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Article:
Matei, Raluca, Ackermann, B., Allen, J. et al. (2026) Health promotion in tertiary music institutions: a position paper. Arts Education Policy Review. ISSN: 1940-4395

https://doi.org/10.1080/10632913.2026.2720853

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Arts Education Policy Review

ISSN: 1063-2913 (Print) 1940-4395 (Online) Journal homepage: www.tandfonline.com/journals/vaep20

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To cite this article: Raluca Matei, B. Ackermann, J. Allen, et al. (30 Aug 2026): Health promotion in tertiary music institutions: a position paper, Arts Education Policy Review, DOI: 10.1080/10632913.2026.2720853

To link to this article: https://doi.org/10.1080/10632913.2026.2720853

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ARTS EDUCATION POLICY REVIEW
https://doi.org/10.1080/10632913.2026.2720853

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Health promotion in tertiary music institutions: a position paper

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Supplemental data for this article can be accessed online at https://doi.org/10.1080/10632913.2026.2720853.
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ABSTRACT

Health promotion in tertiary music education lacks shared guidance despite rising concern for musicians' well-being. This position paper addresses that gap with a consensus-based, evidence-informed framework developed by 122 contributors across six continents and a variety of disciplines, including musicians and student representatives. It advances a broad understanding of health—physical, psychological, social, cultural, and occupational—and positions health promotion as integral to musicking rather than an add-on. We offer seven adaptable recommendations for institutions: (1) Reframe musicianship through health-informed cultural transformation; (2) Transform institutional culture and governance; (3) Collaborate across disciplines and expertise; (4) Equip educators, leaders, and staff to promote health; (5) Empower students as agents of change; (6) Build a health-informed music curriculum; and (7) Establish health education as core requirement. To support implementation, the paper outlines concise curriculum content areas (e.g., mental, physical, hearing, and vocal health; disability and neurodivergence; critical thinking and artistic identity; professional advocacy) and learning outcomes mapped to Bloom's taxonomy, progressing from awareness to application, evaluation, and creation. Designed for contextual adaptation, the framework enables institutions to improve student and staff well-being, enhance educational quality, and model a more inclusive, sustainable music ecosystem.

KEYWORDS

Institutional culture; professional advocacy; arts education; cultural policy; arts policy

Beyond the spotlight: overview of musicians' and music students' health

Musicians and music students face a disproportionately high incidence of health problems, many of which are closely tied to how they are educated and the environments in which they work. These issues include musculoskeletal injuries (Cruder et al., 2020; Rodríguez-Gude et al., 2023; Rotter et al., 2020); hearing loss (Di Stadio et al., 2018; Firle & Richter, 2025); voice disorders (Kwok & Eslik, 2019; Pestana et al., 2017); vision-related issues (Beckers et al., 2016); dermatological health (Gambichler et al., 2004); dental and orofacial health (Czech & Alt, 2024; Olufemi et al., 2020); sleep disturbances (Kegelaers et al., 2023; Vaag et al., 2016a); and mental health challenges, e.g., stress, anxiety, depression, and performance anxiety (Fernholz et al., 2019; Moore & Wilhelm, 2019; Musgrave & Lamis, 2025; Spahn et al., 2017; Vaag et al., 2016).

Music students also report challenges related to lifestyle, identity, and interpersonal relationships (Araújo et al., 2017; Matei et al., 2018; Matei & Ginsborg, 2024; Panebianco-Warrens et al., 2015; Rosset et al., 2022). In some cases, these challenges are more prevalent in students than in professional musicians, and tend to worsen by the end of the first year of study (Fernholz et al., 2019; Hildebrandt et al., 2012; Kenny et al., 2014; Matei et al., 2018; Rosset et al., 2022).

These health challenges stem from interconnected systemic factors: intensive workloads, performance pressure, and perfectionist cultures that can normalize suffering as a rite of passage; academic overload and inconsistent feedback; financial precarity; teacher-student power imbalances; social isolation; limited access to health services; and weak collective advocacy (Araújo et al., 2017; Détári et al., 2022; Détári & Egermann, 2022; Ege et al., 2023; European Commission, 2023;

Fujimoto & Uesaka, 2024, 2025; Gaunt, 2010; Jääskeläinen et al., 2023; Jacukowicz, 2016; Matei & Phillips, 2023; Matei & Ungureanu, 2026; Perkins et al., 2017; Spahn et al., 2004; van den Eynde et al., 2016; Vervainioti & Alexopoulos, 2015). These conditions are further intensified by discrimination, harassment, bullying, and unequal power relations, which disproportionately affect underrepresented and historically marginalized groups (Bull, 2025; Equity et al., 2022; Thompson et al., 2025; Women & Equalities Committee, 2023).

Importantly, these problems are not inevitable. They arise from the ways in which music education is often structured: when institutions demand narrow definitions of excellence without adequate pedagogical and psychological support, they undermine the very artistic potential they aim to cultivate. Many students internalize harmful beliefs—that pain proves commitment, rest signals weakness, and success looks uniform—conveyed by messages that restrict creative growth, exclude diverse learners, and perpetuate unnecessary suffering.

Why health promotion must reshape tertiary music education[1]

In this paper, "tertiary music institutions" refers to post-secondary (higher education) settings including stand-alone specialist music/performing arts colleges, schools, academies, and conservatoires, as well as music departments and faculties within larger universities, across undergraduate and graduate programs.

Tertiary music institutions strongly influence the future of the music profession by cultivating artistic excellence and modeling what it means to learn, work, and create in healthy, inclusive, sustainable environments (Lawson et al., 2025; Stepniak & Sirotin, 2019). As educational settings for future performers, composers, educators, music therapists, and scholars,[2] tertiary music institutions carry both opportunity and responsibility, but are now under increasing pressure as evidence mounts of serious challenges affecting music students during and beyond their education (Araújo et al., 2017; Détári & Egermann, 2022; Fernholz et al., 2019; Matei & Phillips, 2023). As we discover later in the paper, this has sparked a plethora of initiatives to support student well-being, but institutions that fail to respond and/or which struggle to enact meaningful changes, risk undermining student potential, staff well-being, their own educational credibility, and the future of musicking (Small, 1998).[3]

The state of play

Momentum around musicians' health is building internationally, driven by organizations such as the British Association for Performing Arts Medicine (BAPAM), the Performing Arts Medicine Association (PAMA), the Australian Society for Performing Arts Healthcare (ASPAH), SwissMedMusica, the German Society for Music Physiology and Musicians' Medicine (DGfMM), the Austrian Society for Music Physiology and Musicians' Medicine (ÖGfMM) and the Japanese Performing Arts Medicine Association (JPAMA). The Association for European Conservatoires (AEC) has taken this further, addressing diversity, equity, inclusion, and power relations as interconnected issues through EU-funded projects and working groups.

Policy is beginning to catch up with practice. The European Commission's 2023 report on the health and well-being of music creators in the EU recommends that tertiary music schools integrate psychological and mental well-being risks and prevention directly into the curriculum (European Commission et al., 2023). In the UK, the Healthy Conservatoires Network has articulated principles underlying healthy institutions, foregrounding collaboration, shared responsibility, and the embedding of health within institutional culture rather than treating it as an add-on (Healthy Conservatoires, n.d.). In the US, the health-related recommendations set out by Chesky et al. (2006) paved the way for the National Association of Schools of Music (NASM) to incorporate health and safety standards into its accreditation framework (NASM, n.d.), a significant step in placing health on the agenda, although current standards still focus on informing students of risks rather than mandating comprehensive education or institution-wide health promotion.

At the institutional level, change is visible but uneven. Many institutions now offer health initiatives ranging from in-house counseling and physical therapy to partnerships with external specialists (Ripani & Matei, forthcoming; Tinoco et al., 2024), and a growing number of institutions, across more than 20 countries, are introducing dedicated health education courses (Evans et al., 2024; Matei & Ginsborg, 2024; Tinoco et al., 2024a). This is a promising trajectory, but one that still needs sustained expansion and refinement to move from isolated initiatives to systemic norms.

What's missing—and what's possible

Despite decades of research, a striking disconnect persists between what is known about musicians' health and what is implemented. Many institutions recognize the issues—chronic stress, injury, performance anxiety—but lack integrated frameworks for

long-term intervention. Other disciplines focused on health promotion (e.g., public health, occupational health science, and behavior change science) emphasize the importance of utilizing frameworks that consider factors beyond individual capability (Norton, 2020; Shoebridge et al., forthcoming). Existing efforts often remain fragmented: optional workshops, one-off lectures, or signposted resources sitting at institutional margins, rarely embedded fully in curriculum or strategy, and seldom addressing the cultural and structural foundations giving rise to health challenges.

