

Pedagogical tact in music education in the paediatric ward: the potential of embodiment for music educators' pedagogical interaction

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Abstract

This article aims to contribute to the current theoretical and practical understanding of music educators' pedagogical tact through a theoretical lens of embodiment within a children's hospital. Embodied pedagogical tact as a form of practitioner knowledge can effectively serve as a means for music educators, working along healthcare professionals, in the interdisciplinary field of healthcare. The article argues that intertwining pedagogical tact with an epistemological view that relies on the mind-body connection, enables music educators to operate in complex educational situations in paediatric wards. It is concluded that bodily reflections may serve as key competencies beyond musical skills for the educator in navigating through emotional arousal, while supporting the well-being of children and their families in a tactful, sensitive manner.

Keywords: *embodiment, healthcare, music education, paediatric ward, pedagogical tact*

Introduction

The purpose of this article is to enrich the theoretical basis of music practitioners' work in hospitals. In Finland, among other countries, there is an increasing number of initiatives at the political, practical and theoretical levels that justify the art practitioners' entries into the most fragile of healthcare environments, such as palliative care wards, neonatal intensive care units and oncological wards (Dileo & Bradt, 2009; Liikanen, 2010). However, scholarly discussions in the field of music in healthcare have generally focused on medical, therapeutic and rehabilitative frameworks. Music education has been part of curriculum and teaching in hospital schools (Ruiz & Álvarez, 2016),

and musicians performing in hospitals is a well-established practice (Preti & Welch, 2013). Regarding music practitioners' work in bedside music alongside families and hospital communities, more research and professional debate is required. This debate would enable the construction of music practices in a more systematic manner¹ and the organisation of future education and interdisciplinary work of music educators, as well as facilitating professional music practitioners' (e.g. musicians', folk musicians' or ethnomusicologists') work overall. In this article, we look beyond the concept of the "healing power of music" by examining music educators' pedagogical tact in and through embodiment in the context of paediatric care (Merleau-Ponty, 1962/2014; van Manen, 1991). With the healing power of music, we refer to approaches taking music as an entity with its own ontology and laws of subordination (see DeNora, 2013) that is difficult to evaluate, examine or explicitly describe.

In the context of music, health and wellbeing, music education has been mainly introduced in the framework of *community music* that has an objective of increasing access to music activities outside conventional institutional settings (Higgins, 2006; Hallam & MacDonald, 2008). Another intriguing concept is *health musicking* (or *health musicing*), an interdisciplinary area of research and practice where professionals and volunteers are engaged in health-promoting music practices in social and healthcare contexts (Bratt-Rawden, Trythall & DeNora, 2009; Ruud, 2012; Stige, 2012). *Care music* can be described as musicking (or musicing) mainly in care environments and mainly by music professionals (Foster, 2014). A conceptual framework of music, health and wellbeing was introduced by MacDonald, Kreutz and Mitchell in 2012 (see MacDonald, 2013). This framework is focused on music education, music therapy, everyday uses of music and community music as an interdisciplinary theoretical model that allows a broad understanding of participation in musical activities. The context of this study is delineated from these frameworks by contributing to the under-researched theory and practice of music education in the specific context of paediatric care. We use the designation of "music educator" to refer to a music practitioner. A music educator is assumed in this article to be a professional, who has an education and maintains a professional degree in her own discipline.

Specifically, this article does not aim to analyse any similarities or differences in music-related professions in healthcare settings. Instead, we intend to provide some

1 For example, there are viewpoints that music can be detrimental to the babies' development (see Standley, 2003); for instance, in cases of neurological overstimulation or overstepping the sound level recommendations. Therefore, education and professional knowledge of music practitioners should follow evidence-based practices when entering these fragile environments.

interdisciplinary insights applicable to a variety of music-based professional practices. This article argues that intertwining pedagogical tact with an epistemological view that relies on the mind-body connection could help music educators understand in a more profound way their work in paediatric wards. Our research question is: *How could concepts of embodiment and pedagogical tact enable music educators to operate in complex educational situations in paediatric wards?* Embodiment offers ways to rethink music educational processes, situations and environments, as it fundamentally emphasises that the mind-body connection forms the core of consciousness (Merleau-Ponty, 1962/2014). Hence, a starting point for this article is that a human being is embodied all the time. Embodiment is not something that music educators convey to the people that they work with; rather, it is a theoretical insight intertwined holistically in music educational practice. In this article, we contribute especially to theoretical and conceptual understandings of practitioners' work and emphasise that there is no empirical enquiry as part of this examination. However, we use some empirical vignettes in the form of short story, constructed from the main author's experiences in the field, in order to make the theoretical analysis more concrete and accessible.

