

Original Paper

The Evolution of Hospital Play in the UK and Repercussions for Japan: A Socio-historical Perspective

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Abstract

All children need the time, place, and opportunity for play, regardless of who they are or where they live. This fundamental need is embodied in the United Nations Convention on the Rights of the Child. This paper addresses the interpretation of the child's right to play in the case of children who are sick or in need of hospital or community healthcare. Over the course of the past 150 years, the care of sick children has evolved to the point where play is recognized as a key element of pediatric provision in many nations of the world; the 'hospital play' profession has grown from its tentative introduction in the UK in the 1950s to become part of a worldwide movement for the child's right to play. Written in collaboration with Japan Hospital Play Association, which marks fifteen years of hospital play in Japan, this paper celebrates the importance of understanding the history of the past in order to make meaning of the history of the now.

Keywords

children's rights, history, hospital play, Japan, play specialist

Introduction

Play lies at the very heart of childhood. It is the way that children and young people learn about themselves and about the world around them; the way in which they create a sense of self and of their place in society (De Koven, 2014). Physically active play builds strong, healthy bodies (Aggio et al., 2017) and mentally inspiring play develops a capacity for creative thinking, problem-solving, and personal resilience (Liu et al., 2017). All children need the time, place, and opportunity for play, regardless of who they are or where they live and this fundamental need is embodied in Article 31 of

the United Nations *Convention on the Rights of the Child* (CRC) which declares the right of every child ‘to rest and leisure, to engage in play and recreational activities ... and to participate freely in cultural life and the arts’ (UN General Assembly, 1989).

This paper addresses the interpretation of the child’s right to play in the case of children who are sick or in need of hospital or community healthcare. It relates how the ‘hospital play’ professions emerged from changing attitudes towards the needs of children, and from a period of cultural transformation during which the perception of play has been elevated from that of mere pastime to a key component of health and wellbeing.

There is great significance in studying history, which is about much more than knowing what happened in the past (Corfield, 2008). To study history is to acquire a knowledge and understanding of complex social systems and, through that understanding, to develop the judgement and decision-making skills needed to live in the present. Making connections between the past and the ‘now’ is essential for ‘[securing] the roots that will allow for continuity but also for growth and change’ (ibid.). During a period of global instability (political, economic, cultural, geographic), tracing the meaning of what went before enables us to chart a course towards the sort of future that we want for ourselves and for the generations that follow.

Like history, hospital play is about making connections. It is to understand that ‘inside each child there is a universe’ (Kawai, 1987, cited in Matsudaira, 2022) and that the purpose of play is to connect ‘the world without’ to ‘the world within’ (Yano, 2006). When play specialists help to guide a child through a healthcare experience, they acknowledge the child as an autonomous individual with infinite capacities for adaptation and growth, capacities which will transport them from the reality of ‘the now’ to the potential of the future.

Over the course of the past 150 years, the care of sick children has evolved to a point where play is accepted as a key element of pediatric provision in the United Kingdom (UK) (National Institute for Health and Care Excellence [NICE], 2021). At the time of writing, almost 700 specially trained and registered ‘Health Play Specialists’ (HPS) are integrated in the UK’s National Health Service (Healthcare Play Specialist Education Trust [HPSET], 2021), with counterparts in the USA and Canada, Australia and New Zealand, and Hong Kong. Throughout Europe, there is a growing movement for play as an essential element of pediatric healthcare (European Association of Children in Hospital [EACH], n.d.; Perasso, 2021). In Japan, Hospital Play is in its adolescence and boasts a workforce of over 200 HPS which increases year on year (Japan Hospital Play Association [HPS Japan], 2014).

Hospital Play finds its origins in the pioneering activities of the female social reformers of the early 20th century, and today it is a profession whose future will be determined by the actions of those who continue to advocate for the child’s right to play ‘in sickness and in health’, the continuation of a living history with global reach.