Current approaches often emphasize individual resilience (Doğantan-Dack, 2025; Matei & Phillips, 2023b; Norton, 2020; Shoebridge & Osborne, 2025), thus shifting the burden to students while leaving institutions to remain unchanged (Evans et al., 2024; Ripani et al., forthcoming).

At the same time, genuine knowledge gaps persist. Educational body-awareness, somatic, and movement-based approaches, such as Alexander Technique, Feldenkrais Method, Body Mapping, yoga, and Dalcroze-informed pedagogy could support musicians' health and well-being by enhancing movement efficiency, bodily awareness, performance confidence, embodied learning, expressive engagement, musicianship, enjoyment, and group dynamics. They may also help musicians explore alternative interpretations of Western classical music scores and reduce excessive muscular tension, performance anxiety, and performance-related pain or discomfort (Buchanan & Hays, 2014; Chan, 2014; Détári & Nilssen, 2022; Juntunen & Hyvönen, 2004; Khalsa & Cope, 2006; Klein et al., 2014; Lee, 2018; Ridout & Habron, 2020; van der Merwe, 2025; West, 2019). As with many health promotion interventions in music, the evidence base remains uneven and methodologically limited. Training pathways, credentialing standards, and professional oversight also vary across these approaches. When incorporating any health promotion intervention into tertiary music curricula, institutions should evaluate practitioner competence, alignment with educational and health objectives, accessibility, student needs, psychological safety, and the available evidence for the desired outcomes. While literature offers insights into determinants of musicians' health (European Commission, 2023), causal relationships remain difficult to establish (Rotter et al., 2020). We lack clarity as to the interventions that prevent specific problems and even the problems that can or cannot be prevented. Research accounting for instrument-specific demands, diverse genres, career stages, and mental health beyond performance anxiety remains urgently needed (European Commission, 2023; Rodríguez-Gude et al., 2023). Progress also requires more attention to social, structural, and institutional determinants, alongside ethically grounded research prioritizing systemic change over individual responsibility.

More fundamentally, there is limited consensus as to what kinds of professionals tertiary music institutions should prepare: graduates trained for yesterday's jobs, today's employment realities, freelance and portfolio careers, or equipped to reshape the field itself. Without strategic alignment and a clear vision, music education risks becoming fragmented and disconnected from 21st-century artistic and professional realities (AEC, 2010; Heile et al., 2017; Jørgensen, 2017; Lawson et al., 2025; Musgrave, 2024).

Despite important progress, health promotion in tertiary music institutions remains inconsistent worldwide. Clear, evidence-informed recommendations that are both globally relevant and locally adaptable are lacking. This document addresses that gap with adaptable recommendations supporting a multidimensional approach centered on care, agency, sustainability, and shared responsibility.

Tertiary music institutions as healthy settings and responsible leaders of culture change

Tertiary music institutions are powerful cultural agents influencing professional identities, values, and how music is understood in society. As such, they are well placed to lead a shift in how the profession relates to health, not as a peripheral concern, but as integral to education, with lasting effects on students, staff, and the wider sector.

This requires rethinking what it means to educate well: to cultivate reflective, adaptable, socially engaged professionals who can meet the complex demands of contemporary artistic life (AEC, 2010; Jørgensen, 2017). It also means aligning institutional identity with inclusive values and embedding health into structures and everyday practices—across curriculum, teacher–student relationships, leadership, and governance (World Health Organization [WHO], n.d.a).

To respond to 21st-century challenges—cultural pluralism, interdisciplinary work, environmental urgency, and social justice—music education must broaden its understanding of musicianship to include musicking: integrating theory and practice, composition and interpretation, collaboration and transformation, and valuing the creative process alongside the artistic product (Campbell et al., 2016; Weatherly, 2025). This reframes excellence, not by lowering

standards, but by redefining them in relation to diverse audiences, contemporary relevance, and the evolving social role of musicians.

Health, as per the WHO's definition, is not merely the absence of injury but a foundational element of artistic development and institutional relevance for tertiary music institutions. This requires understanding health as a dynamic process influenced by interconnected factors (WHOb, n.d.): practice habits, and/or work routines pedagogical methods, institutional hierarchies, cultural expectations, financial precarity, and support services.

Grounded in the WHO's definition of health as physical, mental, and social well-being (WHOc, n.d.) and the principle of health as a fundamental human right (Universal Declaration of Human Rights, n.d.), this paper argues for a cohesive, systemic approach to health promotion, one that reframes health as a shared institutional value, rather than an individual one, enabling institutions to cultivate healthier, more reflective artists prepared to shape a creatively vibrant and socially enduring profession. Such an approach aligns with institutional priorities (e.g., retention, curriculum innovation, equity, public engagement) while supporting long-term careers and enabling musicians to contribute creatively and ethically to society.

Health promotion is therefore a shared institutional responsibility, with implications for curriculum, pedagogy, staff development, assessment, student support, and performance culture. Institutions that take this approach can reduce preventable challenges, support professional sustainability and personal fulfillment, and help reshape the performing arts by graduating musicians who engage analytically, compassionately, and imaginatively with the world.

Health education is foundational to this work. Beyond risk reduction, it equips students to navigate the social, economic, cultural, environmental, and political determinants of health. Combined with critical thinking and ethical awareness, health literacy supports self-care, strengthens professional cultures, and deepens community engagement (WHO, 2021) (Figure 1). Tertiary music institutions therefore have both an opportunity and an obligation to provide this public good.

Reframing health as shared institutional value, rather than an individual one, enables institutions to cultivate healthier, more reflective artists prepared to shape a creatively vibrant and socially enduring profession. Fulfilling this responsibility also means designing learning environments that respond to students' lived realities, including disability, chronic illness, financial precarity, and structural discrimination, and advancing broader definitions of thriving in music (Bennett et al., 2019). Strategically, institutions that prioritize health are better positioned to attract diverse talent, stimulate innovation, and adapt to a rapidly changing arts landscape.

This position paper synthesizes existing research with expert consensus gathered through a structured

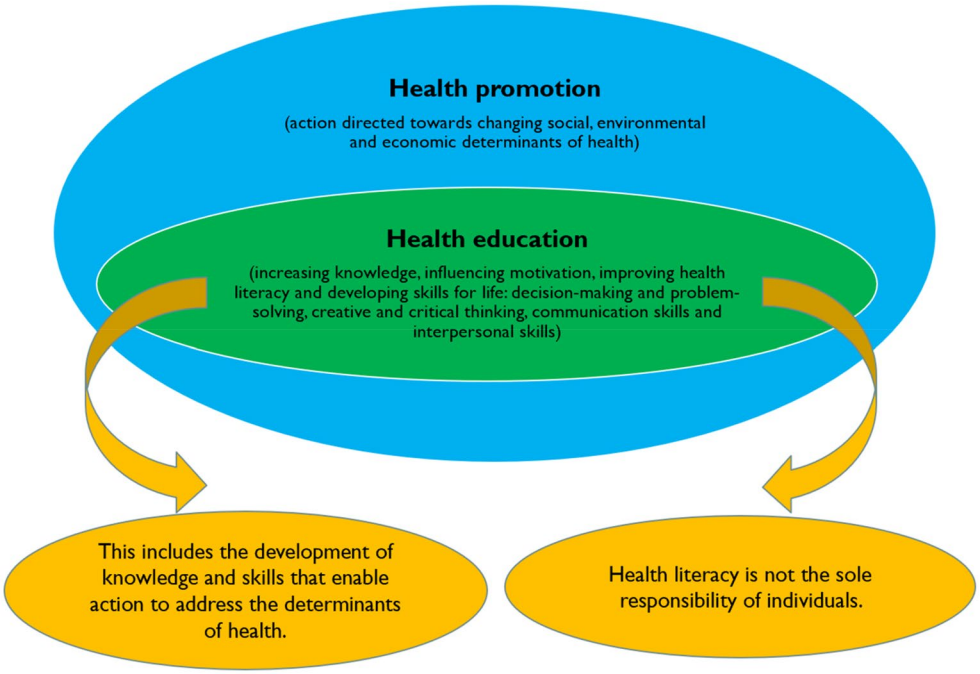


Figure 1. Health education and promotion, adapted from WHO, 2021.

consultation process. While it draws on qualitative methods, its purpose is to establish shared principles rather than report empirical findings; the recommendations reflect collective professional judgment informed by literature, practice, and lived experience.

Ultimately, institutions can preserve valuable traditions while questioning those that harm students, positioning human flourishing as central to artistic achievement.

