# HEART RHYTHMS

## CHAPTER 2: DISSONANCE

I’m running late on my first day, which is absolutely not the impression I wanted to make at Manhattan Memorial. The security guard at the main entrance takes forever to process my temporary ID, the hospital map might as well be written in ancient Sumerian, and I’ve already taken two wrong turns that led to what appeared to be abandoned research labs from the 1970s. So much for my carefully planned punctual arrival with coffee and confidence.

“Excuse me,” I ask a passing nurse, trying not to sound as frazzled as I feel. “Could you point me toward the administrative offices? I’m supposed to meet with HR before orientation, and I think I’m in the wrong building entirely.”

She gives me directions that involve three different elevator banks, a skybridge, and landmarks like “the statue of the guy with the weird beard” and “where the vending machine that steals money used to be.” I thank her with what I hope is professional gratitude rather than desperate confusion and set off again, my rolling bag of supplies clattering behind me like an announcement of my disorientation.

Ten minutes and another wrong turn later, I find myself in what appears to be a supply closet. Not a small closet, but an actual room filled with medical supplies, where two doctors are engaged in what can only be described as enthusiastic non-medical interaction against a shelf of IV fluids. They spring apart when the door opens, the male doctor adjusting his scrub pants while the female doctor attempts to smooth her hair into something less obviously disheveled.

“I am so sorry,” I blurt, already backing out. “Wrong turn. Completely lost. Looking for HR. Please continue… I mean, not continue that specifically, but… I’m going to close this door now.”

I pull the door shut with perhaps more force than necessary, my face burning with embarrassment as I hear muffled cursing from inside. Welcome to Manhattan Memorial, Sophie. You’ve been here twenty minutes and already witnessed workplace indiscretion in the supply closet. This is definitely not covered in the employee handbook.

After another ten minutes of increasingly desperate wandering, I finally locate the administrative offices where a bored-looking receptionist directs me to Human Resources without looking up from her phone. I arrive at the HR office seventeen minutes late, rolling bag slightly scuffed from its journey through the hospital labyrinth, coffee now lukewarm, and professional confidence somewhat dented.

“Dr. Winters?” The HR coordinator looks up from her computer with the particular expression of someone who has been waiting longer than they consider reasonable. “We were expecting you at nine.”

“I’m so sorry,” I apologize, trying to sound professionally contrite rather than personally mortified. “I got a bit turned around in the hospital complex. The map is… challenging.”

“Mmm,” she responds noncommittally, neither accepting nor rejecting my explanation as she slides a stack of forms across the desk. “These need to be completed before orientation. Medical history, emergency contacts, direct deposit information, benefit selections, confidentiality agreements, and technology usage policies. The orientation video will begin in forty-three minutes in Conference Room B.”

I take the forms and settle into an uncomfortable chair in the corner of the office, balancing the clipboard on my knees while trying to complete detailed personal information without spilling my now-cold coffee. By the time I finish the paperwork, I have exactly seven minutes to locate Conference Room B, which—given my track record so far—seems wildly optimistic.

Miraculously, I find the conference room with two minutes to spare, slipping into a seat at the back just as the lights dim for the orientation video. The room contains a mixture of new employees—a few doctors in white coats, several nurses in scrubs, and what appear to be administrative staff in business casual attire. No one else seems to have a rolling bag of music therapy equipment, which makes me feel conspicuously out of place despite my professional attire and hospital ID badge.

The orientation video begins with production values that suggest it was created during the Clinton administration. A narrator with the particular vocal quality of someone who usually announces local car dealership sales introduces Manhattan Memorial’s “commitment to excellence” while stock footage of doctors looking at clipboards plays in the background. This transitions to a sexual harassment segment featuring actors in shoulder pads and hairstyles that confirm my suspicion about the video’s vintage.

“Remember,” intones the narrator as two actors demonstrate inappropriate workplace behavior with the subtlety of a daytime soap opera, “compliments about appearance can create a hostile work environment. Keep comments professional and work-related.”

I glance around the room, wondering if anyone else is finding this as absurdly outdated as I am, and catch the eye of a young doctor who seems to be suppressing laughter. He gives me a small nod of shared amusement before returning his attention to the screen, where the video has now transitioned to fire safety protocols featuring equipment that probably hasn’t been used in the hospital for at least a decade.

By the time the video concludes with a message from the hospital director (who, based on a quick Google search on my phone during the presentation, retired three years ago), I’m beginning to wonder if Manhattan Memorial’s commitment to cutting-edge medicine extends to any aspect of its administrative functions. The lights come up, and a current administrator who introduces herself as Ms. Patel provides updated information on security protocols, parking permits, and cafeteria hours before dismissing us to our respective department orientations.

I check my schedule and see that I’m supposed to meet Dr. Foster, the hospital administrator overseeing the new integrative medicine initiative, in his office at eleven. This gives me approximately twenty minutes to locate his office, which—based on my morning navigation success rate—means I should start looking immediately.