The early history of hospital care for children

The first hospitals in the UK designed especially for children were established during the second half of the nineteenth century. Changes in social attitudes at that time acknowledged that children were more than just 'little adults' and that they had a unique need for special protection from the State. *The Prevention of Cruelty to, and Protection of, Children Act (1889)* enabled state authorities to intervene to protect a child from harm, and an extension of the legislation in 1894 made it a new offence to deny a sick child medical attention (Batty, 2005). The future of the British Empire was seen to reside with its children, so these changes in the law reflected 'not only a growing concern for the safety of children, but also the safety of the nation' (Oxford Brookes University, 2016). This sense of national purpose is mirrored in our contemporary understanding that a healthy society is built on the health of its young people and determined by how the state looks after its youngest citizens (Marmot, 2010).

From the outset, female social reformers were at the forefront of the drive for children's hospitals, through their concern to protect women and children from the negative impact of industrialization (Sloane, 2005). They were motivated as much by a sense of moral obligation as by welfare concerns. However, throughout the 19th century, children's lives were fragile and still widely regarded as expendable. Victorian sentimentality meant that, when children fell sick, it was considered preferable for them to remain at home in the care of their mothers. This was a sentiment encapsulated in the words of George Armstrong (1719-1789), so-called 'father of pediatrics', as long ago as 1772: 'If you take a sick child from its parents or nurse you break its heart immediately' (cited in Lindsay, n.d.).

Consistently high rates of child mortality throughout the late 1800s (Statista, 2021) meant that it was only a small minority of children who reaped the benefits of early hospital care. When the world-famous Hospital for Sick Children at Great Ormond Street opened in London in 1852, it had just ten beds! (Historic Hospital Admission Records Project [HHARP], 2010). This new children's hospital, the first in the UK, was regarded as something of a novelty. High society ladies would visit the hospital, not only to help the nurses and amuse the children, but also as a fashionable pastime. An engraving published in *The Illustrated Times* in 1858 (ibid.) hints of a place for play in children's healthcare which would subsequently lie dormant for decades. The engraving depicts a lively scene with lots of toys, visitors, and what appears to be a group activity taking place in the children's ward (ibid.)

The rapid advance of industrialization, and the corresponding influx of people to the cities, was matched by a fast-growing need for hospital care and, from the outset, hospitals played a major role in caring for socially disadvantaged children (Casimir, 2019). By the start of the 20th century, Great Ormond Street Hospital had grown dramatically, both in size and reputation, and by 1901 it was treating over 2000 inpatients and almost 2500 outpatients (HHARP, 2010). In other parts of the UK, the pattern of care for sick children was more variable. While the larger cities followed the example of Great Ormond Street Hospital, with similar initiatives for dedicated children's hospitals in Manchester, Sheffield, and Glasgow, many children were still looked after in general hospitals alongside adult patients (Casimir, 2019).

Despite these developments, the infant mortality rate at the start of the 20th century remained stubbornly high (Statista, 2021) and the responsibility for this was attributed to maternal incompetence and neglect (Cunningham, 2006). Advances in science and technology during the early 1900s led to a popular focus on hygiene, discipline, and habit formation, and behavioral psychologists such as Cyril Burt (1883-1971) promoted the idea that child-rearing was best undertaken according to these new scientific principles. Compliance was the order of the day and gone was the idea that children thrived on a mother's love: an attitude which permeated the care of sick children.

The plight of children in hospital during the first half of the 20th century was generally dismal. The proliferation of infectious diseases saw many child patients nursed in isolation hospitals, frequently alongside adult patients, where they were expected to endure painful treatments and conform to unfamiliar routines. Patients stayed in bed throughout their confinement and parental visiting was prohibited. Aside from the risk of cross-infection, it was firmly held that any expression of emotion aroused by parental presence would disrupt the treatment and recovery process (Whitehead, 2003). There were no dayrooms or play areas and no education, and with no telephones or televisions 'it was indeed an isolated world.' (ibid., p. 28)

Mrs. Clarke was 9 years old when admitted to hospital with Scarlet Fever in the 1920s. She recalls that during her 9-week confinement:

'No visitors ever came into the hospital, nor were there any visiting days during my whole stay. However, parents would come to the hospital wall and attempt to see their children if they happened to be on the wall side of the building. ... Our only contact with family members was a wave over the wall if your bed was well placed.' (cited in Whitehead, 2003, p. 28)