How this position paper was developed

This paper is the result of a coordinated international initiative involving 122 contributors across disciplines, conducted between May 2024 and February 2025.

Developed as part of the Oxford Handbook of Musician Health Advocacy (Chesky, 2026; Palac et al., forthcoming 2027), its purpose was to identify shared concerns, promising practices, and actionable strategies to advance health promotion in tertiary music institutions.

This initiative embodies principles of community-based participatory research (Collins et al., 2019): sharing power across the research process by meaningfully involving community members: representatives of tertiary music schools, students, professional musicians, researchers, and stakeholders across regions and institutional contexts. Guiding questions and recommendations were co-created by the community itself, driven by their needs. The design was flexible, iterative, and inductive, guided by an ecological, multideterminant perspective emphasizing collaborative, equitable partnerships and striving to create relevant, positive change.

Notably, the project's focus evolved through co-design. Initially centered on the development of a health education curriculum, early discussions with contributors revealed the need for a broader health promotion framework addressing institutional culture, governance, and systemic transformation, not merely course content.

The project is aligned with the WHO's Ottawa Charter for Health Promotion (1986), which advocates for addressing broader determinants of health, enabling people to achieve their full potential through supportive environments, and mediating between differing interests by promoting local adaptation. The Charter's action principles—creating supportive environments, strengthening community action, developing personal skills, and reorienting services toward comprehensive health promotion—informed the structure of our recommendations.

Contributor selection and demographics

The first author identified contributors through purposive sampling strategies targeting multiple dimensions of expertise and representation:

- Disciplinary expertise: Researchers who had published peer-reviewed health education interventions among musicians or literature reviews; experts representing broad health domains (physical, mental, visual, hearing, vocal) from both medical and non-medical disciplines (social sciences, humanities, public health, sports psychology); and specialists at the intersection of policy, law, and musicians' well-being (sociology, law, disability studies).
- Musical contexts: Specialists across diverse student populations and professional roles (performers, conductors, composers, music therapists, educators, and researchers) and genres (classical, popular, jazz); experts in various areas of music research (performance science, education, musicology, pedagogy, music technology).
- Institutional representation: Individuals representing diverse tertiary music institutions (stand-alone specialist music schools and music departments/faculties) and roles within these institutions (students, educators, administrators), as well as adjacent sectors (musicians' unions, orchestras). Student representatives were recruited through the chairs of Conservatoires UK Student Network and the European Performing Arts Students' Association.

The search began with the first author's professional network and expanded through snowball sampling based on recommendations from initial contacts. This approach had limitations: geographic reach was constrained particularly in Africa and Asia, where researcher networks are less developed and accessible; and not all those approached were available to participate.

Final contributors represented expertise in: music leadership, policy, and administration; music performance, education, and pedagogy; musicology, performance science, and music technology; music therapy; music and health; psychology (music, performance, health, clinical); sociology, law, and disability studies; biomedical and clinical sciences (physical therapy, occupational therapy, hearing and voice science, visual, dental, and dermatological health, physiology); performing arts health and medicine; music physiology;

as well as public health, health promotion, and health education. These are experienced professionals who lead, teach, research, and practice within and beyond tertiary music education. The Chair of Conservatoires UK Student Network and a board member from the European Performing Arts Students' Association contributed essential perspectives on lived experience and institutional culture.

The initiative spanned six continents and 31 countries: Australia, Austria, Brazil, Canada, Costa Rica, Cyprus, Denmark, Finland, France, Germany, Hungary, Iceland, India, Israel, Italy, Japan, the Netherlands, Norway, Philippines, Romania, Singapore, Slovenia, South Africa, Spain, Sweden, Switzerland, Taiwan, Thailand, Türkiye, United Kingdom, and United States. Although international in scope, the project acknowledges the overrepresentation of Western institutional contexts (Table 1): 32% of contributors were based in North America (the US and Canada), 25% in Europe, 24% in the UK, and 14% in the Asia-Pacific region, while South Africa, the Middle East, and Latin America each accounted for 2%. Sixty-eight percent of contributors were female.

Pre-meeting procedure

About two weeks before the discussion meeting took place, all contributors received a preparatory document. This document outlined: the meeting's purpose and timeline; context including determinants of health for music students, ideological norms in Western classical music, and existing guidelines (e.g., NASM) emphasizing individual responsibility over institutional action; WHO concepts (healthy settings, health promotion, health education, health literacy); and a literature summary of existing health education courses (Evans et al., 2024; Matei & Ginsborg, 2024). Three guiding questions were posed: (1) What are your views on the proposed course aims? (2) What are your views on suggested health education content? (3) What other points should the position paper address?

The provision of this document was designed to accommodate non-native English speakers, and focus the content of the discussion, keeping sessions to no more than 75 min each.

Data collection consisted of seven individual interviews and 16 multidisciplinary focus groups *via* Zoom, all conducted in English. Individual interviews accommodated contributors with disabilities (e.g., anxiety, Multiple Sclerosis), language barriers, or scheduling constraints. Focus groups ranged from 4 to 8 participants. In larger sessions (8 participants), groups subdivided to discuss the three questions before representatives reported back summaries. Each session lasted 75 min, beginning with a 10-minute introduction by the first author contextualizing existing guidelines and gaps. Group summaries were audio-recorded and automatically transcribed *via* Zoom.

Analysis and consensus-building

This consultation employed qualitative methods to achieve consensus, but the document represents collective professional insights rather than empirical findings. The first author conducted iterative thematic analysis of all transcripts (Braun & Clarke, 2006), combining inductive pattern recognition with deductive engagement with established frameworks (e.g., Ottawa Charter, social determinants of health). This pragmatic approach identified recurring tensions that required negotiation and resolution. One key tension emerged between individual resilience training (emphasized by physical therapists and psychologists) and critiques of this framing for ignoring structural barriers (raised by disability studies and sociology experts). A balanced position was ultimately negotiated: acknowledging resilience as a personal skill while recognizing health as multiply determined and requiring advocacy training. Similarly, the tension between not wanting to push responsibility onto individuals while simultaneously educating individuals to take responsibility for their health was resolved by acknowledging the multiple determinants of health that extend beyond individuals, whilst also empowering students to challenge structures and systems that impact their health and well-being.

Further tensions required resolution around knowledge and practice. Contributors debated the tension between needing more research—acknowledging current gaps in understanding risk factors for playing-related injuries and other health challenges—and the urgency of translating existing knowledge into practice. The resolution emphasized acknowledging what remains unknown while embedding health-informed practices from the outset. Related to this was the tension between teachers' practice-oriented priorities and researchers' evidence-based agendas, resolved through flexible, adaptable recommendations that can be contextualized across diverse institutional settings. Contributors also identified the need to address the contradictory messaging students might experience between learning healthy practices and confronting historical or traditional pedagogical norms; this was resolved by emphasizing critical thinking and the

Table 1. Co-author details.

