Staying close to practice: Which evidence, for whom, by whom.

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Clinical practice is a messy laboratory and the purity of academia is often polluted by day to day realities. This is not to say that I am against controlled clinical trials nor evidence-based medicine. Indeed, throughout the last two decades I have written expressly that medical practitioners and music therapists need to be reflect on their own practice through research and share that with others – that is, to become reflective practitioners in a community of inquiry (Aldridge 1996). Controlled trials are one of the research methods that we have in the toolbox of research. There are many valid methods; finding the appropriate method to answer the question that we are asking is the central issue. To force all questions into one method is methodolatry, not methodology. Unfortunately, we have the same problem today with the concept of evidence-based medicine. The concept is sound when it stays within its own borders. When randomised controlled trials become the only evidentiary basis for health care delivery then we have a triumph of a scientific technocracy that ignores the caring and social dimension of health care delivery. This is
particularly exacerbated when inexperienced practitioners, often with no direct experience of therapy, and sometimes with a very limited background of research experience, begin to suggest to others that they are not doing their job properly or how they could be doing their job better from a highly restricted set of research evidence.

I was in a conference a few years back in Ferrara, Italy when a leading music therapy researcher began to explain to me how best melody could be understood. More than that, the researcher began to explain how I should best understand melody to make my work appropriate. When I asked the researcher “What do you experience when you play a melody?”, he had no answer. Not being a musician, he had no experience to fall back on. Yet, he assumed that by being an eminent researcher he could tell me how best to do research into “melody”, when a vital aspect of understanding was missing. We seem to be experiencing the same in music therapy practice. Some “experts” are advising practitioners without adding the rider that they are speaking from a limited practice experience or from a limited research experience. A research elite, with limited practice and experience, are trying to assume the mantle of advisers by adopting a set of rules from an essentially bureaucratic culture of medical hegemony.

The delivery of health care is still a contentious issue. The initial assumptions by Beveridge were that the cost of the National Health Service in Britain would fall as therapy brought about reductions in illness. Instead we have a spectrum of redefined health needs that have continually expanded. Health care needs are increasingly medicalized and self-care is becoming a lost cause abandoned to a consumer culture of medical services. What were once called alternative and complementary approaches have been commodified as modern health care. Rules governing guidelines for the application of the medical product, misguided called a ser-
vice, is controlled by the recommendations of an increasing medical elite, the purveyors of evidence-based medicine. These guardians of the medical scientific culture have undertaken to engineer the delivery of health care based on a set of rules that are far removed from the everyday practice of clinical medicine, healthcare delivery and certainly music therapy practice. Evidence-based medicine can tell us little about suffering and dying, nor about healing, and nothing about caring. Neither does it celebrate those artisans of clinical practice, music therapists, where tradition and expertise are the daily tools of the trade. Expertise is not evidence but in the healing relationship it is paramount.

Medical bureaucracy is establishing an orthodoxy that is impoverishing our healing cultures. By denying recognition of a variety of evidences for healing, then we are denying our communities the right understand their own healing resources and express their own needs. We may have a statistical basis for successful treatment but suffering will continue.

We need an approach to music therapy research that stays close to the practice of the individual clinician; that is, the musician as therapist. Each therapeutic situation is seemingly unique. Yet, we compare our cases and share our knowledge with each other. Research methods are means for formalising our knowledge so that we can compare what we do.

What I argue for is a flexible structure that can be applied to clinical practice (see “Case studies in music therapy research” Jessica Kingsley Publishers: London, forthcoming). The practice is allowed to remain true to itself, although any research endeavour, by the nature of its reflexivity scrutiny, alters practice. In doing research we ask questions of ourselves as clinicians, and when we involve our patients in the process, then they too will reflect about what is going on.
Therapy, treatment or care?

There is a tension inherent within music therapy research. It is music research, an aesthetic activity contextualised by a therapeutic situation. We can utilise a broad spectrum of musicological approaches. It is also a therapy research, albeit defined by its emphasis on music, and therefore subject to forms of therapeutic scrutiny. When we attempt to enter systems of health care delivery, then we must be aware of the conventions of legitimate research. But, those conventions are not fixed. We can demand that they accommodate what we have to say if we argue our point articulately and rigorously, just as we must be prepared to offer appropriate research related to those conventions. Case study designs offer such formats. The task that we have before us is to explicate and negotiate those flexible conventions.