In the years between the First and Second World Wars, the most common forms of childhood illness were *tuberculosis* (TB) and orthopedic conditions such as *ricketts* (Whitehead, 2003). These were both associated with poverty and overcrowding, and often necessitated hospital stays of a year or more. Child patients were rarely given any information or explanation for the painful and frightening procedures they often had to endure. Mrs. Pederson was admitted to hospital in 1939:

'I was quite a bright child, but was given no explanation that I can recall, about my stay in hospital. I well remember feeling ill, abandoned and convinced that I had done something wrong to be so incarcerated.' (cited Whitehead, 2003, p. 44)

Ms. Edwards describes how the memory of childhood fears can linger, even after 70 years:

'I was in bed for a month, with tubes in my neck to drain [a] cyst (on the throat). I became frightened that if I got out of bed, the tubes in my neck would be dislodged and my head would fall off!' (cited Whitehead 2003, p. 48)

During the 1930s, important shifts in social attitudes marked another change in thinking about children's needs, both in sickness and in health. Social reformers such as Eglantyne Jebb (1876-1928), founder of *Save the Children Fund*, advocated for the rights and welfare of children to be seen as a universal responsibility, rather than resting solely with the family. In 1924, Jebb presented a

Declaration of the Rights of the Child to leaders from around the world at the League of Nations convention in Geneva. This declaration formed the foundation of the United Nations' *Convention on the Rights of the Child* (UN General Assembly, 1989) which has become the most widely ratified human rights treaty in the world.

The birth of 'therapeutic' play

In the 1930s, the behaviorism which had been popular since the start of the century came up against early psychoanalytic theory and, for the first time, there was a professional acknowledgement that children had unique psychological, as well as physical, needs. Finally, 'people began to listen to what children were saying' (Cunningham, 2006, p. 201).

The psychoanalyst and educator, Susan Isaacs (1885 - 1948), is considered a notable early influence on changing the way people regarded children and childcare. She promoted the idea that children's play was a form of self-expression: a safe outlet for their feelings and a means for them to rehearse ways of managing a range of emotions (Mickelburgh, 2018). Isaacs saw play as a vehicle for development, describing it as the 'breath of life to the child, since it is through play activities that he finds mental ease, and can work upon his wishes, fears and fantasies so as to integrate them into a living personality' (Isaacs, 1951, p. 210). Isaacs packaged her ideas for a popular audience, writing an advice column for parents in the magazine *Nursery World*. She encouraged parents to be more tolerant, to show an interest in what their children were saying, thinking, and doing, and to attempt to understand their anxieties and fears (Grenier, 2009).

Child psychologist, Margaret Lowenfeld (1890-1973) also advocated for play as the natural means of expression for the child, as their 'first language' (Goddard Blythe, 2011). Lowenfeld explained that children commonly 'think with their hands' and are better able to express their thoughts and feelings through play than through words (ibid.). Her *World Technique* (Lowenfeld, 2004), involving the use of a sand tray of small objects with which children could share the story of their inner 'world', became a blueprint for therapeutic play with children who had experienced emotional trauma. Lowenfeld's contemporary, Donald Winnicott (1896 - 1971), advanced the idea of play as integral to a child's emotional development, and both Lowenfeld and Winnicott recognized that the play drive is inhibited when a child is deeply anxious or distressed (Lowenfeld, 2008). Anticipating a future role for the professional play practitioner, Winnicott (1969) wrote, 'If the patient cannot play, then something needs to be done to enable the patient to play'.

A call for reform

The emerging discipline of therapeutic play as a means of addressing emotional distress, was matched by medical and academic interest in the effects of parent-child separation as a result of evacuation and bereavement during the Second World War (Horst & Veer, 2009). In 1939, John Rickman, a medical doctor, wrote in a letter to *The Lancet* (cited in Horst & Veer, 2009, p. 121):

*'at a time when [the child's] need for security, and the comforting assurance of familiar faces, is great, his removal from his parents will tax him severely
[and may show itself] in unsatisfactory or unhappy social relationships later in life.'*

The Second World War also saw the publication of a number of studies into 'the hospitalization effect' (Horst & Veer, 2009, p. 122) which identified high mortality rates among infants nursed in isolation in hospitals, compared with the rapid recovery of similar patients when they were returned home to the care of their parents. In 1950, John Bowlby summed-up these research findings in a report for the World Health Organization (Bowlby, 1951) which recommended:

'living in [by parents] for children under 3 years old, frequent visiting for children 3–6 years old ('daily if possible'), assigning one nurse to one child, creating a family structure, keeping wards small, relaxing discipline, [and] preparing children for the hospital stay.'