In the next section, the context of the paediatric ward for music educators' work is discussed, followed by an enquiry combining music educators' pedagogical tact and embodiment. Finally, we reflect on the ways in which embodied pedagogical tact may support the wellbeing of a child and their family in the setting of a paediatric ward. Embodied sensitivity and balance of power relations between the educator and students in educational interaction are also discussed.

Music educators in healthcare settings

The Finnish healthcare system and parallel systems in the other Nordic welfare states are characterised by the individual's right to access social welfare and healthcare services. The objective of healthcare services requires that everyone is treated fairly; social inclusion and participation are encouraged, and everyone's health and functional capacity are supported. The availability of public services includes preventive, primary and specialised healthcare as well as environmental healthcare (Ministry of Social Affairs and Health, 2018). Although many private enterprises and non-governmental organisations also provide services, hospital districts provide specialised medical care services that cannot be expediently incorporated into primary healthcare (Ibid.). In this study, we focus on specialised medical care in a paediatric context, where the

treatment of the most severe diseases and disorders of newborns (i.e. neonates), children and youth are conducted.

Currently, health and social services in Finland are undergoing the most comprehensive reforms since the introduction of the Primary Health Care Act of 1972. By reshaping structures and services, the aim of the current reform is to reduce inequalities in health and wellbeing, improve access to services and curb costs (see Regional Government, Health and Social Services Reform, 2018). Simultaneously, in the healthcare sector, engagement with art and health promotion has increased, and there is a growing number of professional music practitioners who call themselves, for example, *hospital musicians*, *care musicians* and *health musicians* (Bonde, 2011; Ruud, 2012). In the Finnish context, this means that professional musicians, music educators or other professionals conduct their work through active music-making with both patients and the wider hospital community. This way, their work is interlinked with social justice and cultural rights discourses, which have been promoted through governmental initiatives (Liikanen, 2010; Stickley & Clift, 2017) during the past two decades. Overall, there is very little research on interdisciplinary music practitioner knowledge in the field which could help in mediating and integrating knowledge between different branches of music-related research within practice. This fragmentation has already generated under-theorised musical practices in the music educators' expanding working environments in healthcare (MacDonald, 2013; Koivisto & Lilja-Viherlampi, 2019). Accordingly, the practical discussion beyond the effects and impacts (referred earlier as the "healing power of music") of music remains rather scarce, and there is a risk of simplification and misinterpretation that may lead to non-critical, popularised narratives that exaggerate the benefits of music in healthcare settings (see Bradt, 2018; Tervaniemi, 2018).

It is common practice that music educators work on a regular basis in hospital schools in Finland² (Merimaa, 2009), and the National Core Curriculum is the key political and practical instrument for teachers working in hospital schools. Besides hospital schools, music education is not a common practice in the Finnish healthcare context. In Finland, the paediatric ward usually indicates that specialised treatment and care of children and young people aged 0–18 years is conducted in the wards³ (FINLEX,

2 The thorough five-year teacher education in universities, involving a great amount of practical training, is linked with autonomy and broad respect for teachers in everyday life; this view is also applied in master's programs in music education. Additionally, four-year music pedagogue bachelor's degrees are awarded from Universities of Applied Sciences; moreover, the first official in-service training for community musicians (including an option for hospital musicians' training), started in 2017.

3 The Regional State Administrative Agencies are responsible for planning, guidance and supervision concerning specialised medical care within their area of operation.

Act on Specialized Medical Care, 1062/1989), so the setting entails adolescents as well. In paediatric care, the interdisciplinary ward team normally consists of the head of department, specialists in paediatrics, a head nurse, nurses, a department secretary and at least one rehabilitation assistant. The wards cooperate with, for example, physiotherapists, nutritionists, psychiatric nurses, psychiatrists, teachers and healthcare chaplains. They may also collaborate with early childhood educators and healthcare clowns (HUS, 2018). During the past decade, music practitioners with diverse backgrounds have started to work in paediatric care. These professionals call themselves hospital musicians (working mainly in public hospitals), care musicians (working mainly in eldercare and other care environments) and music educators (having a pedagogical or interactional emphasis in their work); typically, they work part-time and as part of short-term projects, often funded by grants (Koivisto & Lilja-Viherlampi, 2019). Within this article, we decided to call these practitioners music educators because the emphasis is on exploring educational and pedagogical aspects of their practice. In the context of the paediatric ward, music educators work, for example, in neonatal intensive care units, oncological and haematological wards, and paediatric surgery and neurology wards.