Surprisingly, I find the administrative wing without major detours, arriving at Dr. Foster’s office five minutes early. His assistant, a meticulously groomed man with the particular efficiency of someone who actually runs the department while his boss takes the credit, looks up as I approach.

“Dr. Winters, I presume?” he asks, standing to greet me. “I’m Michael, Dr. Foster’s assistant. He’s running slightly behind schedule this morning—budget meeting with the board. Can I get you anything while you wait? Coffee? Water?”

“Water would be great, thank you,” I reply, grateful for this small kindness after my chaotic morning. “And please call me Sophie.”

Michael provides water in an actual glass rather than a paper cup, another small but welcome civility, and I settle into a chair in the waiting area, using the time to review my department setup notes and orientation materials. After fifteen minutes, the office door opens, and Dr. Foster emerges with the particular expression of someone who has been asked to reduce expenses without reducing services.

“Dr. Winters,” he greets me, extending his hand. “Welcome to Manhattan Memorial. Sorry to keep you waiting—budget discussions always run long this time of year.”

“No problem at all,” I assure him, shaking his hand with what I hope is the perfect balance of professional firmness and collegial warmth. “I appreciate you making time for me on my first day.”

Foster ushers me into his office, which features the expected diplomas and awards along with photographs of him with various hospital donors and local politicians. He gestures toward a chair across from his desk and settles into his own seat with the practiced movement of someone who spends most of his day in administrative meetings.

“So,” he begins, folding his hands on the desk, “I understand from your previous director at Mount Sinai that you’ve developed quite an impressive program there. We’re excited to implement something similar here at Manhattan Memorial as part of our expanded integrative medicine initiative.”

“I’m looking forward to the opportunity,” I respond, shifting into the professional presentation mode I’ve perfected over years of explaining music therapy to skeptical medical administrators. “The outcomes data from Mount Sinai demonstrated significant benefits across multiple departments, particularly in cardiac rehabilitation, stroke recovery, and pain management for oncology patients.”

Foster nods with the particular expression of an administrator who cares less about specific clinical outcomes than about donor appeal and marketing potential. “Yes, the board was quite impressed with those results. Several of our major donors have expressed specific interest in expanding our integrative medicine offerings, particularly for our cardiac patients. The Bennett Cardiology Wing donors are especially enthusiastic about innovative approaches.”

The name catches my attention—Bennett is a recognized name in cardiology research, with several groundbreaking studies on arrhythmia prediction and management. I make a mental note to review the department structure and key personnel before my first cardiology department meeting.

“I’ve prepared an implementation timeline and departmental integration plan,” I tell Foster, removing a folder from my bag and placing it on his desk. “It outlines a phased approach beginning with the departments where we’ve seen the most significant outcomes data, along with staffing requirements and equipment needs.”

Foster glances at the folder without opening it, his expression suggesting it will be reviewed later, possibly by Michael rather than himself. “Excellent. I’ve scheduled introductory meetings with the department heads over the next two weeks. The cardiology department will be particularly important given the donor interest, though I should warn you that some of the attending physicians there can be… traditionally minded in their approach to treatment modalities.”

His diplomatic phrasing suggests I should expect resistance, which isn’t surprising. Cardiology departments are often among the most skeptical of integrative approaches, their practice heavily grounded in pharmaceutical interventions and procedural techniques with clearly measurable outcomes. It’s a challenge I’ve faced before, though each hospital has its own particular flavor of medical territorialism and disciplinary skepticism.

“I’m familiar with the integration challenges,” I acknowledge with professional confidence rather than defensive anticipation. “The key is establishing clear outcome metrics that align with departmental priorities while demonstrating practical implementation that doesn’t disrupt existing workflows. The data tends to speak for itself once we have initial cases documented.”

Foster seems satisfied with this response, and we spend the next thirty minutes discussing administrative details—office space (smaller than promised in my recruitment package), initial budget allocation (also smaller than discussed during interviews), and reporting structure (more complicated than necessary, with dotted-line relationships to three different administrative entities). By the time we conclude the meeting, I have a clearer picture of the institutional landscape I’ll be navigating, including the political currents beneath the official organizational chart.

“Your office should be ready by tomorrow,” Foster informs me as our meeting wraps up. “For today, you can use Conference Room C to organize your materials and prepare for tomorrow’s research committee meeting. Michael will show you where it is and help with any immediate needs.”

I thank him for his time, we exchange the expected pleasantries about institutional commitment to innovative care approaches, and I follow Michael to Conference Room C, which turns out to be a glorified storage room with a table hastily cleared of boxes. He apologizes for the accommodations with the particular sincerity of someone who has no control over the situation but genuinely wishes it were better.

“Budget constraints affect everything except the executive suite,” he comments with carefully measured candor as he helps me arrange the space into something resembling a functional work area. “But once the program shows results, things tend to improve. The cardiac rehabilitation space on the fourth floor is quite nice—that’s where you’ll be conducting most of your clinical sessions once everything is set up.”

“Thanks for your help,” I tell him, genuinely appreciating his assistance and insider perspective. “Any other unofficial orientation advice you think might be useful?”