In the late 1940s, James Robertson, a psychoanalyst at the Tavistock Institute in London, was engaged in research into the effects of maternal deprivation (Robertson & Robertson, 1971). He suggested that emotional disturbance in later life may be attributable to early disruption of the mother-child relationship, such as occurs when a child is admitted to hospital (ibid.). In 1952, Robertson's film *A Two-Year-Old Goes To Hospital* shocked a professional audience with its vivid portrayal of a child so emotionally distraught by separation from her mother that she is left 'entirely unprovided for in a world in which [she] must survive the impossibility of experience' (Cadava & Cortez-Rocca, 2006, cited in Wierzchowska, 2020). The film was regarded as so explosive that it was withheld from public release until 1961 when it sparked a huge public outcry (Routledge, n.d.) and ignited a widespread demand for reform.

However, there is some evidence of isolated attempts to make the hospital experience more tolerable for children. An image from 1953 of the children's ward at Bow Street Hospital in East London, alludes to efforts to create a child-friendly environment with a piano, mini merry-go-round, ride-on toys, and pictures on the walls – although the child subjects of the image look unvaryingly miserable (Hand, n.d.). The picture hints of interpersonal interaction between the young patients and their nurses, suggesting an attitude of care which was rarely observed at a time when the psychological needs of children were generally poorly understood (ibid.). Whitehead (2003, p. 77) cites the case of 'Margaret' who asked to listen to the radio during a hospital stay in the 1950s, only to be told, 'you are in hospital for treatment – not to be entertained'.

By the end of the 1950s, there was an evident need for a major overhaul of children's healthcare provision. A report in 1959, by Harry Platt on behalf of the government's Ministry of Health (Platt, 1959), made 55 recommendations which included the separation of child and adult patients; unrestricted parental visiting; and the appointment of healthcare professionals specially trained to work with children. The report proposed that hospitals should incorporate opportunities for play and education, and that children should be prepared for hospital admission in line with their level of understanding (Davies, 2010). Change had been a long time coming and progress was variable but,

within five years of the publication of the Platt Report, eighty per cent of UK hospitals allowed daily visiting, compared with just twenty-three percent in 1952 (Horst & Veer, 2009, p. 135).

The arrival of the ‘Play Ladies’

In 1958, in advance of the wider developments recommended by the Platt report, St Bartholomew’s Hospital in London became the first to appoint a member of staff with the specific brief ‘to play’ with the patients on its children’s wards. Known as ‘Lady Greens’ on account of their green uniforms, these ‘play ladies’ initially came from the ranks of trained schoolteachers and later were nursery nurse recruits from the famous Norland Institute (National Association of Health Play Specialists [NAHPS], n.d). Judith Dibble, who was a Lady Green from 1959-60 writes (personal communication):

St Bartholomew’s Hospital (Barts) pioneered the creation of a post to promote the provision of play for children admitted to the two Childrens Wards, called Kenton and Lucas. I was appointed in 1959 as a Lady Green. The title came from the green uniform which was a follow-on from the colour of the uniforms of Sister Blue and Sister Pink on the Childrens Wards. The playscheme had been initiated by a teacher and I was covering her maternity leave before taking up my place at university. During my year at Barts, we worked with patients with various complicated conditions requiring medical and surgical treatments. The hospital admitted both local children and those from overseas and play proved the best communication tool.

Barts is a city the hospital, surrounded by buildings, but it had leafy grounds, and it was often possible to get onto the roof garden where we had sand and play equipment. Porters helped to take the children outside and up in the lifts and even bedbound children had access to the fresh air. I worked closely with the occupational therapist and, as the playscheme was an innovation, team working was paramount; everyone was hands-on, including the nursing and medical staff and their students.

Once again, it was observations made during the war years which highlighted the value of play for children affected by emotional trauma. During the 1940s, the UK charity, *Save the Children Fund* (SCF), had set up residential nurseries for young children who were evacuated from the cities during the Second World War, as well as day nurseries for those whose parents were working in wartime industries. The charity created play centers in the inner cities and launched ‘Hopscotch’, the first ever play group in Britain, which was to become a model for the hospital play schemes which followed (Save the Children Fund, n.d.)