In paediatrics, there are numerous challenges faced by healthcare professionals when encountering and interacting with patients and their families (Aagaard & Hall, 2008; van der Heijden et al., 2016). Instead of reaching out to attain personal growth and development, such patients may be chronically hospitalised, in pain and fearful of dying, under stress and dealing with various emotions (Hall, 1987; Korttesluoma & Nikkonen, 2006; Rollins, 2004). Despite the family-centred care implemented in hospital wards, there can be changes in family dynamics, parental interaction and in the levels of parents' own anxiety (Preti & Welch, 2004; Shoemark & Dean, 2016). This indicates that considerable sensitivity and holistic comprehension of the vulnerability of children and families, as well as the contextual and situational understanding of the environment, is required from music educators entering the hospital environment.

Healthcare personnel have multiple responsibilities and liabilities, and in Finland they have specific obligations under the Health Care Act⁴ (FINLEX, 1326/2010). While the competencies and responsibilities of healthcare personnel tend to be focused on the treatment and cure of children's conditions, the work of music educators aims to contribute primarily to the cultural wellbeing of children, their families and personnel.

4 Some of these obligations, such as the confidentiality obligation, ethical codes and hygiene instructions, are assigned to the music educators' practice as well, and hospitals may require non-disclosure agreements and cooperation contracts from music educators and/or the organisations they represent.

Therefore, a key element from the educational perspective is to actively encourage arts educators to adopt an ethos that demonstrates concepts of inclusion, equality and accessibility in their research and practice; this is particularly pertinent when justifying music educators' work in healthcare. In fragile healthcare environments, the objectives and means of achieving and maintaining high-quality practices require alternative ways of conceptualising music education. Cultural wellbeing, a concept linking to (cultural) equality, is spreading fast in Finland as well as in other Nordic countries (see Lehtikoinen & Rautiainen, 2016), facilitating cross-sectoral discussion and collaboration from practical to political levels. Lilja-Viherlampi and Rosenlöf (2019) define cultural wellbeing as one's own experience of and connection to culture and arts that thereby increases one's wellbeing. Given this background, we aim to contribute to knowledge-creation in this area by building a conceptual framework that combines embodiment and pedagogical tact when working in paediatrics.

The relationship between music educators' pedagogical tact and embodiment

In the context of this article, pedagogical tact (van Manen, 1991) is integral to the entirety of a music educator's professionalism. In our view, pedagogical tact includes both pedagogical thoughtfulness and sensitivity; it is a way for educators to grow, change and deepen their insights as a result of holistic reflection. The concept of pedagogical tact relates to the theoretical framework of embodiment, a mind-body unity, through which individuals are able to sense others' actions, feelings, intentions and thoughts (Lakoff & Johnson, 1999; van Manen, 1991, 1992; Merleau-Ponty, 1962/2014; Shapiro, 2010; see Bonde, 2017). Pedagogical tact is acquired largely through association with other people and requires shared activities to be imparted from one to the other.

More specifically, pedagogical tact is defined through the different types of reflection that can take place. These reflective types are *anticipative*, *active* or *interactive*, *mindful*, and *recollective*. *Anticipative reflection* occurs before the interaction begins. This type of reflection enables educators to be deliberate about possible alternatives on the courses of (inter)action, enabling them to approach situations in an organised manner. This is followed by *interactive* or *active reflection*, which takes place during the interaction, "allowing educators to decide virtually on the spur of the moment" (1991, pp. 512–513). Van Manen maintains that the reflection can also be *mindful*, which is not produced by conscious reflection (van Manen, 1991). This could also be referred

to by using the term *pre-consciousness*, a central notion in the field of embodiment studies (Lakoff & Johnson, 1999; Merleau-Ponty, 1962/2014; see Bonde, 2017). Some types of reflection contain an unwritten, unspoken and hidden understanding that is held by an educator through previous experience, whereas other types are more explicit (van Manen, 1991).