Michael glances toward the door to ensure we’re alone, then lowers his voice slightly. “The cafeteria serves decent food, but avoid Tuesdays when they do ‘international cuisine’ experiments. The doctors’ lounge on the third floor has better coffee than the public areas, and no one will question you if you look confident enough. Dr. Sharma in neurology is already using music interventions for her stroke patients, so she’ll be a good ally. And…” he hesitates, then continues, “the cardiology department can be challenging for new programs, especially anything they consider ‘alternative.’ Dr. Bennett—the younger one, not his father—is brilliant but skeptical of anything without double-blind randomized controlled trials and statistical significance at the p<0.01 level.”

This additional information about the Bennett name confirms my earlier mental note to research the department dynamics before my first cardiology meeting. “Thanks for the insider intelligence,” I reply with a smile. “It’s always helpful to know the landscape before navigating it.”

Michael leaves me to organize my materials, and I spend the next hour setting up my temporary workspace and reviewing department information on the hospital intranet. The cardiology department proves particularly interesting—led by Dr. Winters (no relation, despite the shared surname), with several attending physicians including Dr. Eli Bennett, son of the renowned Dr. William Bennett whose research I’ve cited in my own publications. The younger Dr. Bennett’s profile shows impressive credentials—medical school at Columbia, residency at Johns Hopkins, fellowship at Mayo Clinic, with research focusing on arrhythmia prediction and management using advanced algorithmic approaches.

His publication list is substantial for someone his age, with several papers on autonomic nervous system influences on cardiac function—directly relevant to my own research on music therapy applications for arrhythmia patients. Interestingly, his early undergraduate work included a music minor alongside his pre-medical studies, though there’s no mention of musical background in his professional biography. This unexpected connection to music might provide common ground despite his likely skepticism about therapy applications.

After completing my departmental research and organizing my materials for tomorrow’s meetings, I decide to familiarize myself with the clinical areas where I’ll be working, particularly the cardiac rehabilitation space Michael mentioned. I gather my things, lock the conference room as instructed, and head toward the elevator banks, feeling more oriented than I did this morning despite the continuing complexity of the hospital layout.

The cardiac rehabilitation area on the fourth floor is indeed impressive—recently renovated with modern equipment, large windows providing natural light, and a layout that allows for both group activities and individual treatment stations. As I’m exploring the space, a nurse approaches, her expression curious but not unwelcoming.

“Can I help you find something?” she asks, her ID badge identifying her as Elena Rodriguez, Cardiac Rehabilitation Coordinator.

“I’m just familiarizing myself with the space,” I explain, extending my hand. “Sophie Winters, the new music therapy program director. I’ll be working with cardiac patients as part of the integrative medicine initiative.”

Elena’s expression brightens with recognition. “Oh! We’ve been told about the new program. Several of our patients have asked about music therapy options after reading about it online. When will you be starting clinical sessions?”

Her enthusiastic response is encouraging after Foster’s warnings about departmental resistance. “I’m hoping to begin initial assessments next week, with clinical sessions starting the following week once I’ve completed the required orientations and department introductions.”

We discuss logistics for integrating music therapy sessions into the existing rehabilitation schedules, and Elena provides valuable insights about patient population characteristics and current rehabilitation protocols. She seems genuinely interested in the potential benefits for her patients, asking thoughtful questions about implementation and outcome measures rather than expressing the skepticism I often encounter from medical staff.

“The afternoon group might be particularly receptive,” she suggests, showing me the schedule board where patient sessions are tracked. “Many of them have been in the program for several months and are looking for new approaches to maintain motivation and engagement. And Mr. Abernathy specifically asked about music options—he was a jazz musician before his cardiac event, and he’s been talking about the research he’s read on music therapy for cardiac recovery.”

I make notes about these potential early adopters, appreciating Elena’s insider knowledge and supportive attitude. As we’re discussing equipment placement and storage options, a patient monitor alarm sounds from one of the treatment rooms, and Elena excuses herself to check on the situation. I continue exploring the space, mentally planning how to arrange equipment and materials for different intervention types based on the available layout.

I’m examining the private treatment room that would be ideal for individual sessions when I hear voices approaching—one female with the particular authoritative tone of an experienced nurse, and one male with the confident cadence of an attending physician.

“Her rhythm has been stable since the medication adjustment,” the female voice is saying, “but she’s still reporting significant anxiety during activity, which is limiting her functional progress.”

“Anxiety is a normal response to cardiac events,” the male voice replies, his tone reflecting the particular certainty of someone accustomed to having the final word in clinical discussions. “The psychological adaptation typically resolves with time and progressive rehabilitation. Her cardiac function is improving appropriately based on the objective measures.”

“Yes, doctor, but her subjective experience is limiting her participation,” the nurse persists with respectful determination. “She’s capable of more based on her clinical indicators, but the anxiety is creating a functional barrier.”