Susan Harvey, advisor to SCF, is credited as the founder of ‘Hospital Play’ (Harvey & Hales-Tooke 1972). In 1963, Harvey introduced the first hospital play group in the UK at the Brook Hospital in London, with the endorsement of innovative consultant pediatrician, Dr David Morris, and Gabi Marston as the first representative of hospital play staff (NAHPS, n.d.). This experimental venture was perceived with ‘slight bemusement, along with interested appreciation’ by the nursing staff, and required a degree of ‘tact and ingenuity’ on the part of the play worker applying principles of child

development to the care of sick children for the first time (Marston, 2013, p. 7). Over the course of the following decade, SCF sponsored many similar play schemes in hospitals, prior to their full integration into the National Health Service.

In 1965, ‘children’s champion’ Dr Hugh Jolly, was another of the first medical consultants to employ play-leaders, at Charing Cross Hospital in London. An outspoken advocate for child-centered care, he asserted that a child’s illness could only be fully understood in the context of their family experience and the feelings of their parents (Jolly, 1981). In most cases, the family is the child’s main source of support, and the needs of the whole family and the mobilization of their collective resources remain key to a holistic approach to child health (NICE, 2021). Like Susan Isaacs, Hugh Jolly was a ‘media doctor’ and popular author, and his ‘common sense’ advice included entreaty to parents and grandparents to participate in their child’s play (Jolly, 1981).

One of the first nursery nurses to be employed in a hospital play scheme was Jean Evans (Evans, 2000). In a moving tribute to his wife and to hospital play, Jean’s husband has written of how she set about demonstrating that play could be used as a therapeutic tool to minimize the distress of a hospital admission and to build on a child’s natural resilience (ibid.). Jean established the playroom as a secure base, where children could freely ‘play out’ their feelings in domestic scenarios, thus creating a valuable link with home (ibid.). She also worked with parents, to help them understand the value of playing and of telling stories to their children. Nowadays, this interaction with parents has become a key feature of the role of the HPS (Starlight Children’s Foundation, 2021).

The development of play in hospital needs to be understood in the context of the evolution of play in education and other settings (Whitaker, 2014). Play has long been accepted as the starting point for early education, and the link between play and learning was reinvigorated during the early decades of the 20th century through the influence of educational pioneers such as Froebel (1782-1852), Steiner (1861-1925), and Montessori (1870-1952) who emphasized the experiential nature of learning; and of developmental theorists such as Vygotsky (1896-1934), Piaget (1896-1980), and Erikson (1902-1994) who claimed beneficial effects of play for children’s development (Whitaker, 2022). The resulting ‘child-centered’ approach to education recognizes each child as a unique individual with the capacity for self-determination and a right to autonomy (ibid.). No longer regarded as just ‘adults in the making’ (ibid.), children are now understood to be complete beings whose experiences in the present have validity in the here-and-now, as well as for their future development (James & Prout, 2014). This conceptual shift has had implications for how the State perceives its role and responsibilities, not only in the educational context but in relation to children’s health and wellbeing.

Mothers take action

In 1961, it was a group of mothers who managed to persuade hospital authorities to implement the recommendations of the Platt Report (Williamson, 2010). Their meetings with professionals and other parents led to the formation of a network of lobbying groups which came together under the name

Mother Care for Children in Hospital (MCCH) (ibid.). One of the pioneering members of MCCH was Peg (Margaret) Belson (1921-2012) who was a fearless campaigner for the rights of children in hospital for almost 50 years. Like Eglantyne Jebb and Susan Harvey, Belson was ‘a woman ahead of her time’ (Walker, 2012, p. 8) who acted tirelessly to nurture the burgeoning movement for child-centered pediatric services, not just in the UK but in Europe and around the world.

In 1965, MCCH changed its name to the *National Association for the Welfare of Children in Hospital* (NAWCH) and became a UK-wide multi-disciplinary organization of parents and professionals, defined as ‘a unique pressure group dedicated to promoting the message that sick children need more than clinical attention, they need the continuing care of those who are closest to them’ (Brandon et al., 2009, p. 176). Similar groups followed in the USA, Canada, and Australia (Shields & Mohay, 2001).

