Published in final edited form as:

Crit Care Med. 2018 November ; 46(11): e1085–e1086. doi:10.1097/CCM.0000000000003408.

Letter to Editor, Patient-directed Music Therapy in the ICU Commentary

Linda L. Chlan, PhD, RN, ATSF, FAAN¹, Annette Heiderscheit, PhD, MT-BC, LMFT², Debra J. Skaar, PharmD, FCCM³, and Marjorie V. Neidecker, PhD, MEng, RN, CCRP⁴

¹Nursing Research Division, Department of Nursing, Mayo Clinic, Rochester, MN

²Music Department, Augsburg University, Minneapolis, MN

³College of Pharmacy, University of Minnesota, Minneapolis, MN

⁴College of Nursing and College of Pharmacy, The Ohio State University Columbus, OH

First and foremost, any reference to “music therapy” should be reserved for professionals credentialed in the field of music therapy. The American Music Therapy Association (www.musictherapy.org) (3) provides distinction between music therapy implemented by a specially trained, credentialed music therapist and music listening interventions. Many clinical research studies that do not utilize a music therapist to deliver a music intervention should use the term music listening or music intervention. The parent randomized clinical trial upon which our economic evaluation manuscript was based was a music intervention study.

Second, it is important to review the main results from the parent study testing patient-directed music intervention (PDMI) that informed our economic evaluation paper. The primary aim of the parent RCT was to test the efficacy of patient-directed music intervention on anxiety and sedative exposure (4). Thus, the central salience of anxiety as a primary outcome in this clinical trial. PDMI was modeled after patient-controlled analgesia concepts whereby patients were empowered to self-manage their anxiety. The implementation and length of each PDMI session was at the individual patient’s discretion based on the perceived need for the self-management of anxiety with relaxing music, not at a pre-prescribed time of day controlled by a clinician. We did not screen for delirium, however our protocol required patients to be alert and cooperative given the human subjects’ committee insistence that patients’ provided their own informed consent. Further, the parent RCT was conducted in 5 different hospitals (12 ICUs total) that had different electronic health records, alertness/mental status assessment practices, as well as varying sedative management practices. Not all participating sites used, for example, the Richmond Agitation Sedation Scale (RASS) for alertness/motor movement assessments making comparisons among study subjects unwieldy.

Copyright form disclosure: Dr. Chlan’s institution received funding from a National Institutes of Health (NIH), National Heart, Lung & Blood Institute grant. Drs. Chlan, Heiderscheit, and Skaar received support for article research from the NIH.

Dr. Neidecker disclosed that she does not have any potential conflicts of interest.

It is curious that the authors chose to reference the paper by Hetland, et al., (5) and not the parent RCT on which the economic evaluation data were obtained (4). The cited paper by Hetland is a review and not the primary source. We recommend appropriate citation of original sources to avoid any errors or misunderstandings.

As Bamikole, et al. point out (2), the parent trial that provided the data for the economic evaluation was conducted 2006-2011. As such, clinical practice has changed since that time. We agree that a replication of our parent clinical trial would contribute to the evidence base surrounding the implementation of non-pharmacological interventions, such as music, into ICU patient care settings, inclusive of salient outcomes of importance to patients, family members and ICU clinicians. In addition to patient-centered outcomes, economic data should be obtained prospectively with research participants followed for longer periods of time in order to calculate the more standard cost-effectiveness analysis metric of quality adjusted life years. We welcome future collaborations with investigators who are willing to undertake this type of investigation.

Sincerely,

Linda L. Chlan, PhD, RN, ATSF, FAAN

Annette Heiderscheit, PhD, MT-BC, LMFT

Debra J. Skaar, PharmD, FCCM

Marjorie V. Neidecker, PhD, MEng, RN, CCRP

Acknowledgments

Thank you for your interest in our recent article published in *Critical Care Medicine* (1). We would like to take the opportunity to respond to your Letter to the Editor (2).

References

1. Chlan LL, Heiderscheit A, Skaar D, Neidecker MV. Economic evaluation of a patient-directed music intervention for ICU patients receiving mechanical ventilatory support. *Crit Care Med*. 2018 ePub ahead of print 5/4/2018.
2. Bamikole PO, Theriault BM, Caldwell SL, Schlesinger JJ. Patient-Directed Music Therapy in the ICU. *Crit Care Med*. 2018 Letter to the Editor: xxxx.
3. <https://www.musictherapy.org/> Accessed July 17, 2018 4:08pm.
4. Chlan LL, Weinert CR, Heiderscheit A, et al. Effects of patient-directed music intervention on anxiety and sedative exposure in critically ill patients receiving mechanical ventilatory support: A randomized clinical trial. *JAMA*. 2013; 309:2335–2344. [PubMed: 23689789]
5. Hetland B, Lindquist R, Chlan L. The influence of music during mechanical ventilation and weaning from mechanical ventilation: A review. *Heart Lung*. 2015; 44:416–425. [PubMed: 26227333]