Country	Role/qualifications	Institution	Sex
1.UK	Researcher and Lecturer in Performing Arts and Health; Chartered Psychologist, PhD	University/Conservatoire	Female
2.Australia	Associate Professor, Biomedicine/physical therapy, PhD and physical therapist	University	Female
3.US	Chair of Music Therapy, Ph.D., MT-BC	College of Music	Female
4.Türkiye	Professor and President of MÜZED (Turkish Music Educators Association), PhD	Association	Male
5.US	Professor of Music (Piano), DMA (Doctor of Musical Arts)	University	Female
6.Canada	Assistant Professor in Applied Performance Sciences, PhD, Chartered Psychologist	University	Female
7.UK	Reader in Performance and Sport Psychology, PhD	University	Female
8.Iceland	Physical therapy; MSc in Performing Arts Medicine, PhD	University	Male
9.US	Disabled Independent Scholar-Activist, PhD	Independent	Female
10.US	Singing voice specialist and voice faculty	Conservatoire	Female
11.US	Assistant Professor; Occupational Therapy, MD	Conservatoire	Female
12.US	Consultant and Researcher in performing arts medicine, PhD	Independent	Female
13.Denmark	Resident Physician in Occupational Medicine, MD	University Hospital	Female
14.US	Speech-language pathologist and singing specialist	University	Female
15.Canada	Clinical lecturer, Doctor in dental surgery, dentist, with a focus on performing arts medicine	Private/University	Female
16.UK	Senior Lecturer in Music Education/Sociology, PhD	University	Female
17.UK	Senior Lecturer in Health with a focus on physical activity in the sports context, PhD	University	Male
18.US	Senior Physical therapist	Conservatoire	Female
19.US	Professor Performing arts medicine, PhD	Conservatoire	Male
20.Taiwan	Postdoctoral researcher in musicians' health; physical therapist	University	Male
21.US	Professor of Musicology and Chair of Musicology, PhD	Conservatoire	Male
22.US	Professor of Piano and Piano pedagogy, DMA (Doctor of Musical Arts)	University	Female
23.UK	Postdoctoral research assistant in music students and competition, PhD	University	Female
24.UK	Researcher in Musicians' Hearing, PhD	University	Male
25.UK	Lecturer in Performance Science, PhD	Conservatoire	Female
26.India	Professor and Head of Department of Speech and Hearing, PhD	University	Female
27.UK	Professor of Music/Musicology, PhD	University	Female
28.US	Professor of Saxophone, DMA (Doctor of Musical Arts)	University	Female
29.Norway	Deputy Head of Physiotherapy, MSc, Music physiology teacher	University Hospital	Female
30.Australia	Postdoctoral Research Fellow in Music Performance and health, PhD	University	Female
31.UK	Audiologist and Hearing Therapist	Private	Male
32.Japan	PhD candidate in Education	University	Female
33.UK	Director of Performance, Orchestra	Orchestra	Male
34.UK	Director of Academic and Educational Programs, PhD	University	Female
35.US	Assistant Professor in Instrumental Music Education, PhD	University	Female
36.UK	Professor Emerita of Music Psychology, PhD	Conservatoire	Female
37.US	Associate Professor in Music Therapy, PhD	University	Female
38.Spain	Professor in Occupational Therapy, PhD	University	Female
39.UK	Vice Principal and Director of Innovation and Engagement	Conservatoire	Male
40.UK	Professor of Music Psychology, PhD	University	Female
41.Canada	Associate Professor, Rehabilitation Science, PhD	University	Female
42.Slovenia	Associate Professor of Psychology, PhD	University	Female
43.UK	Head of Music, Health, and Wellbeing, PhD	Conservatoire	Male
44.Norway	Professor in Educational Psychology, Researcher in music psychology, PhD	University	Male
45.UK	PhD candidate, Performance Science	Conservatoire	Female
46.Switzerland	Professor of Music Physiology and Musicians' Medicine, MD, PhD	University	Male
47.US	Associate Professor in Acoustics	Conservatoire	Male
48.US	Assistant Professor in Music Theory, DMA	Conservatoire	Female
49.Germany	Professor of Music Physiology, PhD	Hochschule / Conservatoire	Female
50.Australia	Physical Therapist	Private	Male
51.Finland	Lecturer in Music Performance/Wind Instruments, MMus	University	Female
52.Sweden	Board Member, European Performing Arts Students' Association (EPASA)	EPASA	Male
53.Brazil	Physical therapist, Postdoc, and researcher in performing arts medicine, PhD	University	Male
54.Finland	Postdoctoral Researcher and music therapist, PhD	University	Female
55.The Netherlands	Senior Lecturer in Law with focus on orchestral musicians and the law, PhD	University	Female
56.US	Associate Professor of Music: Horn and Theory, DMA	University	Female
57.Germany	Professor of Music Physiology and Musicians' Medicine, MD, PhD	University	Male
58.US	Associate Professor in Conducting, DMA (Doctor of Musical Arts)	Specialist music school	Female
59.UK	Emeritus Professor of Music and Musicologist, PhD	University	Male
60.US	Director of Bands and Instrument Music Coordinator	Music High School	Female
61.Canada	Assistant Professor, Community Medicine and Implementation Science; researcher in musicians' health, PhD	University	Female
62.UK	Independent Researcher in Musicians' Health from a sociological perspective, PhD	Independent	Female
63.US	Physician dermatology	University	Male
64.Switzerland	Professor of Musicians' Health; psychologist, PhD	Hochschule	Female
65.USA	Professor Emeritus of Music and Jewish Studies, PhD	University	Male
66.France	MD, Sports Medicine	Specialist music school	Male
67.Germany	Scientific Staff, Researcher in Performing Arts Medicine, PhD	University	Male
68.Costa Rica	Vice President, Musicians' Union; orchestral player	Musicians' Union	Female
69.Japan	Associate Professor in Music Education, PhD	University	Female
70.Germany	Professor and Chair of Instrumental and Vocal Music Education, PhD	University	Female
71.US	Faculty in Music and Movement	Specialist music school	Female

(*Continued*)

Table 1. Continued.

Country	Role/qualifications	Institution	Sex
72.UK	Senior Lecturer in Cultural Sociology and Creative Industries, PhD	University	Male
73.UK	Lecturer in Music Education, PhD	University	Female
74.Australia	Clinical audiologist, educator and orchestral musician, PhD	Conservatoire	Male
75.Israel	Associate Professor of Music, PhD	College of Education	Male
76.Australia	Associate Professor of Psychology and Music; Registered Psychologist, PhD	University	Female
77.US	Associate Professor Emeritus of Music Education, DMA (Doctor of Musical Arts)	University	Female
78.UK	Head of Learning and Teaching	Conservatoire	Male
79.South Africa	Professor in Musicology, PhD	University	Female
80.UK	Professor of Music, Health, and Social Science, PhD	Conservatoire	Female
81.UK	Access to Work Support, PhD in Music Psychology	Conservatoire	Male
82.Germany	Music Therapist and Lecturer in Musicians' Health, PhD	University	Female
83.South Africa	Senior Lecturer in Music; Researcher in Health, Arts, and Performance, PhD	University	Female
84.US	Assistant Professor of Music & Music Education, PhD	University	Female
85.UK	PhD candidate in Sports Psychology	University	Female
86.Switzerland	Professor and researcher in music psychology, PhD	University	Female
87.Cyprus	PhD in piano performance and teaching, PhD	University	Female
88.US	Lecturer and wellness advocate, DMA (Doctor of Musical Arts)	University	Female
89.Austria	PhD candidate in Musicians' health education	University	Female
90.UK	Senior Lecturer in Music Education, PhD	University	Male
91.US	Professor of Horn and Musicology, PhD	University	Female
92.UK	Associate Professor of Optometry and Vision Science, PhD	University	Male
93.Hungary	Musicologist, psychologist, pianist, PhD Habil. (Lecturer and Research Fellow)	University	Male
94.US	Assistant Professor in Vocal Pedagogy, PhD	University	Female
95.Singapore	MD with expertise that includes performing arts medicine	Private	Female
96.Australia	Alexander Technique teacher and physical therapist, PhD	University	Female
97.Japan	Associate Professor of performance science and music psychology, PhD	University	Male
98.Germany	Professor of Piano Improvization, PhD	University	Male
99.UK	Professional Doctorate candidate in Sports Psychology, DMA (Doctor of Musical Arts)	University	Female
100.US	Professor of Public Health trained in Clinical Psychology, PhD	University	Male
101.The Netherlands	Lecturer and Musician, PhD	Conservatoire	Male
102.The Netherlands	PhD candidate in musicians' health	Conservatoire	Female
103.US	Assistant Professor of Music; Director of Musical Theater, DMA (Doctor of Musical Arts)	University	Female
104.The Netherlands	Professor of Arts and Wellbeing, PhD	Conservatoire	Female
105.Taiwan	Professor of International Intercollegiate PhD Program, PhD	University	Female
106.Canada	Independent Researcher and Musician, PhD	Independent	Male
107.Germany	Postdoctoral Research Fellow, Musicians' Health, PhD	University	Female
108.US	Musician-researcher and wellness educator, PhD	University	Female
109.Thailand	PhD candidate in Music Education	University	Male
110.Romania	MD and Piano Lecture, PhD	University	Female
111.Austria	Assistant Professor of Musicians' Health	University	Female
112.US	Associate Professor of Musicology, PhD	Conservatoire	Female
113.Spain	Senior Lecturer in Education; International Society for Music Education Board, PhD	University	Female
114.Italy	Sociologist and Author of book on music sociology, PhD	University	Female
115.UK	Chair, Conservatoire UK Student Network, UK	Conservatoire	Female
116.Australia	Associate Professor; DMA (Doctor of Musical Arts)	Conservatoire	Female
117.UK	Professor of Performance Science, PhD	Conservatoire	Male
118.US	Professor of Piano and Piano Pedagogy, PhD	University	Female
119.Philippines	Clinical Associate Professor; Rehabilitation Medicine Physician, MD	University	Female
120.US	Wellness Faculty, physical therapist	University	Female
121.Japan	Senior Researcher in Performance Psychology, PhD	Research Institute	Female
122.US	Bassoon Instructor	Conservatoire	Male

willingness to challenge outdated traditions where they undermine health.