They enter the room where I’m standing, the conversation pausing as they notice my presence. The nurse is Elena, returning from the monitor alarm, and the doctor is—based on his ID badge and my earlier research—Dr. Eli Bennett. He’s taller than his profile photo suggested, with the particular posture of someone who projects confidence as habitually as breathing. His expression shifts from clinical focus to questioning assessment as he notices me, his eyes taking in my professional attire and visitor badge with rapid evaluation.

“Dr. Bennett,” Elena says, smoothly integrating my presence into the clinical discussion, “this is Dr. Winters, the new music therapy program director. Dr. Winters, Dr. Bennett is one of our attending cardiologists.”

“Music therapy?” he repeats, his tone suggesting he’s encountered a particularly unusual specimen in his otherwise orderly medical environment. “You’re the new… music person Foster mentioned in the department meeting.”

The deliberate replacement of “therapy” with “person” doesn’t escape my notice—a subtle but clear indication of his perspective on my professional status. It’s a familiar microaggression I’ve encountered throughout my career, and I’ve developed multiple response strategies depending on the situation. Given that this is my first interaction with a key department physician, I opt for professional correction rather than confrontational challenge.

“Music therapist,” I clarify with a pleasant but firm smile, extending my hand. “Sophie Winters, PhD. I’m heading the new integrative medicine program focusing on evidence-based music interventions for various patient populations, including cardiac rehabilitation.”

He shakes my hand briefly, his grip professionally appropriate but his expression maintaining skeptical assessment. “Eli Bennett, Cardiology. What exactly brings you to the cardiac rehabilitation area today? We don’t typically have visitors in active treatment spaces without clinical purpose.”

His question carries the particular tone of territorial marking that certain specialists adopt when they perceive encroachment on their clinical domain. I maintain my professional composure, recognizing this as a predictable response rather than a personal challenge.

“I’m conducting a space assessment for program implementation,” I explain, my tone balancing collegial information-sharing with professional confidence. “Elena has been helping me understand the current rehabilitation protocols and patient flow to ensure our integration is complementary rather than disruptive. The research committee has approved initial implementation in cardiac rehabilitation based on the outcomes data from similar programs at Mount Sinai and Mayo Clinic.”

The mention of research approval and established medical centers creates a slight shift in his expression—not acceptance, but a recalibration of his initial dismissal. He glances at Elena, who nods confirmation of my explanation.

“Dr. Winters will be working with some of our patients beginning next week,” she adds, her tone suggesting this is established fact rather than speculative possibility. “Mr. Abernathy specifically requested music therapy as part of his rehabilitation program.”

“Mr. Abernathy requests many things,” Dr. Bennett responds with the particular patience of someone accustomed to managing patient expectations. “Including experimental medications he finds on internet forums and treatment approaches based on his neighbor’s cousin’s experience. Our responsibility is to provide evidence-based care with demonstrated clinical benefit, not accommodate every patient preference regardless of scientific validity.”

His response is directed at Elena but clearly intended for me—a professional boundary statement establishing his perspective on what constitutes appropriate treatment. Rather than becoming defensive, I recognize an opportunity to establish my own scientific credibility.

“I completely agree about the importance of evidence-based approaches,” I reply, maintaining professional engagement rather than reactive defensiveness. “That’s why our protocols are based on randomized controlled trials published in peer-reviewed journals, with specific outcome measures aligned with standard cardiac rehabilitation goals. The Journal of Cardiopulmonary Rehabilitation published a meta-analysis last year showing statistically significant improvements in functional capacity, anxiety reduction, and treatment adherence when structured music interventions are integrated with standard rehabilitation protocols.”

I cite the specific p-values and confidence intervals from the study, watching as his expression shifts slightly—not to acceptance, but to a more evaluative assessment than his initial dismissal. He wasn’t expecting research literacy or statistical knowledge, despite my introduction including my doctoral degree.

“I’m familiar with that meta-analysis,” he responds after a moment, though his slight hesitation suggests this might not be entirely true. “The methodological limitations in several of the included studies raise questions about the generalizability of the findings, particularly regarding long-term outcomes and specific patient populations.”

It’s a standard critique used to dismiss research outside one’s own specialty—acknowledging awareness while questioning methodology, a technique I’ve encountered frequently when introducing music therapy in traditional medical settings. I’ve learned to respond with specific methodological details rather than general defenses, addressing the implicit challenge directly.

“The heterogeneity of included studies was addressed through subgroup analysis and sensitivity testing,” I explain, maintaining collegial discussion rather than argumentative defense. “The most robust effects were observed in patients with preserved ejection fraction but elevated anxiety scores, particularly during the first three months of rehabilitation—exactly the population Elena was just describing with your patient experiencing activity limitation due to anxiety despite improving cardiac function.”

This specific application to his current clinical challenge creates another shift in his assessment—still skeptical, but with a new element of reluctant intellectual engagement. Before he can respond, a monitor alarm sounds from another treatment room, and Elena excuses herself to check on the patient, leaving Dr. Bennett and me in a moment of direct professional confrontation without the mediating presence of the nurse.