It is reasonable to question how maternal care in hospital relates to the development of hospital play and the answer lies in the observation that, ‘the key to play and well-being at any age is a basic sense of safety’ (Gordon, 2014). As both Lowenfeld and Winnicott pointed out, children do not freely engage in play when they feel unsafe or distressed. They need to be brought ‘from a state of not being able to play into a state of being able to play’ (Winnicott, 1971, p. 44). The mother’s presence represents a secure base from which a sick child might feel free to be themselves, to play, and through that play to communicate their thoughts and feelings and, in so doing, to take an active part in their care.

In 1991, NAWCH changed its name to *Acton for Sick Children* to reflect the growth in community healthcare (Children’s Health Scotland, 2021), and it continues to be an influential contributor to government consultations, advocating for a model of care which meets the social, emotional, and psychological needs of sick children. *Children’s Health Scotland* (2021) and *Children in Hospital Ireland* (2021) fulfil a similar function elsewhere, supporting the child’s right to play and access to hospital services which meet the needs of the whole family.

Setting standards for play in hospital

Whilst the employment of playleaders in children’s wards had been envisaged in the Platt Report of 1959, several studies (e.g., Stacey et al., 1970; Hawthorn, 1974) showed a continuing lack of play provision, ‘with the result that most of [a child’s] stay was spent in bed, often bored and miserable’ (Hall, 1977, p. 64). There was ambiguity around the role of the proposed hospital playleaders, whether it was primarily to amuse and entertain young patients or whether it should have a more therapeutic or educational value. This is a debate which remains relevant to HPS up to the present day (Whitaker, 2022).

A 1970 survey of play in hospitals (Hall, 1975, cited in Hall, 1977) identified three distinct types of play provision: the deployment of junior nurses in a recreational or entertainment capacity; the employment of teachers for educational purposes; and the appointment of play workers or therapists through voluntary organizations, with a focus on physical or occupational therapy. There were no clear standards about what these playleaders were expected to do, resulting in a fluid interpretation of their

role. The consequent conflation of expectations led to a blurring of boundaries between playleaders and parents, and playleaders and nursing staff. Hall (ibid.) cites examples of playleaders sharing medical information with parents and undertaking what were essentially basic nursing tasks.

In 1972, the UK government's Department of Health and Social Security (DHSS) established an expert group on play for children in hospital to produce much-needed guidance for hospital authorities. The report which followed in 1976 emphasized the child's need for play, both for their 'normal development' and to alleviate the stresses associated with their hospitalization (DHSS, 1976). Most significantly, the report recommended the employment of 'play workers to meet children's play needs' acknowledging that 'children in hospital need emotional support and understanding help if they are to play' (ibid).

It had become evident that playleaders working in hospitals needed a clearly defined role and professional identity, and it was to this end that the first training course for HPS was established under the guidance of Susan Harvey, Gabi Marston, and Dr Hugh Jolly, followed two years later by the inauguration of the *National Association of Hospital Play Specialists* (NAHPS, n.d.).

However, it would not be until 1990 and the publication of *Quality Management for Children: Play in Hospital* (Hogg & Rodin, 1990) that the provision of hospital play services would achieve full recognition as an essential component of pediatric healthcare. The report acknowledged that play services require specialist expertise and qualified staff, and a distinct identity within the healthcare system. It emphasized that playing with children is something that everyone involved in their care should do, denoting HPS as 'enablers' as much as 'service providers' with a role to educate and encourage other staff and parents about the value of play (ibid.). The clear message was that play was central to quality, rather than an 'added extra' and that all children visiting or staying in hospital, including the siblings of patients, should have access to play organized by a suitably qualified play specialist, in 'an environment where they can play and act as normally as possible' (ibid.).

A Focus on Children's Rights

In 1993, The European Association for Children in Hospital (EACH) was established as an international umbrella organization of non-governmental, non-profit, associations involved in the welfare of children in hospital and other healthcare services (EACH, n.d.). The EACH Charter has served as a basis for pediatric healthcare legislation and professional guidance throughout Europe and beyond, and it includes the contention that children in hospital should have 'full opportunity for play, recreation and education suited to their age and condition and shall be in an environment designed, furnished, staffed, and equipped to meet their needs' (ibid., Article 7). The charter further asserts that suitably qualified staff should be available to facilitate that play.