A critical conceptual tension emerged around the definition of health itself. The WHO's definition of health as "a state of complete physical, mental and social well-being" (WHOc, n.d.) risks excluding disabled or chronically ill individuals who cannot achieve this standard, potentially making them feel excluded from health promotion discourse. We resolved this by embracing a broader framework grounded in the social determinants of health (WHOb, n.d.), which enables discussion of living well with disability or chronic illness under the umbrella of well-being, an achievable goal that does not require "complete" health.

Themes were synthesized into seven core recommendations, structured from broader systemic change to more specific interventions in alignment with the Ottawa Charter's action principles: 1) rethinking approaches to music , 2) transforming institutional culture and governance, 3) fostering cross-disciplinary collaboration, 4) training leaders, educators, and staff, 5) empowering students, 6) building health-informed curricula, and 7) establishing health education as a core requirement. This structure reflects the broader Oxford Handbook of Musician Health Advocacy's emphasis on training multiple stakeholders, comprehensive health promotion, and transdisciplinary approaches across regions and disciplines.

An initial draft was circulated to all participants for feedback. The document underwent three iterations, with contributors submitting amendments *via* email and tracked changes. After each round, the first author collated suggestions and revised accordingly. All contributors provided feedback and endorsed the final document.

The final position paper reflects a negotiated consensus, a shared midpoint across diverse disciplinary, institutional, and regional perspectives. It is not intended to be exhaustive or prescriptive; instead, it offers a flexible, evidence-informed resource designed to support reflection, stimulate action, and enable adaptation to local contexts. Institutions with greater ambition are encouraged to pursue more radical or innovative applications. The views expressed are sector-wide and do not necessarily represent any individual author's views of their own or other institutions. The examples of existing programs listed in the appendix were gathered through coauthor recommendations to capture some of the variety of current provision.

Author positionality

The first author, who conducted the thematic analysis, approaches health from a multidisciplinary perspective shaped by work in music performance, psychology, and health promotion across multiple institutional contexts. Their interpretation prioritizes challenging restrictive institutional norms, particularly in Western classical music. This lens likely influenced how themes were identified and synthesized.

The broader authorial team of 122 contributors represents diverse disciplinary perspectives (music, biomedical sciences, social sciences, humanities), professional roles (educators, healthcare providers, administrators, musicians, student representatives), and institutional contexts. However, the team predominantly reflects Western institutional perspectives and may have attracted contributors already aligned with broad health-promotion frameworks. The document's multiple iterations and unanimous endorsement requirement ensured collective ownership despite these inherent biases.

Scope and limitations

We recognize the remarkable diversity of tertiary music institutions—conservatoires, faculties, colleges, and universities—and the varied paths students pursue across performance, composition, conducting, musicology, education, therapy, production, and beyond. Our recommendations are designed to be flexible: sensitive to institutional contexts, educational traditions, and resource levels, while advocating for clear, ambitious, coordinated change. The timeline for completion (approximately nine months of active data collection) and reliance on existing networks limited geographic reach, particularly in underrepresented regions. Future work should prioritize expanding perspectives from Africa, Asia, and Latin America.

Recommendations

The recommendations that follow progress from broad systemic considerations to more targeted, practical implementations. They begin with the need to transform the wider music culture (Recommendation 1) and institutional culture (Recommendation 2). Next, they highlight the importance of multidisciplinary collaboration with relevant experts and researchers (Recommendation 3), followed by the need to train and empower staff—including educators and leaders (Recommendation 4)—and to equip students with advocacy skills (Recommendation 5). Finally, they focus on integrating health into the broader curriculum (Recommendation 6) and provide suggestions for learning outcomes and key content areas for a health education curriculum (Recommendation 7). Real-world examples for each recommendation can be found in Appendix 1.[4] The recommendations also incorporate direct voices from contributor consultations. All quotes reflect anonymized summaries of group discussions.

Recommendation 1. Reframe musicianship through health-informed cultural transformation

Shift the definition of musicianship toward creativity, connection, and sustainability by challenging traditions that compromise well-being

This recommendation addresses the broader institutional cultures, values, and practices that shape how musicianship is defined and rewarded. As one contributor noted, "if you don't function as a human being, you can't function as a musician."

Tertiary music institutions have a unique opportunity to redefine musicianship, not simply as the flawless execution of canonical works, but as a dynamic, embodied, socially impactful, and sustainable form of human expression. This requires a cultural shift away from traditions that prioritize perfectionism, costly perseverance, stoicism, and competition, toward a

model that centers creativity, experimentation, relationality, and care.

This shift can begin with rethinking what is rewarded, showcased, and celebrated across the institution:

a. Expand the definition of musical excellence, grounded in technical and musical foundations, to also embrace emotional expressivity, risk-taking, and social relevance.
   - Encourage and reward students for considering the emotional, ethical, and social impact of their performances, not only on juries or examiners, but also on the communities with which they engage, and examine how assessment criteria might reflect this broader artistic purpose (Dolan et al., 2013, 2018; Stepniak & Sirotin, 2019).[5]
   - Broaden visible definitions of success beyond traditional performance careers to include teaching, research, arts leadership, community engagement, creative health, and portfolio careers.
   - Foster interdisciplinary collaboration with fields such as dance, theater, film, design, and health, recognizing the artistic and professional opportunities that such exchanges can create.[6]
   - Recognize diverse World Music traditions and musical languages as equally valid curricular foundations, and create opportunities for meaningful intercultural exchange and collaborative music-making, for example through joint improvization-based projects.
   - Encourage students to critically examine normative constraints within musical genres, including rigid notions of "right" and "wrong" interpretation, and to challenge the assumption that any single reading of a work is definitive.
   - Diversify performance opportunities to include informal, experimental, cross-genre, and community-based contexts, rather than focusing predominantly on high-stakes juries and recitals.
   - Reconsider the hierarchy of the score by promoting improvization, experimentation, and creative reinterpretation, not just fidelity to notated texts (see Matei & Chiu, 2026).[7]
   - Integrate philosophical, theoretical, and sociocultural perspectives into music education to support critical examination, rather than mere contextualization, of inherited norms and traditions.

b. Raise awareness of professional rights and protections by introducing students to unions, international bodies, legal frameworks, and advocacy strategies.
c. Teach applied career skills including budgeting, taxation, contract negotiation, freelancing, music production, authorship rights, and the political and ethical implications of technology and AI.
d. Embed reflective practices such as journaling, post-performance debriefs, and critical dialogue throughout the curriculum, when appropriate.
e. Uphold creative autonomy as a human right (United Nations, 2026n.d.) allowing students to co-design aspects of their learning, including repertoire choices, project formats, and assessment criteria.

To reframe musicianship in this way is to affirm that artistry and health are not in tension, but interdependent. When students are empowered to take creative risks, express their identities, and engage in music-making that is meaningful to them, they are arguably more likely to experience growth, fulfillment, and long-term engagement with their art.

Institutions that take this cultural shift seriously do more than reduce harm; they lay the foundation for innovation, equity, and relevance in a changing musical landscape. As one contributor reflected, this work is ultimately about "finding the joy, or rediscovering the joy" in music-making, restoring to musicianship what perfectionism and competition may often strip away.

Recommendation 2. Transform institutional culture and governance

Align institutional policies, leadership practices, and accountability systems with a broad, equity-based approach to health. As one contributor noted, "it's gotta be cultural change."

Embedding health into the fabric of a tertiary music institution requires far more than occasional well-being initiatives or isolated support services. It demands sustained, institution-wide transformation, reimagining governance, leadership, and accountability structures so that health and equity become core institutional values.

When institutional actions and policies are grounded in a broad understanding of health that recognizes

social, cultural, occupational, psychological, economic, political, and environmental determinants (WHOb, n.d.), health becomes a shared institutional responsibility rather than an individual burden. This shift moves institutions beyond narrow, medicalized approaches and enables more coherent, equitable decision-making across curriculum, workload expectations, assessment, staff development, student support, and safeguarding.

Cultural transformation then becomes actionable: courageous leadership can translate this model into governance and accountability, strengthening trust, improving the ability to attract and retain students and staff, and preparing graduates to lead with integrity across the arts and education sectors.