“Look,” he says once Elena is out of earshot, his tone shifting from clinical discussion to direct address, “I understand the administration is enthusiastic about ‘integrative approaches’ because they appeal to donors and create marketing opportunities. But in my department, treatment decisions are based on physiological mechanisms and measurable outcomes, not subjective experiences or placebo effects magnified by confirmation bias and selective reporting.”

His statement is both a professional boundary declaration and a challenge to my legitimacy—exactly the response Michael warned me about, though delivered with more articulate precision than blunt dismissal. I’ve encountered this perspective throughout my career, and while it once triggered defensive reactions, I’ve learned that demonstrated competence is more effective than argued credentials.

“I respect your commitment to evidence-based practice,” I reply, maintaining professional composure while meeting his direct approach with equal directness. “It’s a commitment I share, which is why our program includes rigorous outcome measurement using the same physiological indicators and functional assessments you use in standard rehabilitation protocols. The mechanisms of music’s effects on autonomic nervous system function, neuroendocrine response, and psychological engagement are well-documented in the literature, including studies specifically examining cardiovascular parameters during structured music interventions.”

I pause, then add with calculated precision, “In fact, the autonomic regulation patterns observed during certain music therapy protocols show interesting parallels to the arrhythmia prediction models you’ve published on, particularly regarding heart rate variability parameters and their correlation with subsequent rhythm stability.”

The reference to his specific research creates a visible reaction—surprise followed by reassessment, his expression shifting from dismissive boundary-setting to reluctant intellectual curiosity. He hadn’t expected me to be familiar with his work, much less identify relevant connections to my own field.

“You’ve read my research on arrhythmia prediction?” he asks, his tone suggesting this possibility hadn’t occurred to him.

“Of course,” I confirm with professional matter-of-factness rather than defensive justification. “Your work on autonomic influences on cardiac rhythm stability is directly relevant to music therapy applications for arrhythmia patients. Your 2022 paper on heart rate variability parameters as predictive indicators was particularly interesting in light of our findings on parasympathetic activation patterns during specific musical interventions.”

This explicit connection between our professional domains creates a moment of recalibration in our interaction—not agreement or acceptance, but a shift from hierarchical dismissal to collegial assessment. Before he can respond, however, a patient is wheeled into the rehabilitation area on a transport gurney, accompanied by a nurse and what appears to be a family member. The patient—an elderly man with the particular pallor of someone recently discharged from intensive care—notices Dr. Bennett and calls out with surprising vigor.

“Doc! Perfect timing. Tell this drill sergeant I’m ready for the advanced program. I’ve been doing the exercises in my room, and I’m stronger than I look.”

Dr. Bennett’s demeanor transforms instantly from confrontational colleague to attentive physician, his focus shifting completely to the patient with a warmth that contrasts with his previous professional coolness.

“Mr. Abernathy,” he greets the patient, moving to the gurney with a genuine smile. “Glad to see you’re feeling energetic, but let’s follow the protocol we discussed. Your heart has been through a significant event, and proper progression is essential for optimal recovery.”

“Protocol, schmotocol,” the patient responds with good-natured frustration. “I’ve got a gig in three months that I’m not missing. Jazz festival at Lincoln Center—first time playing there in fifteen years, and probably my last chance at my age. Need to get these fingers back in shape.” He wiggles his hands demonstratively, the movement slightly shaky but determined.

“The jazz festival is an excellent goal,” Dr. Bennett acknowledges, his tone balancing encouragement with medical realism. “But pushing too hard too fast could create setbacks that jeopardize your participation entirely. Let’s focus on building your stamina systematically so you’re ready when the festival arrives.”

As they continue discussing rehabilitation progression, I observe the interaction with professional interest. Dr. Bennett’s patient communication shows a different side of his clinical approach—still evidence-based and protocol-focused, but with genuine attention to the patient’s personal goals and emotional needs. It’s a more nuanced picture than the dismissive specialist he presented in our initial interaction.

The rehabilitation nurse begins setting up Mr. Abernathy’s session, and Dr. Bennett turns back to me, his expression suggesting he hasn’t forgotten our interrupted discussion despite the patient distraction.

“I should continue rounds,” he says, his tone returning to professional neutrality. “But I’d be interested in seeing the specific research connecting autonomic regulation patterns in music therapy to arrhythmia prediction models. If there are legitimate physiological mechanisms beyond subjective patient experience, that would be relevant to our rehabilitation protocols.”

His statement is carefully calibrated—not accepting the validity of music therapy, but acknowledging the possibility of relevant physiological mechanisms that might merit consideration. It’s a small opening in his initial dismissal, created by the specific connection to his research interests rather than general claims about music therapy benefits.

“I’ll send you the relevant studies,” I offer, recognizing this as a potential foundation for professional dialogue rather than territorial conflict. “Including our recent work on parasympathetic activation patterns during structured music interventions for post-MI patients, which shows some interesting correlations with your arrhythmia stability indicators.”

He nods acknowledgment, then turns to leave, but Mr. Abernathy’s voice interrupts his departure.