The EACH Charter also acknowledges that children need timely and accurate information appropriate to their age and understanding in order for them to retain a sense of control and to be involved in all decisions involving their health care (ibid., Articles 4, 5). It identifies the therapeutic potential of play

in hospital: as a means of information sharing and preparation for clinical procedures (e.g., West et al., 2020); as an aid to coping with pain and emotional distress (e.g., Ullan & Belver, 2019); and as a means of expressing and communicating strong feelings (e.g., Matsudaira, 2022). This focus on the therapeutic benefits of play in hospital has enhanced the status and integration of the HPS in the multidisciplinary team while also raising a new dilemma. In many of the larger children's hospitals, inadequate staffing (Starlight Children's Foundation, 2021) means that play is provided exclusively on a referral basis, through the delivery of focused therapeutic interventions to individual children. This creates a risk that the child's need for the 'normalizing' domestic, social play, facilitated by the likes of Gabi Marston and Jean Evans, can become sidelined to more specialized 'play interventions' (Hubbuck, 2009, p. 138) rather than being acknowledged as the bedrock on which all other therapeutic support depends. Frohlich et al. (2013) caution that the appropriation of play for extrinsic purposes, however well-intentioned, 'may undermine the promotion of play as a health-inducing socio-cultural behavior in practice'.

In 2003, forty years after the setting up of the first hospital play scheme, Hospital Play came of age with the publication of *Getting the right start: National Service Framework for Children* [NSF] (Department of Health, 2003) which set a national standard for the care of children in hospital, including the routine provision of play services – although it was never incorporated into policy. Acknowledging the unique needs of children, the NSF includes a recognition that 'children visiting or staying in hospital have a basic need for play and recreation' and that this 'should be met routinely in all hospital departments providing a service to children' including for neonates and for the siblings of patients (ibid., p. 14). The NSF endorses the therapeutic potential of play 'as a way of helping the child to: assimilate new information; adjust to and gain control over a potentially frightening environment; and prepare to cope with procedures and interventions' and recommends that children staying in hospital should have 'daily access to a play specialist' who will model the use of play techniques which other members of the multi-professional team could then adopt (ibid., p. 15). The pediatric team is expected to be able to offer 'a variety of play interventions to support the child at each stage in his or her journey through the hospital system' including in the Emergency Department (ibid.).

Learning from history: the advent of HPS Japan.

In 2007, the first training course for HPS in Japan was established at the Junior College Division of the University of Shizuoka, based on the UK training model (Japan Hospital Play Association [HPS Japan], 2007). The course came about through the inspiration of Chika Matsudaira, a social worker and play therapist who had undergone play specialist training in the UK, and was fully funded by the Ministry of Education, Culture, Sports, Science and Technology of Japan.

The introduction of play to Japanese healthcare settings came up against two significant obstacles from the outset. Firstly, there was a marked status differential between medical staff and play staff in Japan's traditional healthcare system, which seemed insurmountable. In contrast to the field of social welfare,

which resisted hierarchical divisions, there was still a keen sense of hierarchy in the medical profession in Japan at the start of the twenty-first century, and this made it difficult for the newly qualified hospital play practitioners to position themselves as play ‘specialists’. The second cultural stumbling block was the lack of a shared value of play within healthcare. The procedural preparation and support conducted by the new HPS was spotlighted, while the underlying ‘play’ on which it was based was overlooked. With the play element neglected, child patients were denied a sense of control and, with their dignity undermined, they were unable to receive and experience the full benefits of the therapeutic intervention. Faced with this impasse, Professor Matsudaira turned towards the UK, the country where Hospital Play had gestated half a century before. Researching the history of the profession, why it came about, and the processes that had led to its current configuration, revealed a well-trodden path from a lack of knowledge and understanding to a healthcare system that had found a way to accommodate play. Interviews with three Health Play Specialists who had been among the first to train in the UK in the 1970s exposed a history which paralleled the present Japanese scenario. The UK of ‘the past’ had become the Japan of ‘the now’ and learning of the battles and victories encountered by the pioneers of Hospital Play, revealed a path to a future for hospital play in Japan. As in the UK, the future history of hospital play in Japan will depend on digging-up the facts of the past, reading the past, and practicing ‘dialogue between the past and the present’. The accumulated wisdom of those such as Robertson (1958), Winnicott (1968), and Harvey (1972), who recognized that that play is the most prominent expression of a child’s existence, is more relevant now, in the aftermath of a global pandemic, than it has ever been (Starlight Children’s Foundation, 2022).