This begins with how institutions define and enact their mission:

a. Adopt a settings-based approach to health promotion (WHO, n.d.a), to ensure coordinated action across institutional policies, cultural norms, and educational activities (WHO, n.d.d).[8]
b. Make health and well-being visible in institutional strategies, mission statements, and quality assurance processes.
c. Ensure that institutional policies are not only aligned with, but actively embed, the values of equity, inclusion, and dignity, shaping everyday practices from ensemble/group participation and access to resources, to complaints procedures and support systems, so that all students, staff, and educators experience safe, supportive, and culturally responsive environments.
d. Develop transparent, accessible, and accountable reporting systems for harassment, discrimination, bullying, or abuse. These should include multiple pathways for raising concerns, co-designed with students and staff, with clear protection for those targeted and ongoing institutional learning.
e. Establish working groups, task forces, or councils focused on health promotion, with representation from students, educators, leaders, and external experts.
f. Collect anonymized well-being/health data (e.g., through regular health surveys) and use findings to inform institutional change. Be transparent about the steps taken in response.
g. Audit institutional practices regularly to ensure alignment with health-promoting goals and address persistent inequities.
h. Lead cultural change beyond the institution by advocating for health promotion in the policies and practices of partner organizations, including pre-tertiary music education, examination boards, orchestras, and funding bodies.

Ultimately, governance reform is not a bureaucratic add-on but the structural expression of an institution's values. As one contributor put it, health and well-being should be embedded "in every facet of the institution," woven into policy, leadership, and accountability rather than treated as a peripheral concern. When institutions govern with this conviction, they not only protect those within their walls but they model, for the wider sector, what it looks like to take collective responsibility for health seriously.

Recommendation 3. Collaborate across disciplines and expertise

Build sustained partnerships with health professionals, researchers, and lived-experience experts to reflect the multidimensional nature of health. As contributors noted, "I think this integrated model could be better applied, not sort of come to us [healthcare professionals] as a last resort when everything else fails."

Health promotion in music education is most effective when grounded in interdisciplinary knowledge and cross-sector collaboration. Health is shaped by social, psychological, economic, cultural, environmental, and political factors. No single discipline or institution can address it alone.

Tertiary music institutions can strengthen their efforts by drawing on a wide range of expertise:

a. Partner with healthcare and allied health professionals, such as physical therapists, psychologists, audiologists, and physicians, to offer workshops, consultations, and tailored services for musicians, bringing in external expertise for topics beyond what internal resources can cover.
b. Collaborate with researchers across fields including public health, clinical science, performance science, education, musicology, disability studies, and the social sciences to co-create, evaluate, and improve institutional initiatives.
c. Engage artists with lived experience, including musicians with disability, neurodivergent musicians, and those from marginalized backgrounds, to inform accommodating, culturally relevant practices.
d. Involve student associations and representatives in designing and reviewing health-related programming and policy.

e. Foster internal connections across student support services, equity offices, career development centers, researchers, and educators to coordinate well-being efforts.
f. Provide in-house services, such as counseling, mental health care, and physical therapy, staffed by professionals familiar with musicians' needs; where this is not feasible, ensure affordable access through clear referral pathways and student insurance plans that cover appropriate external care.
g. Collaborate with professionals and training organizations in health, education, and social sciences to help future practitioners understand the professional challenges of music-making and better support musicians' unique needs.

By embedding collaboration into the fabric of their operations, institutions can move from isolated interventions to sustained, systems-level change, promoting the health of individuals while modeling a collective approach to care. As one contributor working at the intersection of acoustics and education observed, professionals across fields "have to consider these things" together, recognizing that even seemingly distant areas of expertise, from architecture to audiology, shape the health of musicians' everyday environments.

Recommendation 4. Equip educators, leaders, and staff to promote health

Train, educate, and support educators, leaders, and staff to model diverse, health-conscious teaching and leadership, while addressing systemic inequities that undermine well-being. In one contributor's words, "it can't just be educating the student and saying, 'student, you need to know this and do this differently, and health will result.' It's got to be the music teachers. It's got to be the administrators."

Educators, leaders, and staff play a central role in shaping the health of a music institution. Despite their daily influence on student norms and expectations, they tend to receive little to no training in health promotion, equitable pedagogy, and may not have clear information on how to recognize and respond to student distress.

Tertiary music institutions must build the capacity of educators, leaders, and staff, and the necessary systems to foster supportive, equitable, and lifelong learning environments.

a. Provide inclusive, health-informed, and ethically grounded training:
   - Provide mandatory training for educators, including those offering one-to-one instruction, on health-informed pedagogy that is responsive to diverse needs. This should include healthy performance practices; strategies for working with students with disability, chronic conditions, or neurodivergence; and clear guidance on the limits of their role and when to refer to health professionals.
   - Train educators to reflect on their relational power and ethical responsibilities in teacher-student dynamics. This includes recognizing and challenging harmful pedagogical norms—such as unrealistic performance ideals, outdated technical approaches, or rigid score fidelity—and replacing them with student-centered, reflective, and psychologically safe practices.
   - Offer anti-oppression awareness-raising to equip educators, leaders, and staff to recognize, prevent, and mitigate racism, sexism, ableism, transphobia, homophobia, fatphobia, and other forms of harm that can compromise student and staff well-being.
   - Ensure that educators, leaders, and staff receive training on accessibility, flexible assessment, and accommodation practices, supporting equitable learning and working conditions for all students and staff.
b. A commitment to educator, leader, and staff health must also include structural support:
   - Acknowledge economic inequality as a key health determinant, and pursue structural reforms that address the impact of precarious employment and financial insecurity. Increasing secure, full-time roles with benefits is essential, as educators' well-being is inseparable from student success.
   - Advocate for universal support systems to reduce class-based exclusion and instability. If this is not possible, ensure that means-tested support is proactively offered to students who may need it.
c. Finally, institutions should embed long-term systems of support and accountability:
   - Incentivize ongoing professional development in health-promoting and accessible practices.
   - Establish mechanisms to monitor engagement and impact, ensuring that staff training translates into improved learning environments.

Empowering educators, leaders, and staff is essential not only to institutional health but to the development of learning spaces where all students can

thrive, regardless of background, health status, or educational trajectory.

Implementing health promotion requires careful attention to professional boundaries and appropriate expertise. Music educators are not expected to become therapists, clinicians, or counselors. Rather, their role is to: recognize signs that a student may need professional support; create psychologically safe learning environments; integrate health-conscious practices into musical instruction (e.g., warm-ups, break schedules, injury prevention); and know when and how to refer students to qualified specialists. Music faculty should receive professional development in: trauma-informed pedagogy (without conducting therapy); recognizing distress signals and making appropriate referrals; creating accessible learning environments; integrating evidence-based practices (e.g., deliberate practice principles, motor learning science) into musical training. Health-related coursework should be taught by or in partnership with qualified professionals.

When institutions lack in-house expertise, they should seek professionals with an understanding of musicians' specific contextual needs. While campus-wide health services may provide general support, they often lack the specialized knowledge to address musician-specific issues such as performance anxiety, playing-related injuries, or the unique pressures of music training. Institutions should therefore prioritize partnerships with external specialists such as guest lecturers; develop consortium arrangements with neighboring institutions; and/or utilize telehealth or online expert resources where appropriate. Without proper training and supervision, well-intentioned health initiatives can cause harm. As such, institutions should establish clear protocols for scope of practice boundaries for faculty; referral pathways to qualified professionals; crisis response procedures; confidentiality and mandatory reporting requirements; and regular supervision for those teaching health-related content.

This need for context-sensitive oversight is especially clear in music therapy, where curricula vary significantly in theoretical orientation (cognitive-behavioral, psychodynamic, humanistic, eclectic) and structure. Some programs integrate personal therapy as a degree requirement—either within the curriculum or through external providers—while others encourage but do not mandate it. These variations reflect different pedagogical philosophies about therapist development. Institutions should not assume a one-size-fits-all approach to music therapy education in their health promotion strategies.

Empowering educators, leaders, and staff is essential not only to institutional health but to the development of learning spaces where all students can thrive, regardless of background, health status, or educational trajectory. As one contributor cautioned, when a teacher's guidance conflicts with what students learn elsewhere, "the student is gonna go with the teacher," a reminder that no curriculum, however well designed, can substitute for educators who are equipped, supported, and aligned with the institution's broader commitment to health.

Recommendation 5. Empower students as agents of change

Enable students to critically engage with tradition, advocate for systemic change, and lead healthier futures for themselves and the profession. As one contributor noted, "it's when we get students building agency to talk about this, that things do start to change."

Whereas Recommendation 1 addresses institutional definitions of musicianship and cultural practices, this recommendation focuses on equipping students with the skills, confidence, and critical perspective to navigate and reshape those environments.