“Hey, Doc, is this the music lady they told me about?” the patient calls, having apparently overheard portions of our earlier conversation. “The one who’s starting the program for heart patients?”

Dr. Bennett pauses, glancing between Mr. Abernathy and me with a slightly trapped expression. “This is Dr. Winters,” he confirms with careful neutrality. “She’s implementing a new program that will be evaluated for potential integration with our existing rehabilitation protocols.”

His phrasing is deliberately noncommittal—acknowledging my presence without endorsing my approach, maintaining his clinical authority while avoiding direct contradiction of patient interest. Before he can manage expectations further, Mr. Abernathy’s face lights up with enthusiasm.

“Perfect timing!” the patient exclaims. “I’ve been telling everyone we need music in this place. Been reading all about it—music therapy for heart patients. Makes perfect sense to me. Rhythm is rhythm, whether it’s in music or heartbeats. When can we start?”

His genuine enthusiasm creates an awkward moment for Dr. Bennett, who clearly hasn’t endorsed this approach but now faces direct patient interest in a treatment option he’s just been questioning. I decide to navigate this delicately, respecting the physician’s authority while acknowledging the patient’s interest.

“We’re just setting up the program now, Mr. Abernathy,” I explain, moving closer to include both patient and doctor in the conversation. “Once we’ve established the protocols and integration with the existing rehabilitation program, Dr. Bennett and your treatment team will determine which patients might benefit from specific interventions based on their clinical status and rehabilitation goals.”

This response acknowledges the physician’s decision-making authority while maintaining the possibility of program participation, a diplomatic navigation of the complex dynamics between innovative approaches, established medical hierarchies, and patient preferences.

“Well, put me at the top of the list,” Mr. Abernathy insists, looking directly at Dr. Bennett. “Doc knows I’ve been a jazz pianist for sixty years. Music is medicine for me—always has been. Now there’s science backing up what musicians have known forever.”

Dr. Bennett’s expression suggests he’s calculating the most appropriate response to maintain both his medical authority and his positive relationship with this clearly determined patient. After a moment, he offers a carefully measured reply.

“We’ll consider all appropriate treatment options as your rehabilitation progresses, Mr. Abernathy. For now, let’s focus on the established protocol we’ve discussed, and we can evaluate additional approaches as we assess your progress.”

It’s a diplomatically noncommittal response that neither dismisses the possibility nor commits to implementation—the particular verbal skill of experienced physicians managing patient expectations while maintaining treatment authority. Mr. Abernathy seems about to press the issue further when the rehabilitation nurse announces it’s time to begin his session, creating a natural transition that allows Dr. Bennett to excuse himself with professional courtesy.

As he turns to leave, he gives me a brief nod that acknowledges our interrupted discussion without conceding any change in his perspective. “I’ll look for those studies,” he says, his tone suggesting scientific evaluation rather than enthusiastic interest.

“I’ll send them this afternoon,” I confirm, maintaining professional collegiality despite our earlier tension. “And I look forward to discussing potential physiological mechanisms when you’ve had a chance to review them.”

He departs without further comment, leaving me with the distinct impression that I’ve encountered exactly the type of traditionally minded physician Foster warned me about, but also with the recognition that his skepticism is grounded in scientific standards rather than mere territorial defensiveness. It’s a challenging but potentially navigable dynamic if I focus on the research evidence and physiological mechanisms rather than general claims about integrative approaches or holistic benefits.

As I continue my space assessment, I observe Mr. Abernathy’s rehabilitation session from a professional distance, noting his musical background and enthusiasm as potential factors in early program implementation. His jazz experience suggests particular receptivity to rhythm-based interventions, and his upcoming performance goal provides a specific functional target that could align music therapy with his rehabilitation objectives.

Elena returns from the other patient situation and continues showing me the rehabilitation facilities, her attitude suggesting she considers music therapy integration a positive development despite Dr. Bennett’s evident skepticism. As we discuss equipment storage options and scheduling logistics, she offers additional context about the department dynamics.

“Dr. Bennett is actually one of the more approachable cardiologists,” she explains with the particular candor of an experienced nurse who has worked with multiple generations of physicians. “He’s evidence-focused but patient-centered, which is a better combination than some of the others who are evidence-focused and ego-centered. If you can demonstrate measurable outcomes that benefit his patients, he’ll come around eventually.”

“I appreciate the insight,” I tell her, genuinely valuing this insider perspective on the physician I’ll need to work with for program implementation. “I’m used to initial skepticism—it comes with the territory when introducing new approaches in established medical settings. The research evidence is solid, and the outcomes speak for themselves once we have initial cases documented.”

Elena nods agreement, then adds with a knowing smile, “Just be prepared for the research committee meeting tomorrow. Dr. Bennett will definitely have methodological questions prepared after your interaction today. He doesn’t like being caught off-guard on research topics, especially in his specialty area.”

This warning is valuable preparation for tomorrow’s meeting, giving me time to review specific studies connecting music therapy interventions to cardiac autonomic function—particularly those most relevant to Dr. Bennett’s research on arrhythmia prediction. I make mental notes about which papers to reference and which methodological details to emphasize, recognizing that establishing scientific credibility will be essential for successful program implementation in this department.