Music educators' pedagogical tact is based on their experiences, observations, insights, emotions, intuition and internalised understanding (van Manen, 1991, 1992). It thus has an essential connection to the concept of embodiment, whereby there exists a pre-consciousness of how and where the body is. Embodiment abandons the Cartesian mind-body division and offers ways to rethink music educational processes, situations and environments, as it fundamentally emphasises that the mind-body connection forms the core of consciousness (Merleau-Ponty, 1962/2014; Shapiro, 2010). In other words, embodiment suggests that the mind, reasoning and knowledge are inherently shaped by the body (e.g. Lakoff & Johnson, 1999; Shapiro, 2010). In addition, embodiment theories suggest subjectivity is embodied, relational and social; that is, individuals come to know the world, others and themselves through their bodily interactions (Lakoff & Johnson, 1999; Sutela, Kivijärvi & Anttila, in press). Accordingly, van Manen (2008, p. 21) argues that "The ultimate success of teaching actually may rely importantly on the 'knowledge' forms that inhere in practical actions, in an embodied thoughtfulness, and in the personal space, mood and relational atmosphere in which teachers find themselves with their students". Pedagogical tact, therefore, may depend exactly upon the internalised and embodied, but thoughtful, habits and qualities that constitute actual teaching (van Manen, 2008).

Pedagogical tact is "a form of practical knowledge that realizes itself in the very act of teaching" (van Manen, 2008, p. 16). For example, in hospital settings "teaching" takes place in the actual moment when the music educator enters the paediatric ward and starts to interact with the people present in that moment. The pedagogical space requires keen attention from a music educator, and sensitivity is needed when creating practical knowledge on how the musical moments are taking place; whether there will be singing, playing, improvising, discussion, or exploration of music-making themes. In practical terms, a music educator's pedagogical tact is achieved through seeing, hearing, smelling, tasting, touching and emotional arousal as the educator connects with the educational environment and interactional processes (see Juntunen & Hyvönen, 2004; Sutela, Ojala & Juntunen, 2017). Given this, we argue that pedagogical tact can be achieved and manifested through embodiment, which can help music educators operate in complex educational situations in paediatric care.

Pedagogical tact in and through embodiment in paediatric care

A music educator working in a paediatric ward will frequently encounter children and families going through a challenging physical, psychological and emotional process, and, in many cases, a multi-level crisis (Aasgaard, 2002; Hartling et al., 2013). For the music educator, these kinds of settings will require sensitivity when interacting with others and in relation to space and place. In the context of this article, these complexities are referred to in conjunction with the concept of pedagogical tact (van Manen, 1998). As such, the notion of embodiment may advance the navigation in and through pedagogical situations that include the vulnerability of both child and family at many levels: fear of pain or death and various ethical aspects. According to van Manen (1998), the professionals within the healthcare setting should come to accept their own emotional lives, which is an essential aspect of their professionalism as are their differing work assignments, personalities and backgrounds.

In the hospital setting, a concentrated moment of shared music-making will most likely be abruptly interrupted at some point. The pressing schedules of procedures, a child's emerging pain or visiting guests are typical interruptions, of which shared music-making is one part. In hospitalised life (Lupton, 2012), these kinds of interruptions combined with a hospital's soundscape, create a unique atmosphere and setting for music education, challenging the music educators' traditional ways of working (Livesley et al., 2016; van der Heijden et al., 2016). In what follows, we reflect on exemplary music educational situations from the standpoint of pedagogical tact (van Manen, 1991, 1998) and embodiment (e.g. Lakoff & Johnson, 1999; Merleau-Ponty, 1962/2014). The context for this analysis is set within a Neonatal Intensive Care Unit (NICU) and adolescents' care unit within a paediatric ward in a Finnish hospital.

Embodied pedagogical tact in the Neonatal Intensive Care Unit

The following introductory vignette is constructed from the main author's experiences in the field.

When I walk into the room, there are two babies in the incubators and three nurses nurturing them. I start with humming a lullaby and playing Finnish kantele. My voice is very low, just recognisable, slowly strengthening. I observe at the same time the atmosphere of the room and the wellbeing of the newborn. In one bed, a baby is stretching her fingers. Her head is turning

towards the voices and music, and her small toes are curling in response. I start to play for her, interact with her, react to her movements, and get closer to her incubator. After fifteen to twenty minutes of playing in different places in the room, I start to move to another room. The atmosphere seems to be quite calm and relaxed. A nurse is looking into my eyes, but no words are exchanged.