Students are not only learners but future leaders, advocates, and cultural contributors. Tertiary music institutions have a responsibility to equip them with the skills, confidence, and critical perspective to navigate and shape a profession that often presents both structural and interpersonal challenges to health and well-being. Achieving this requires collaboration across disciplines and areas of expertise (see Recommendation 3).

Empowering students requires more than offering individual resources; it involves integrating health literacy, advocacy, and reflective practice into their education from the outset.

a. Develop self-advocacy and health agency
    - Embed self-advocacy skills into core education, including how to identify and communicate health needs, seek professional help, and make informed choices about health and career sustainability.
    - Introduce health systems navigation, such as understanding insurance, musicians' health services, and accessing appropriate mental and physical healthcare.
    - Educate students on their rights as professionals, including safe working environments, hearing conservation, sound exposure management, contract

negotiation, union representation, and relevant international standards (Kurzbauer, 2023).
- Ensure students are educated to navigate and hold institutions accountable through established reporting procedures.

b. Promote critical thinking about health, norms, tradition, and the art form (Leech-Wilkinson, 2020; Chiu & Lockhart, forthcoming).[9]
- Educate students to question assumptions and beliefs that affect health, distinguishing historical, empirical, and ideological claims, recognizing cognitive biases, and assessing evidence (Matei & Phillips, 2023a).
- Support students to examine how musical norms and pedagogical practices reflect broader social inequities—including perfectionism, hierarchy, ableism, and Eurocentrism—and to explore more diverse, health-supportive approaches (Bull, 2025; Lubet, 2002, 2010; Ramstedt, 2023).

c. Foster student leadership and collaboration
- Involve students meaningfully in institutional decision-making on health, inclusion, and curricular reform. For example, offer roles in health task forces and co-design initiatives; and/or support student-led activities, such as well-being clubs, mentoring programs, or campaigns, with visibility and institutional backing.
- Students should be offered opportunities to collaborate on interdisciplinary and socially engaged projects, using music to promote well-being beyond campus, e.g. in healthcare, education, or justice settings.

d. Reframe professional identity
- Encourage students to interrogate diverse artistic values and reimagine what success means to them, including consideration of how their work can be socially responsible.
- Highlight essential professional skills—such as communication and advocacy—as central to musicianship.
- Normalize varied career outcomes across performance, teaching, outreach, arts administration, and socially engaged practice, challenging hierarchies that privilege performance alone.
- Normalize the possibility that not all students will build lifelong careers in music, and help them recognize how their musical education develops transferable skills applicable across many fields.

When students are empowered to question norms, advocate for themselves and others, and imagine new roles for music in society, institutions do not just support individual well-being, but they also help shape a more welcoming, ethical, and sustainable professional culture. As one contributor noted, the central challenge is one of ownership: "how do students get the buy-in, and then how do you empower them to get ownership," a question institutions must keep asking if empowerment is to become more than rhetoric.

Recommendation 6. Build a health-informed music curriculum

Integrate health as a core component of artistic and professional development through flexible, reflective, and discipline-relevant learning. As one contributor noted, "health and well-being, the way that an initiative like this needs to be targeted is that it is a core part of every facet of the institution. Not a bolt on."

When health is integrated as a routine, evidence-informed consideration within music education—rather than treated as an add-on—it creates structural change that supports musicians' well-being and performance over the long term, grounded in scientific physiological and psychological evidence. When tertiary music institutions weave health across teaching, learning, and assessment, moving beyond standalone workshops or optional electives, it becomes a natural part of how music is taught and practised in ways that are context-sensitive, actionable, and aligned with students' artistic development. This integration helps students understand well-being not as separate from artistry or musicianship, but as foundational to both personal sustainability and creative freedom.

a. Integrate health themes across core teaching such as ensemble/group work, one-to-one tuition, history, theory, and professional development. For example: discuss mental focus and pressure management, and teach effort allocation (e.g., attentional focus, pre-performance routines, recovery after errors); address hearing safety during rehearsals and performances; integrate reflection on emotional impact and creative choices into performance assessments; raise awareness among composers about avoiding unplayable parts or excessive repetition that could cause injury; integrate notions of vocal health in voice studies; address injury prevention in performance classes, including load management and practice design (e.g.,

coordination, distributed practice, micro-breaks, gradual exposure); address reasonable workloads across all areas of music study and practice, including student workload; and include discussions about inclusive concert formats in arts administration.

b. Ensure artistic and professional relevance
c. Connect health topics to students' future professional realities. For example, topics might include managing freelance life sustainably, recognizing early signs of burnout, and advocating for building safe working practices in their artistic settings.
d. Encourage practical assignments that integrate health and artistry, for example by curating concerts with audience access and hearing health in mind, and/or by designing equitable learning experiences for future teaching contexts.
e. Guide students to reflect on how artistic practices intersect with health. For instance, topics might include exploring the physical and psychological demands of repertoire, staging, or rehearsal norms, and how these relate to identity, culture, and well-being.
f. Align teaching methods with curriculum content. For example, if performance anxiety is addressed in class, the learning environment should provide a space where students can reflect openly on their experiences and receive appropriate guidance. Assessments should value deep reflection and the development of actionable strategies, rather than performance outcomes alone.
g. Use dialogic and student-centered teaching methods that foster open dialogue, reflection, and mutual respect, encouraging students to express themselves without fear of judgment.
h. For future music educators:[10] prepare students to introduce health-supportive practices in developmentally appropriate ways for children and young people.[11]
i. Embrace inclusion, flexibility, and context
j. Adapt health content to reflect local and institutional realities, as well as cultural and genre-specific risks in Western classical, jazz, traditional, or electronic music.
k. Make space for diverse learning needs by offering alternative performance formats; recognizing the impact of chronic illness, disability, and neurodivergence; and co-creating accessible learning environments with students.
l. Explore alternative instructional models, such as group-based learning, peer mentoring, or team-taught modules, to complement traditional one-to-one tuition, foster collaboration, and reduce hierarchy.
m. Prioritize experiential learning and critical reflection
n. Use interactive, hands-on approaches, such as workshops on movement and injury prevention, role-play, improvization, and guided journaling, to connect health to embodied musical practice.
o. Include reflective assessments that bridge health and musicianship, for example, essays on performance experience or action plans for future professional well-being.
p. Recognize improvization and creative risk-taking as valid forms of self-expression and identity exploration, and as essential components of a healthier, more diverse approach to music-making.

Ultimately, a health-informed curriculum is not a parallel track that runs alongside musical training, but a lens through which musical training itself is reimagined. As one contributor put it, health "needs to permeate everything, it needs to be integrated in everything… filtered in through the teaching all the way through into the performance outcomes." Approached this way, health stops being a topic students learn about and becomes part of how they learn music in the first place.

Recommendation 7. Establish health education as core requirement

A health education curriculum can play a pivotal role, particularly in raising awareness of the many dimensions of health and the broader implications of musicking. But to be effective, it must bridge personal well-being with systemic awareness and equip students to challenge harmful norms and advocate for change. As one contributor noted, "awareness exists already. So, kind of everyone knows about these topics. It's a different thing if they use this information critically, efficiently."

The scope of such a curriculum must be wide-ranging: from mental health, hearing conservation, sound exposure management, and injury prevention to performance psychology, professional advocacy, and the interrogation of norms and evidence. It must also invite reflection on the values underpinning music education, while offering space for students to explore complex identities and navigate uncertainty.

However, a stand-alone health education course alone cannot carry this weight. Without broader

institutional alignment, it risks sending mixed signals, especially if it must push against unspoken norms embedded elsewhere in the institution. In such a context, it may reinforce contradictions rather than spark meaningful progress.

Crucially, health education must engage with ideology. Limiting the notion of health to individual behaviors, personal ability to manage challenges, or clinical interpretations—while ignoring the structural realities of abuse, hierarchy, and tradition—risks reinforcing the very harms it seeks to address. A course that teaches students to discipline their bodies and minds without asking why that discipline is demanded—or who benefits from it—does not serve them; it silences them (Chiu & Lockhart, forthcoming; Leech-Wilkinson, 2020). Health education that avoids systemic questions risks reinforcing existing hierarchies rather than enabling genuine transformation.

Students deserve space—and tools—to reflect analytically on the values that underpin their education. Whatever choices they ultimately make, those choices should be informed, deliberate, and free. For that, they need critical thinking.

For critical thinking to flourish, a health course cannot stand alone. It must be embedded within a broader institutional ecosystem, underpinned by equitable policies, a supportive culture, partnerships with health experts and collaborators from relevant disciplines, research-informed approaches, and mandatory training for all staff. Only in this context can a health course move beyond simply informing students to truly transforming the culture, becoming a catalyst for renewal across the art form.