After completing the space assessment and thanking Elena for her assistance, I return to Conference Room C to organize my notes and prepare for tomorrow’s meetings. The temporary workspace feels even more makeshift after seeing the well-equipped rehabilitation facilities, but I remind myself that program results will eventually determine resource allocation more than initial administrative promises.

I spend the remainder of the afternoon reviewing department structures, preparing implementation materials, and selecting the specific research studies to send to Dr. Bennett as promised. By five o’clock, I’ve compiled a concise email with five key papers demonstrating physiological mechanisms of music therapy effects on cardiac function, with particular emphasis on autonomic regulation patterns and their correlation with arrhythmia susceptibility.

I craft the email carefully, maintaining professional tone without either defensive justification or excessive deference:

*Dr. Bennett,*

*As discussed during our conversation in the cardiac rehabilitation area, attached please find several studies examining the physiological mechanisms of structured music interventions for cardiac patients, with particular focus on autonomic regulation patterns and their correlation with arrhythmia stability indicators.*

*The Okada et al. study (2022) may be of particular interest given its methodological parallels to your work on heart rate variability parameters as predictive indicators for rhythm stability. Their findings on parasympathetic activation patterns during specific musical interventions show interesting correlations with the stability indicators you identified in your 2022 paper.*

*I look forward to discussing potential physiological mechanisms and their clinical applications at your convenience. I’ll be attending the research committee meeting tomorrow afternoon if you have any initial questions after reviewing these materials.*

*Regards,* *Sophie Winters, PhD* *Director, Integrative Music Therapy Program* *Manhattan Memorial Hospital*

I review the email twice before sending, ensuring it strikes the right balance between scientific substance and professional concision. The attached studies are methodologically rigorous and published in respected medical journals rather than specialty music therapy publications, selected specifically to address the physiological mechanisms Dr. Bennett questioned rather than general claims about music therapy benefits.

After sending the email, I gather my materials and prepare to leave for the day, reflecting on the various challenges and opportunities presented during my first day at Manhattan Memorial. The institutional complexity, departmental skepticism, and resource limitations are familiar challenges from previous program implementations, while Elena’s support, Mr. Abernathy’s enthusiasm, and the well-equipped rehabilitation space represent promising opportunities for successful integration.

As I’m leaving the hospital, I pass the cardiac care unit where Dr. Bennett is visible through the glass doors, examining a patient monitor with focused attention. His clinical concentration is evident even from a distance—the particular intensity of someone fully engaged in their professional element, analyzing cardiac rhythms with the same focused attention a musician might give to a complex score. The parallel strikes me as I observe him briefly before continuing toward the exit, a reminder that different disciplines often share underlying patterns of expertise and attention despite their apparent differences.

My apartment welcomes me with the particular comfort of a space that reflects my personality rather than institutional neutrality. I drop my bag by the door, kick off the professional heels that have been pinching my feet all day, and head directly to the kitchen where I pour a glass of wine with the particular enthusiasm of someone who has successfully navigated a challenging first day in a new professional environment.

The first sip provides momentary relaxation as I mentally review the day’s events—the chaotic navigation, the outdated orientation, the supply closet incident (which seems more amusing now than mortifying), the territorial cardiologist, the enthusiastic patient, and the supportive nurse. It’s a typical first day mixture of challenges and opportunities, institutional absurdities and professional possibilities that characterize new program implementations in established medical settings.

I carry my wine to the living room where my cello waits in its stand—not my professional therapy instruments that remain in their cases by the door, but my personal instrument that serves as both comfort and creative outlet beyond clinical applications. I sit with it between my knees, not playing formally but simply running my fingers over the strings, feeling the resonance through my body as I decompress from the day’s tensions.

The cello has been my instrument since childhood—not my first instrument (that was piano) or my most professionally utilized (guitar and percussion dominate my clinical work), but the one that connects most directly to my musical core beyond therapeutic applications or professional requirements. Its voice resonates at a frequency that bypasses intellectual processing and speaks directly to something essential within me, a connection I’ve never been able to fully articulate despite years of studying music’s neurological and psychological effects.

After a few minutes of informal connection with the instrument, I begin playing more deliberately—a Bach suite that my fingers remember despite irregular practice time during the relocation and new job preparation. The mathematical precision and emotional depth of Bach has always provided a particular comfort during transitions, the structured patterns creating a sense of order while allowing emotional expression within established frameworks.

As I play, I find my thoughts returning to the day’s interactions, particularly the unexpected challenge from Dr. Bennett and his skepticism about music therapy’s physiological mechanisms. His research on autonomic influences on cardiac rhythm stability actually parallels aspects of my own work on music’s effects on autonomic regulation—a connection he clearly hadn’t considered despite his evident intelligence and medical expertise.