An NICU is an intensive care unit specialising in the care of premature or ill newborn infants. When entering this unit that offers highly specialised care for children in critical stages, a music educator aims to enhance the wellbeing of the child, family and hospital personnel. The educational interaction may have medically-oriented features and objectives, such as decreasing the heartbeat of the neonate, and artistic views in selecting repertoire, instruments and musical tools, but the focus of the work is in the advancement of the holistic wellbeing of the parents and the newborn (Staricoff & Clift, 2011; van der Heijden et al., 2016). The music educator's bodily capacities to assess complex situations in a hospital setting and handle their emotional response can be hypothesised as a key competency in this context. Accordingly, central aspects involve whether the pedagogical situation is suitable within the ward schedule and present atmosphere, whether the newborn is receptive to the music, or if the music should be directly addressed to the newborns, families or to the ward as a whole. The ensuing practice of the music educator will be based not only on those present in the ward but will function as confirmation for the educator's body schema, which will adjust according to finding the best approach to work in these complex situations.

The NICU environment can be a contradictory atmosphere: on one hand, a neonate is very vulnerable, and it is likely that encountering a child in such a fragile condition elicits various emotional responses from care professionals and families. On the other hand, the physical environment is impersonal, including the soundscape in the room which can be harsh as a result of various electronic and measurement devices. There may also be other newborns in the room vocalising or crying. The reactions of hospital personnel and parents can also vary towards music educational activities. The staff and family members may be observing or participating in the music-making process and commenting on it, but not necessarily. The modern neonatology environment is parent-friendly; for example, kangaroo care is recommended to be delivered by parents of newborns and may include parental singing (Aden et al., 2016; Haslbeck et al., 2016). Depending on the circumstances, the atmosphere of the ward can also be stressful (Loewy et al., 2013), even though these types of environments are increasingly family-oriented and friendly.

Music education in this kind of environment does not rely on conventional music pedagogical skills, such as designing and planning the instrumentation, repertoire or consistency of exercising musical skills. Neither are there considerations of such virtues as the “good teacher” or “musical talent”. Instead, the pedagogical interaction can be described as highly tactful, denoting that the educator is carefully observing the situation and the people in it, adapting his or her interactions accordingly (van Manen, 1991). Van Manen (1991) refers to this practice as *anticipative* reflection.

To advance pedagogical tact and multimodal reflection in NICU environments, the educator focuses on their own embodied reactions and the newborn’s movements and vocalisations: how the baby is stretching their fingers, turning their head towards voices, or reacting to music. This kind of sensitivity is essential and emphasises the priority of bodily perception over reasoning, thus opposing the Cartesian body and mind division (Merleau-Ponty, 1962/2014). This kind of focus and reflection, in the here and now, helps in finding meaning and direction for music education. When the parents are present, the music educator can advance the reflection between the newborn and the parents. This may take place in and through *(inter)active reflection* while engaging the parents to interpret the child’s gestures, movements and facial expressions (van Manen, 1991). This can enhance the parents’ understanding of the child as a holistic being, beyond illness and need for medical care, and help them to adapt to a situation that differs drastically from their expectations and ideals regarding family life. In such emotional and unsettled situations, it is important for the music educator to use all presented ways of reflection before, during and after music-making in order to professionally facilitate the wellbeing of the family and also to evaluate whether or not the music should be employed in the situation.

Embodied pedagogical tact in adolescent care

The following introductory vignette is constructed from the main author’s experiences in the field.

I knock on the door of a single room for a young patient. He is going home today and waiting for his parents. I have not met him before, but I had a short briefing with the ward staff, and I know that he is waiting for me. He has agreed to make some music with me. He has a plaster on his leg. Immediately when I open the door, I probe and try to experience the atmosphere inside the room. This time the patient seems wary, but friendly enough for me to enter. He is not in pain, I reflect, but seems to be missing something; maybe

friends or parents. The afternoon atmosphere in the whole ward is very calm, sleepy almost. I hesitate and think of what kind of music he would prefer to start with. There are some instruments in my bag. We look at them together. There is a güiro, a pair of maracas and claves, a triangle and chimes. I have a guitar with me. He takes the güiro and starts to play it in his own, personal way. I start to sing a “school song”, and he shows me that he is familiar with it. He plays in his own rhythm, and I try to follow him as carefully and relaxed as I can. We talk a little about the instrument and continue playing. After the session, his parents come. I say goodbye to the young patient, and I wish him all the best. When I leave the room, I am wondering if I will ever see him again. I wonder also if this session was in any way meaningful for him. Perhaps it was a joyful moment only meant for that time in the hospital.

