the aloneness of the hospital room, one notices that the sounds continue to intrude beyond the four visible walls. The noises are exaggerated, distorted, unending. The din coming from everywhere soon blends into the still characterless walls, never yielding to the fear it creates, enrolling all present in its relentless chorus.

The hospital is the place where individuals in trauma go with the hope of transforming illness into wellness, where physical pain and emotional stress are constant challenges. The above portrayal of a hospital environment is from the point of view of a patient who, by virtue of his diagnosis, has been awarded admission to a hospital that most likely has the best technology healthcare care has to offer. It is also the context for the various aspects of clinical practice and the relationships and events that influence recovery.

For the patient and family embroiled in the midst of a health crisis, the need for care begins upon entering through the sliding glass doors, which is where the healing environment must be felt and heard. For the healthcare professional who may spend more than 200 days a year tending to patients, the healing environment is no less important.

Dynamic and pervasive, the aural environment holds the experiences, beliefs, thoughts, feelings, and the spoken and unspoken communications that occur among all who are involved with the patient. **When devoid of intention and defined only by random occurrences, this sound environment is an “accident.”** Characteristic of any accident, there are victims. In this case, the casualty list is all-inclusive.

Research addressing the therapeutic effects of music has repeatedly confirmed that, when used appropriately, music has positive physiological as well as psychological effects. However, controversies also link music to everything from drug abuse to the potential music has to affect the patient’s

teenage suicide, from being a manifestation of God to being a temptation from Satan. This debate further demonstrates the potential music can have on the patient experience. Thus, the use of music to create and sustain a healing environment must be intentional rather than inadvertent.

Additional data has shown that sound, whether in the form of music or noise, has a definitive impact on individual health. However, other than dealing with cursory nuisance issues, hospitals have been reactive rather than proactive in acknowledging the consequences of an incidental aural environment on patients and staff. Inattention in this regard has hardly rendered a silent environment. To the patient confined to the boundaries of the institution, the sounds of illness become the only song that is heard unless the environment is programmed for healing.

As a therapeutic protocol, music has been used on only a limited basis. Utilizing the patient-therapist model, music therapy is practiced one-to-one or in small groups. Unfortunately, it is typically considered a luxury to be afforded only by exceptional institutions or to be used as a treatment modality only for individuals with a predisposition toward music.

In contrast, the use of music as environmental design extends beyond the individual patient. Its main objective is to create an inclusive environment appropriate to recovery and the objectives that drive all clinical protocols. Using music to *condition* the space to be therapeutic provides on-going care for patients during the long hours between clinical interventions. It extends the therapeutic presence of the nurse to the moments when the patient is alone.

“The primary objective ... is to experience the environment as *shiftable* space, space that has the capacity to respond to a wide range of emotional and physical events that occur in the transition from disease into recovery.”

Given the pressures to move patients through the healthcare system, it is imperative that the hospital be designed to be in alignment with long-term health objectives. The dynamic components of the environment—those that change on a minute-to-minute basis—require attention *and* intention. What the patient hears, what is in his/her line-of-sight, odors that pervade the room, what actually touches any part of his body—all of these things play a critical role in the patient experience, regardless of whether they are considered clinical in nature.

While long-term compliance and adherence is most commonly mandated, a healing environment empowers patients’ participation in their health through meaningful education. Personal lifestyle choices such as unhealthy eating habits, alcohol abuse, smoking, and high-stress living often bring the patient to the healthcare professional. The recovery process offers the patient an opportunity to reconsider lifestyle choices based on what has become relevant and meaningful, rather than what has been experienced as rhetorical.

Nonetheless, educational information—even that which is critical to the patient and family—can have little to no impact if it is provided at an inopportune time or in an environment that contradicts clinical intent. A setting that generates confusion or anxiety, or one that appears negligent in detail, minimizes comprehension and retention and puts at risk the credibility on which medical directives are followed.

Information specific to the intentional design of the physical and aural environment of the hospital assists the patient in gaining an understanding that the space in which he lives and heals has its own outcome. At *St. Luke’s Episcopal Hospital* (Texas Medical Center, Houston) and other hospitals, staff development programs address issues related to altering the dynamic environment to be therapeutic.