The potential integration points between our professional domains become clearer as I play, my thoughts organizing themselves through the structured patterns of Bach’s composition. By the time I finish the suite, I’ve formulated a more specific approach to tomorrow’s research committee meeting—focusing explicitly on the autonomic regulation mechanisms rather than general music therapy benefits, using language and concepts familiar to cardiology rather than therapy terminology, and emphasizing measurable physiological outcomes rather than subjective patient experiences.

I set aside my cello and return to my wine, feeling more centered and strategically focused after the musical interlude. Tomorrow will bring new challenges—the research committee meeting, department introductions, and continued program implementation planning—but I feel better prepared after processing today’s experiences through both intellectual analysis and musical expression.

My phone chimes with an email notification, and I check it with mild curiosity, half expecting a building management notice or personal message from a friend checking on my first day. Instead, I find a reply from Dr. Bennett, sent at 7:43 PM:

*Dr. Winters,*

*Thank you for sending these studies. The Okada paper does indeed show interesting parallels to my work on heart rate variability parameters, though their sample size is smaller than I would consider optimal for definitive conclusions about mechanism specificity.*

*The parasympathetic activation patterns they observed during structured music interventions merit further investigation, particularly regarding potential applications for patients with preserved ejection fraction but autonomic dysregulation contributing to arrhythmia susceptibility.*

*I would be interested in discussing potential research collaboration examining these mechanisms more specifically, perhaps using our arrhythmia prediction algorithms to assess response patterns during your interventions. This could provide more definitive evidence regarding physiological mechanisms beyond the current literature.*

*I’ll see you at tomorrow’s research committee meeting.*

*Regards,* *Eli Bennett, MD* *Cardiology Department* *Manhattan Memorial Hospital*

His response is unexpected in both its promptness and its content—not dismissal or perfunctory acknowledgment, but genuine engagement with the research and suggestion of potential collaboration. The tone remains professionally reserved rather than enthusiastically converted, but the shift from territorial skepticism to intellectual curiosity represents significant progress from our earlier interaction.

I find myself smiling at this small professional victory—not complete acceptance, but the beginning of potential collaboration based on shared scientific interest rather than administrative mandate. It’s a foundation I can build on through demonstrated competence and research evidence rather than territorial arguments or credential assertions.

I draft a brief reply, maintaining professional tone while acknowledging the potential collaboration opportunity:

*Dr. Bennett,*

*Thank you for reviewing the studies so promptly. I agree that larger sample sizes would strengthen the conclusions about mechanism specificity, which is why collaborative research examining these patterns more systematically would be valuable.*

*The potential integration of your arrhythmia prediction algorithms with structured music intervention response patterns could indeed provide more definitive evidence regarding the specific autonomic mechanisms involved. I would be very interested in discussing this research possibility further.*

*I look forward to tomorrow’s committee meeting and subsequent conversation about potential collaboration.*

*Regards,* *Sophie*

I hesitate briefly before signing with my first name rather than full professional title, then decide the slight informality is appropriate given his signature as “Eli” rather than “Dr. Bennett” in his email. It’s a small adjustment in professional distance, but potentially significant in establishing collegial communication rather than hierarchical interaction.

After sending the reply, I finish my wine and prepare a simple dinner, my mind still processing the unexpected development in what I had anticipated would be a challenging professional relationship. Dr. Bennett—Eli—remains skeptical of music therapy as a field, but his scientific curiosity about potential physiological mechanisms creates an opening for professional dialogue that might eventually lead to program acceptance based on demonstrated outcomes rather than administrative mandate.

As I eat, I review my notes for tomorrow’s research committee meeting, refining my presentation to emphasize the physiological mechanisms and measurable outcomes that will address the specific concerns raised during today’s interaction. The initial territorial tension with cardiology isn’t surprising—it’s a predictable challenge in program implementation—but the potential for research collaboration represents an unexpected opportunity to establish scientific credibility through shared investigation rather than opposed perspectives.

By the time I prepare for bed, I’ve developed a clearer strategic approach to navigating the complex institutional landscape I encountered today. The administrative limitations and resource constraints will require creative adaptation, the departmental skepticism will demand evidence-based demonstration rather than theoretical assertions, and the potential collaboration with key physicians like Dr. Bennett will depend on finding shared scientific interests despite different disciplinary perspectives.

I set my alarm, place my phone on the nightstand, and lie down, my mind still processing the day’s events as I drift toward sleep. Just before consciousness fades, a final thought surfaces—I never did locate the cafeteria during my chaotic hospital navigation, meaning I haven’t eaten anything since the breakfast bar I grabbed on my way to work this morning. The realization is accompanied by a sudden awareness of hunger, but exhaustion outweighs appetite, and I make a mental note to remember breakfast tomorrow as sleep finally claims me.

My last conscious thought is of Bach’s mathematical patterns and cardiac rhythms, autonomic regulation and musical structure—connections forming between separate domains of knowledge in ways that might lead somewhere interesting if I can navigate the complex human and institutional dynamics of Manhattan Memorial Hospital. It’s a thought both challenging and promising as I surrender to sleep at the end of my first day in this new professional environment.