The evidence–based medicine debate places case reports as “mere opinion” along with recommendations from expert committees (Sackett, Rosenberg, and Haynes 1996). Yet opinion is the common currency of our daily lives. Opinion is informed and that is what patients and colleagues expect from us. One of the sources of that opinion will be clinical trials but these are only one of the possible sources. The danger of an evidence-based approach is that evidence is restricted, and one of those restrictions is an elite opinion based upon a certain set of defined criteria. Hence my plea for pluralism.

Yet, the concept of evidence is being used here as a legalistic metaphor rather than a scientific metaphor. In a courtroom, various forms of evidence will be produced where experts are invited as witnesses. It makes no sense in restricting the range of evidence. We do have to establish the reliability of the witnesses and the basis of their expertise but not restrict the forms of evidence a priori. I am not advocating the use of dogma, nor
opinions without reasoning, simply that there are various forms of reasoning. Case studies offer reasoning through perspectival forms as research practice conventions. Common to these forms is a focus on a specific theme, locating the evidence within bounded contexts, establishing the sources of the demonstrative material that we are using and arguing our conclusions only from the material that we have presented. This is simply sound research methodology, no matter from what methodological persuasion we come. The demonstrative evidence may be measurements, or it may be recordings, it may be interviews, or it may be questionnaires.

Whether or not we accept the validity of the witness is a political act. In the music therapy research debate we are arguing for wider inclusion in the service delivery of health care. Evidentiary material must have a broad base, if case studies are being refused under the guise of appropriate research then this has to be recognised as simple prejudice by those who determine what is “appropriate”. The basis of many therapies is, in reality, “case” based.

There has been a shift of interest in the concept of disability from an emphasis on biological impairment to the unique experiences of the sufferers. Similarly, we may argue that relevant outcomes are dependent upon what the sufferer has to say. Practitioners also relate outcomes in terms of a clinical narrative and both clinicians and patients have global vocabularies regarding functioning and coping (Bilsbury and Richman 2002). While evidence-based medicine emphasises quantification, it runs the risk of loosing the vital elements of individual difference in particular contexts, which is what we see as clinicians. Change is the experience of qualities relating to stages of transition rather than being a sequence of symptom scores. Case studies allow for us to include transitions as process and as events, as the important moments between the scores.
The greatest challenge of “evidence” is how such evidence finds meaning in everyday practice. While we talk of music therapy, the actual practice is varied across a broad spectrum of practices and these themselves may vary across continents according to which model is being used. In psychotherapy research there has been an attempt to standardise treatment by offering treatment manuals for empirically validated treatments for specific client groups and particular problems (Beutler, Moleiro, and Talebi 2002). The primary reason being to provide insurance administrators with selection criteria in choosing which services to provide.

In contrast, there is research demonstrating that it is common, global qualities related to expectation about treatment, the perceived charisma of the therapist and the relationship between therapist and client that are effective (Luborsky, Singer, and Luborsky 1975).

A difficulty of evidence based medicine, when it sponsors a treatment manual approach, is that the therapist is forced to follow a rigid treatment plan and those elements of spontaneity and creativity, that music therapy cherishes, are discarded. Furthermore, manual-based treatment will be based on treatments that are easily converted into manuals and these will tend to be both highly structured and short-term. This poses a skewed research cycle biased in favour of short term, highly structured interventions, that promote more research studies because they are easier to organise as clinical trials and are of short duration. We are still left with the problem of converting these studies into clinical utility. Nurses have also found the same problem in that “best practice” requires not only comparable outcomes from evidence based research but a knowledge of the context of service delivery that includes the patient and her community (Driever 2002).
What we need to debate is the nature of therapy as treatment or care. If we claim that music therapy is a form of treatment, then we fall under the rules of evidence for establishing the efficacy of treatment. If however, therapy is a form of care, then the rules change, and we can speak more openly of qualities of care. Music therapy is an overarching term for a variety of practices in a plethora of clinical, educational and social fields. This makes it difficult to provide any definitive statements about “music therapy”. We can take heart, however, as we only have to hear surgeons talking about psychiatrists to know that “clinical medicine” is also a craft of diverse practices.

If an aim of health care initiatives is to improve service then we can learn from industry. Quality is improved by attending to the process of delivery where suppliers are in a close dialogue with consumers. This also reduces costs. Any new attempts to collect information must begin at this primary care interface between the practitioner and the patient, and the practitioner and his or her sources for referral. This would mean an emphasis on local networks according to local need (Aldridge 1990) not bureaucracies of the faux elite with neither mandate nor experience.