These programs are not particular protocols or therapies, nor are they merely about the joy of music. They establish the environment as an ethic of care and as a necessary part of clinical practice if outcomes are to be optimized. Thus, the enrollment of the staff is crucial to the success of any healing environment initiative.

At the request of hospitals that identified the need for a therapeutic environment, **The C.A.R.E. Channel®**, a 24-hour environmental programming format for patient television, was produced to create a *continuous ambient relaxation environment*. It offers an alternative to commercial television programming, which may be inappropriate and distracting.

While the television delivers music at the bedside through pillow speakers, on-screen ambient nature scenes become a component of the overall physical contour of the room. Avoiding overly complex, fast-paced video production common to current television formats, the serene images are presented as the human eye sees—slowly paced, with enough time for both contemplation and engagement. For the confined patient, the television functions as a window to the outdoors.

In respect of the importance of the circadian rhythms, The C.A.R.E. Channel is appropriately paced, adjusting as the activity levels change from day to night. During late-night hours, the television provides soft, non-invasive lighting, with music and a midnight starfield that support rest and regeneration. The music can be used independently of the visuals by patients who do not or cannot view the television.

At *St. Luke’s Episcopal Hospital* and *Henry Ford Hospital* (Detroit), patient-focused sound systems have been effective in medical intensive care units, reducing noise and stress levels. Optimized for low-volume broadcast, full-frequency speakers and accessible volume controls offer both quality and flexibility. While each speaker can be adjusted locally, the overall ambience of the unit is set at a central amplifier. The music is intended to neither compete with nor eliminate commercial television and may motivate patients or their families to bring in their own music.

The primary objective in using music as environmental design is for the patients and staff to experience the environment as *shiftable space* that can be transformed from fear-ridden into safe, from stressful into peaceful, one that reflects the ethic with which patient care is delivered. Only such a place has the capacity to respond to the wide range of emotional and physical events that occur in the transition from disease into recovery.

“A positive, empowering, and accessible experience that reaches beyond the institution motivates individuals to become involved in their own care.”

In addressing the issues of *after-care*, one must **confront the imbalance that often occurs between the clinical and the non-clinical objectives**. Although the healthcare staff and administration provide ample information and medical directives, the home environment in which recovery actually occurs is handled as if it were not clinically relevant.

If it is acceptable for the hospital environment itself to be a risk factor, there is in the experience of the family little basis on which to mandate a therapeutic home environment. **The healing environment can be prescribed for the home setting only when it has been modeled in the hospital.**

Clearly, the environment is either friend or foe to the patient. Anecdotal and empirical evidence in the use of music in hospitals have demonstrated reductions in the demand for pain medication, the noticeable lowering of stress levels among both staff and patients, and increased patient satisfaction.

The emergency room at *Washoe Medical Center* (Reno, Nevada) was transformed from its typical noisy chaos to a calmness that had not previously been experienced by long-term staff members. In response to the skepticism of staff who felt that the noise and ambience of stress was unavoidable, music was appropriately introduced to demonstrate that the environment could be both efficient and therapeutic.

Designing Environments that Heal[®], a full-day accredited workshop, establishes the environment of care as a powerful catalyst in healthcare delivery. Empirical and experiential information are used to develop an institutional strategy to fulfill environmental goals. These programs work on the premise that nothing can shift in the institution that does not first shift in the individual. Informed and committed staff can alter the “accident” of institutional ambience into a space that is personal, safe, and sensitive to human suffering.

The decision to design a healing auditory environment is not a matter of imposing one person’s personal taste in music over another’s. Preference for country-western, classical, opera, jazz, or none of the above, should be of little consequence. Personal taste, opinions, and beliefs regarding music used in other settings are no more appropriate in dictating environmental healthcare policy than they are in mandating decisions surrounding other medical modalities. Through education and ongoing staff-development, controversies that surround the discussion of music become a commitment to a higher quality of care.