A vision for the future

Cultural change commonly arises from expressions of public discontent with the status quo and the emergence of a coherent vision of how things can change for the better (Lowe, 2005). We have seen this in relation to the establishment of children’s hospitals in the 19th century, the introduction of hospital play schemes following the Platt Report of 1959, and the focus on children’s rights which resulted from combined parental and professional lobbying in the final decades of the 20th century. The Children’s NSF (2003) arose from a government inquiry into ‘excess’ deaths on a children’s cardiac unit, which identified a flawed system of care, characterized by poor teamwork between professionals (Kennedy, 2001). Kennedy reinforced the view that healthcare professionals who care for children must be able to listen to them, to respect their need for information and ‘to be prepared and able to give such information in the right amount and in a way which is suitable for the child’s age’ and that this demands specific skills and training (*ibid.*, pp. 431-2). The overriding message of the inquiry report seems to be an obvious one: that children are distinct from adults and should receive care provided by appropriately trained staff. This was certainly not a new idea; it reinforced the central tenet of the Platt report more than 40 years earlier, and the principle underpinning the Children’s Charter of 1819.

In 2010, the UK government commissioned a comprehensive review of NHS services for children and

young people. This review (Kennedy, 2010) highlighted the complexities involved in caring for children, and the importance of coordinating services around the needs of the child. It included specific reference to the child's need for therapeutic play (ibid, p. 64). Kennedy pinpointed the value of a holistic approach to children's healthcare, whereby each aspect of care is equally valued. He asserted that Health Play Specialists, like other marginalized professions, 'should not be seen as expendable luxuries to be got rid of when the money is tight' but should be regarded as 'part of the necessary complement of staff ... crucial to the experience that a child may have of care in and out of hospital' (ibid., 101). Despite this, twenty years after the Kennedy Report, research by Starlight Children's Foundation (2022) reveals that a third of hospitals in the UK still have no dedicated play specialist and that many lack the most basic of play resources (ibid.).

The child's subjective experience of their care and treatment is now regarded as a key outcome of healthcare (Kennedy, 2010, p. 65) and it is expected that they will be active participants in the planning and enactment of that care (NICE, 2021, p. 63). Cunningham (2006, p. 245) observes that a major difference between childhood nowadays and the life of a child 150 years ago, when children's hospitals were first introduced, is that in the past children 'were assumed to have capabilities that we now rarely think that they have'. Cunningham reminds us that children are capable of much more than we may give them credit for and that we risk downplaying their abilities and resilience if our desire to 'protect and provide' gets in the way of their potential for self-determination. Hospital play gives sick children a voice and empowers them to be active players in their healthcare encounters.

Conclusion

Play is a process rather than an outcome and play in the healthcare setting presents a valuable opportunity for the child to discover more about themselves and their potential in the world. Health Play Specialists of the 2020s, like their pioneering forebears, have become representatives of a wider movement for play which advocates for children to have the time, space, and opportunity for self-directed play, as a basic human right (Voce, 2015) and as a key determinant of lifelong health and wellbeing (Whitaker & Tonkin, 2021).

Sixty years after the foundation of hospital play in the UK, and fifteen years after the introduction of Hospital Play to Japan, there is widespread international evidence for the role of play as a key component of children's healthcare (Perasso, 2021; Perasso & Ozturk, 2022) and a renewed drive for policy recognition of the child's right to play in sickness and in health (Starlight Children's Foundation, 2022).

Play is an act of living in the present. When children play, they live in the 'present moment' without reference to either past or future. Through their play, children create their own history, building on the present moment to chart a path to the rest of their lives. It is the gift of play for 'living in the present', rather than 'for the future', that endows children with the inner resources and resilience to create a future for themselves which is built on the wisdom of history.

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