However, we must first understand the complex process of health production before we can try to improve it, particularly in the field of chronic illness where many of us work. An understanding of health production must also be supplemented with measurement tools which represent the values of the producers at the work-face (practitioners), and the consumers with whom they meet (patients). Epidemiological methods can be developed to establish baselines from which the success of health care initiatives can be measured and outcomes can be monitored. One of the bases of epidemiology is the case study. From here we have our starting point. It is imperative that we develop a common language for health outcomes that is understood by the consumers (patients), deliverers
(practitioners) and providers (those who pay). This language is not to be dominated by a research autocracy. When we speak of health care we are not only concerned with economic aspects of health, but the practice of 'caring'. It is this qualitative demand which articulates the health care debate and stimulates the inclusion of music therapy into health care delivery.

Meeting health care, educational and social needs is a matter of social strategy and political will. Health is not an homogenous concept, it is differentially understood. Educational and social needs are negotiated not written in tablets of stone. Music therapy like medicine is not an isolated discipline but an agglomeration of concepts taken from a variety of fields. These fields include the arts, the humanities and the sciences.

The social understandings of health and education and how to practice therapy are not fixed. Patients and health care professionals negotiate solutions to health care needs from an extensive cultural repertoire of possibilities. This repertoire is composed of understandings from Western medicine, but also from folk or traditional medicine and modern understandings of psychotherapies and creative arts therapies.

Similarly, professionals working in educational and social care settings have varying agenda set within the communities in which they participate. These repertoires too are varied.

However, there are factors common to a variety of health and educational understandings. These understandings include promotion and prevention, health maintenance and indications for treatment. Such factors are influenced by economic strategies and cannot be divorced from considerations of community welfare. Poor housing and poverty mock any talk of music therapy initiatives based on consumer demand. There has to be a
minimum level of income whereby people are fed and housed before the luxury of health or educational choice can be exercised.

The future delivery of health care will depend upon accurate information about the management of resources. To assess health care we will need accurate and appropriate tools of assessment. Case studies, in their traditional role of advocacy, play an important role in establishing practice models. We can use tools of assessment that relate to the management of resources while remaining true to the people we are trying to represent.

**Music and therapy**

Research from a therapeutic perspective is not medical science in that it has no generalisable reference. The importance of such work is in its particular subjective and unconventional reference. While the aesthetic may appear to occupy a pole opposite to the scientific, I propose that a pluralist stance is necessary to express the life of human beings (Aldridge 2000). Pluralism is being used here in the sense that no political, ideological, cultural or ethnic group is allowed to dominate the discussion. That is why the evidence-based medicine needs a counter balance, not against the concept but to counter the idea that such a perspective is the only legitimate perspective to inform practice delivery.

Emphasising one authoritative base for music therapy research is suspicious. The quest for one superior model for empirical evaluation is the quest for disciplinary power and an attempt to marginalise other opinions. We have differing ways of languaging music therapy, as we have of musicking, but we can still respond to each other and find commonalities of understanding. These will be local rather than global. The concept of pluralism is borrowed from theology. The basis of the understanding is
that no one of us as human beings can begin to claim a full understanding of the divine, thus in all modesty we have to recognise that we have only parts of the picture. Surely the same goes for music therapy, no one group can claim hegemony, nor absolute understanding of the truth of what music therapy is. A challenge is for us all to come together and merge those various understandings. To do that we tell our varying stories in differing ways, all of which have their own validity. Whether they have a validity outside our own field of expertise depends upon how we negotiate that validity and which languages we encourage. One of these languages will surely be research and amongst its dialects will be those of case studies, amongst clinical trials and a rich variety of other methodological approaches.

What we need in clinical research is to facilitate the emergence of a discipline that seeks to discover what media are available for expressing this ecology of ideas which we see as a person, and with which we engage as a therapist or researcher to discern the meaning of change. These media may be as much artistic as they are scientific.

To work in this way is also to consider aesthetics; the essentials of pattern and form. For a research methodology in music therapy we cannot always revert to the questionnaire and a standard test. What we are challenged to develop is a way of presenting the work of art itself as it appears in the context of therapy. This is not to deny the value of the questionnaire and the standard test but to encourage an extension of our research repertoire to include other forms of assessment and presentation.
References