Music, as the least acknowledged and most under-rated means for affecting the recovery process, is often relegated to the status given it by whoever is in the administrative seat. That person’s opinion may include “no opinion,” resulting in an environment driven by issues and biases that may have little to do with patient care.

The healing environment has a very definite feeling, rather than a specific sound or look. Within the hospital setting, healing healthcare can be demonstrated through an active partnership between intentional environmental design and committed healthcare professionals. Prioritizing the healthcare environment as an issue of quality assurance acknowledges the significance of patient spaces as they affect therapeutic outcome. Indeed, the commitment to healthcare that heals as well as cures requires that the clinical environment be a reflection of healing, health, and care.



“When administered with propriety and intention, music is beneficial, effective, non-addictive, affordable, and universally available ... essential to the realization of healing environments ...”

In conclusion ...

The environment of care plays a critical and primary role in determining patient outcomes. While other sentient stimuli can be controlled, the sense of hearing is so active and acute that the sound environment becomes dominant in the patient's experience. To the medicated patient, the anxious family member, and the highly stressed staff member, noises of disease and of recovery often become indistinguishable. Therapeutic objectives, therefore, are embattled with both the diagnoses and the environment in which care is delivered.

In this time of medical transformation and self-investigation, the responsibility for modeling the design of a healing environment lies with the healthcare industry. Participants in the healthcare system, whether patient or staff, must demonstrate what is possible and necessary in designing a healing environment at home and at work. When administered with propriety and intention, music is beneficial, effective, non-addictive, affordable, and universally available.

Healing healthcare uses music as environmental design to ease the time patients are alone, to insulate them from erratic noise, and to make personal that which often feels institutionally generic. When comparing documented results of the therapeutic use of music against the symptoms caused by institutional noise, it becomes obvious that music should best be proactively advocated, rather than regarded as frivolous. Furthermore, environmentally generated symptoms, such as heightened anxiety and pain, can be mitigated environmentally rather than treated solely pharmaceutically.

For those healthcare institutions who will serve as models in the 21st century, music as environmental design will be a “usual and customary” protocol. Providing a healing environment will be an ethic of care that will be visible and audible from the first moment one enters through the sliding glass doors.

HEALING HEALTHCARE SYSTEMS founders, **SUSAN MAZER** and **DALLAS SMITH**, are acknowledged pioneers in the use of music as environmental design for healthcare facilities. They are the authors of *Sound Choices: Using Music to Design the Environments in which you Live, Work, and Heal* (Hay House, 1999).

Trained as classical musicians, Mazer and Smith are a husband and wife team that spent the first 20 years of their careers as full-time performing and recording artists. After being approached by several hospitals and becoming aware of the need for programming specific to the needs of patients and staff, they decided to refocus their efforts on the healthcare environment.

Since 1984, in making the transition from performing to consulting and creating products for the clinical environment, they have deepened the understanding of the capacity of sound in the form of either music or noise to impact the quality of the patient experience. In more recent years, their involvement with hospitals has necessarily expanded to include what they call the dynamic components of the environment, those that are non-fixed, changeable, and affected by patients, families, and staff.

Their work at HHS today includes the development of new products, environmental design consulting, educational training, and producing The C.A.R.E. Channel. Mazer and Smith have been featured speakers at national conferences, including The Healthcare Forum, The Clinical Laboratory Management Association, The Association for the Care of Children's Health, the Planetree Conference, the Association of Healing Health Care Projects, and the Symposium on Healthcare Design. Their presentation to the Symposium on Healthcare Design is published in *Innovations in Healthcare Design* (Van Nostrand Reinhold, 1995). In addition, their substance-abuse prevention workshops are recognized by the U.S. Department of Justice and the Safe and Drug-Free Schools Program of the U.S. Department of Education.

For information about The C.A.R.E. Channel, workshops, and other environmental design products and services, contact:

HEALING HEALTHCARE SYSTEMS
100 West Grove Street, Suite 175
Reno, NV 89509
Tel: (775) 827-0300
Fax: (775) 827-0304
www.healinghealth.com
e-mail: hhs@healinghealth.com



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