When working in a paediatric hospital, a music educator may visit multiple wards within one day. After the NICU environment, there may be, for example, an adolescent waiting in another unit. Usually, the wards are designed with the supposition that small children will be receiving treatment there; adolescents are not particularly highlighted. This also applies to music education, as a young person going through treatment may have different interactional needs or preferences than a younger child, such as those regarding his or her privacy. In practice, this means that music may provide the young patient with multiple identifiable meanings that are personal and of which all cannot be shared, or that the music educator has to reflect upon the space in the individual room in a more careful manner; for example, they may need to assess what is an appropriate physical distance between them and the adolescent, or they may need to consider the size of the room in relation to the intensity of the music.

In van Manen’s (1991) terms of pedagogical tact, *anticipatory reflection* may include aspects such as reading the personal space in the hospital room and entering this personal space in pertinent ways, if entering at all. This connects with the questions of subjectivity and sensitivity regarding power relations between the adolescent and the music educator. Accordingly, as van Manen (1991) presents, a pedagogical situation between a child and an adult is never an equal one but requires high-level active thoughtfulness. Encountering an adolescent going through bodily transformations due to both age and illness may be challenging, requiring sensitivity and even creativity, and the need to act with care and respect. As van Manen (2008) writes, professionals may overestimate their abilities to understand what other people feel. He summarises this by stating: “...we may believe that we are in a certain way caring and are treating his or her physical and psychological needs, but if this person’s experience of what we

say and do differs from what we believe we do, then we may need to suspend our belief in favour of the person's experience" (van Manen 2008, p. 8). This entails questions of how the educator supports not only self-determination and autonomy, but also identity development of the child in, and through, music education. Regarding this, van Manen (1998) reminds us that the body is always involved in awareness, and this should be recognised in the healthcare setting. This includes setting objectives for personal growth and musical agency in the situation at hand. In addition, it is important to consider how to support the adolescent's social abilities when it comes to connecting with peers during and after the treatment, and through music and musical activities. An *active or interactive reflection* (van Manen, 1991) may determine, for example, whether the child at this age can be approached with lullabies, children's songs or popular music repertoires. The reflection also contains embodied views, such as the level of intensity or emotional response for the adolescent in the shared moment, varying from comfort to consolation, refreshment to joy (see Saarikallio & Erkkilä, 2007).

Equally relevant to matters of repertoire, instrument selection, material, timeframe or any other content regarding the musical activities, is the embodiment of the adolescent as well as the music educator. This entails, for example, appropriate ways of sharing space, physical closeness and maintaining distance in the situation (van Manen, 1991; see DeNora, 2013). It may be that the adolescent with a chronic condition is identifying themselves as a patient and has adopted the hospital environment at the embodied level (Prete & Welch, 2004; see Aasgaard, 2002). It cannot be expected that educational work with an adolescent patient has similar grounds as with "non-ill" adolescents who have grown up in environments that are presumably more appropriate for their development. Music-making also creates a new kind of framework for being in the world within the hospital setting. In this framework of music education, it is essential that the adolescent adequately interprets the social relations at hand in order to rebuild her identity beyond the hospital setting.

Discussion and conclusions

In this article, we have enquired how the concepts of embodiment and pedagogical tact could empower music practitioners' work, and we have articulated the emerging environment of music education practices, namely within the setting of a paediatric ward in a children's hospital. In order to contribute to the theoretical and practical views of music educators' transforming professionalism, as well as interdisciplinary

views of music, health and wellbeing, we have presented a non-medical, conceptual premise of understanding the profession through both embodiment and pedagogical tact. This kind of theoretical commitment and practical understanding, which goes beyond the narratives and discourses regarding the “healing power of music”, may open up a window for understanding, evaluating and exploring musical practices in reflective ways, just as van Manen (1991) presented in his conceptualisation of pedagogical tact.

On the basis of our theoretical enquiry, pedagogical tact intertwined with embodied knowledge is integral to the entirety of music educators’ professionalism when working with children in healthcare. In such an environment, a music educator certainly needs conventional pedagogical skills and knowledge; however, they are not relying solely on these but rather need to develop pedagogical sensitivity and thoughtfulness to deepen their insights in a more holistic, embodied manner. We encourage music practitioners to explore beyond implicit and intuitive practices, moving towards more explicit and conscious reflection of their practice in order to enhance practitioner knowledge in the field. Anticipative, active and mindful reflection occurring before, during and after music-making in the paediatric wards gives a music educator a pathway to deepen and transform their pedagogical insights in healthcare settings, which are quite new environments for many educators. In practice this means, for example, thinking of the whole ward as a pedagogical space, including the ward’s corridors, nurse stations, halls, individual rooms, as well as understanding that all relationships within the ward have importance before, during and after the actual singing, playing, improvising or listening to music together. These reflections also include the notions that the music educator may herself have intriguing questions, feel unsettled or experience ethical dilemmas that arise unexpectedly in the moment and within the music practices.

The realisation of embodied and tactful pedagogical knowledge starts in the actual moment when the music educator enters the hospital ward, and the ward environment as a pedagogical space requires great attention and sensitivity from the music educator. Through multimodal sensitivity and interaction, the music educator is able to recognise the needs of the children, their families and hospital personnel in music-making situations, and then select the appropriate themes and musical activities in the moment. Emotional arousal of the music educator is a natural part of pedagogical tact, as well as maintaining a professional attitude when encountering ethical problems or people’s fear of pain or death. This calls for a focus and reflection on elements that can aid in finding meaning and direction for music practices, which, in these cases, may include a whole range of emotional challenges and burdens being experienced by the patients presented by life.

While this article seeks to contribute to active, interactive and mindful reflection of pedagogical tact when working with children and adolescents in paediatrics, future research could also focus on *recollective reflection* (van Manen, 1991, pp. 512–513). Recollective reflection offers a lens for understanding the child's, educator's and the wider community's lived experiences. Intertwining pedagogical tact with an epistemological view that relies on the mind-body connection enables holistic reflection, which helps music educators to operate in complex educational situations within the paediatric ward. Regarding embodied pedagogical tact when working with particular paediatric situations and contexts discussed in this article; that is, those related to babies and adolescents, active and interactive reflection introduced by van Manen (1991) offers a key for relating with children and their families with care and respect.

Despite the equity-oriented pedagogical insights presented in this article, it would be naïve to assume that a “non-ill” professional, in this case a music educator, does not run the risk of objectifying the children, their families or other people in the hospital community. Through recognition of—not necessarily acceptance of—potential imbalances in power relations, the music practitioner, children and their families may have more genuine opportunities in reconstructing their expectations and ideals regarding illness, health, life, family life or social relationships. In and through this kind of embodied practice as a tactful, sensitive pedagogy, a music educator may professionally engage at an interdisciplinary level within the ward community. This way, music educators may have the opportunity to facilitate cultural wellbeing and promote children's rights to access culture, even when they are hospitalised for longer periods.

In conclusion, the conceptual discussion presented in this article offers a window for exploring and advancing the underrepresented research area of music education in healthcare. Hopefully, this article also enriches the understanding of interdisciplinary professionalism in the field of the arts, health and wellbeing, which has been relatively disjointed, particularly in theoretical discourse. More generally, the findings emphasise the opportunity for personal growth and learning as a basic cultural right (Lehikoinen & Rautiainen, 2016) that should be guaranteed in various life situations. A clear focus on the common goal, that is, the wellbeing of children and their families, could offer a way forward in restructuring modern healthcare environments and in establishing a stabilised position for music practitioners' professionalism. In this article, we have emphasised the professional practices and views of music education, but we wish to embrace and acknowledge all other collaborators and levels of music-making in the field: from music therapists and healthcare professionals using music medicine to

individuals and communities using music for self-recovery, and from voluntary music practitioners to performing artists.

In the future, music education programs and in-service training should consider new conceptualisation models that can be implemented in the field of healthcare. A major challenge is to help future music educators to cope with emotional arousal, highly sensitive and reflective practices, and ever-changing working environments, such as those presented in this article. Seeing a child and their family in the middle of the intensive medical treatment, requires the perspective of a holistic lens from the music educator themselves. This involves an understanding of the embodied and tactful sensations experienced firstly within the practitioner themselves, and secondly, being able to take action within the ward environment as a result of these reflections. Additionally, it would be useful to incorporate interprofessional efforts that could be taken during the educational programs, such as teacher-healthcare professional collaborations, shadowing practices, or joint thesis seminars in order to strengthen interdisciplinary cooperation.

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