Below are proposed learning outcomes and key content areas to guide curriculum development. While many of the themes below appear across this document, this section outlines how they can be addressed within a health education curriculum. Across all areas, it is important to acknowledge the limits of current research, particularly regarding musicians' lived experiences and the evidence base for alternative or more inclusive practices.

Learning outcomes

Tertiary music institutions should aim to ensure that students are aware of music-specific occupational health concerns and the broader cultural, social, and psychological dimensions of health in music; competent in applying strategies to protect their well-being; critically engaging with norms that affect health; and navigating support systems; and committed to aligning their music-making with personal values, equitable practices, and long-term sustainability.

As an example, using Bloom's Revised Taxonomy (Anderson & Krathwohl, 2001), by graduation, students should be able to:

- Remember (e.g. identify key risks related to musicians' health; recognize early warning signs of common health issues and know when to seek help).
- Understand (e.g. explain how health and sustainability relate to artistic identity and career longevity; describe how broader social and institutional factors shape musicians' well-being; understand how physical and mental health influence practice efficiency, performance quality, and long-term career sustainability).
- Apply (e.g. use strategies for injury prevention, healthy mental functioning, and sustainable practice routines; apply psychological tools such as self-talk and focus in rehearsal and performance settings).
- Analyze (e.g. identify tensions between dominant norms such as perfectionism and overwork and their own lived experience; examine how traditions in training may reinforce or challenge inclusion, equity, artistic freedom, and/or health).
- Evaluate (e.g. assess the usefulness of health strategies in their own context and adapt them as needed; reflect on how values, norms, and artistic choices impact their well-being and sense of purpose).
- Create (e.g. develop creative approaches, including cross-arts or cross-disciplinary projects, that reflect personal values and engage with community or social contexts; design a personal health and career plan that integrates physical, mental, and artistic dimensions; propose alternative performance formats or artistic practices that support inclusion, sustainability, and well-being).

Curriculum content areas

a. General well-being and lifestyle
   - Develop mental health literacy, including emotional regulation, stigma reduction, and effective help-seeking.
   - Explore physical activity, sleep, and nutrition in the context of musicians' schedules, while interrogating narratives of discipline and willpower that obscure structural health determinants (O'Brien et al., 2016).
   - Understand the role of human relationships for well-being and ways to engage with and

foster healthy social interactions (e.g. recognizing and setting healthy boundaries, learning how to engage with feedback, using social media safely).
- Identify self-care practices and learn about how to seek help effectively.
- Recognize distinctions between primary, secondary, and tertiary prevention,[12] acknowledging that not all health issues can or should be "prevented."
- Cultivate awareness of existing evidence and interrogate existing information to inform individual decision-making.

b. Mental health[13]
- Understand risk factors, prevalence, and symptoms of mental health challenges, including depression, anxiety, trauma, substance use, and suicidality, as they relate to musicians across genres, identities, and career stages.
- Examine the social and structural determinants of mental health (e.g., discrimination, precarity, exclusion) and how these intersect with musical environments.
- Identify local and institutional mental health support services, peer resources, and crisis pathways; understand when and how to seek appropriate help.
- Explore self-care strategies and routines that are relevant to the realities of a music career.
- Engage critically with gaps in research and the limitations of dominant psychological models, especially in relation to developmental, cultural, and occupational diversity.
- Recognize the bidirectional links between mental and physical health: e.g., stress can trigger excess muscular tension and inefficient movement patterns, increasing the risk of injury.

c. Psychological skills and performance sustainability
- Develop skills for effective learning, attentional control, performance-anxiety management, error recovery, and constructive self-talk, while examining the norms that contribute to these challenges.
- Learn goal-setting and practice planning that integrates rest, autonomy, and artistic growth.

d. Physical health and injury prevention
- Learn how the musculoskeletal system supports musical activity, and develop anatomy- and physiology-informed approaches to technique, practice, and injury prevention, across genres, instruments, and developmental stages. This should include skills to minimize unnecessary tension and optimize efficiency.
- Identify harmful or outdated pedagogical norms that normalize pain, dismiss biomechanical insight, or fail to accommodate individual physical needs.
- Recognize early signs of overuse, tension, or physical fatigue, and know when and where to seek specialist care.
- Explore the role of physical activity in sustaining performance health
- Discuss the importance of rest and recovery following periods of intense practice or performance; recognize and respect individual limits.
- Consider how workload, repertoire demands, performance environments, and developmental factors (e.g., growth, aging, menstruation, or health conditions) influence physical capacity and injury risk.
- Recognize the bidirectional links between mental and physical health: e.g., stress can trigger excess muscular tension and inefficient movement patterns, increasing the risk of injury.

e. Hearing health
- Understand how the auditory system functions and why hearing health matters for musicians.
- Identify key risks associated with amplification, monitoring, personal listening devices, environmental exposures (e.g., commuter traffic or power tool use), and prolonged sound exposure for both musicians and audiences.
- Learn and apply preventive strategies, such as using hearing conservation strategies, including sound exposure management, rehearsal and performance planning, monitoring sound exposure, optimizing listening environments, and the appropriate use of hearing protection devices when indicated, and know when and how to seek professional support.
- Recognize the signs of hearing loss including persistent tinnitus or ringing in the ears, difficulty understanding conversations, repeatedly turning the volume up, difficulty scrutinizing amid multiple aural stimuli, or difficulty perceiving high-pitched sounds.

- Prioritize routine hearing examinations on an annual basis with a hearing-care professional and re-testing for abnormal results.
- Maintain proper ear hygiene, e.g., by cleaning the outer ear with a soft cloth and avoid putting anything other than hearing protection inside of one's ear.

f. Vocal health
- Understand principles of vocal hygiene and develop maintainable vocal techniques tailored to individual needs and genre-specific demands (e.g. classical, musical theater, jazz, pop, extreme vocals).
- Explore how developmental and physiological factors—such as voices in transition, hormonal fluctuations, aging, or health conditions—affect vocal function and performance.
- Destigmatize common vocal challenges (e.g. fatigue, strain, loss of range) by encouraging early help-seeking, peer support, and open discussion.
- Examine how identity, performance pressure, and musical context shape vocal choices and well-being.

g. Visual health
- Understand how the visual system functions and why vision care matters for musicians.
- Optimize lighting, legibility of scores/tablets, and positioning relative to the instrument and other players.
- Recognize the potential for increased intra-ocular pressure (IOP) to contribute to a higher risk of glaucoma for those who play high-resistance wind instruments (e.g. the French horn, trumpet, oboe, bassoon).
- Anticipate age-related changes; work with an eye-care professional familiar with musicians to tailor optical correction for rehearsal, stage, and digital device use.
- Prioritize routine eye examinations at least every two years—annually, if over 50 or have risk factors (e.g., cardiovascular disease, ocular hypertension, or a family history of eye disease)—because many conditions are initially asymptomatic and early treatment can slow progression.

h. Dermatological health
- Prioritize hand and instrument hygiene to reduce infection, contamination, and contact dermatitis.
- Recognize and mitigate allergies to instrument materials (e.g., metals, woods, varnishes, dyes, glues, rosin) by using alternative components/finishes, barriers, or protective coverings, especially for those with atopy (eczema/atopic dermatitis, asthma, seasonal allergies), who are at higher risk of contact allergy.
- Acknowledge skin–mind interactions: anxiety or depression may present as skin picking, compulsive washing, or self-harm; signpost students and staff to appropriate support.
- Reject the notion that skin lesions (e.g., "fiddler's neck," chest marks in cellists) signal dedication; prevent them through ergonomic setup, posture adjustments, suitable padding/barriers, regular cleaning, and thoughtful material choices.
- Refer persistent or painful dermatitis for professional evaluation; some performance-limiting conditions (e.g., infection, psoriasis, tinea) can masquerade as "playing-related" problems.
- Provide sun-safety supports institution-wide (shade at outdoor venues, permission for hats/sunglasses where appropriate, sunscreen dispensers, UV-index reminders), and promote personal measures (UV-protective clothing, SPF 30+ sunscreen and lip balm).

i. Dental and orofacial health
- Recognize the effects of instrument–body interactions: mouthpiece pressure and embouchure can affect teeth and lips in woodwind/brass players, while jaw/TMJ load is common in upper-string players. Take preventive digital or physical impressions of the dental arches to ensure reference material is available in case of an accident or dental intervention in wind instrumentalists.
- Coordinate early with dental professionals and educators when changes are planned (e.g., braces or other orthodontic appliances) to adapt technique and equipment and reduce injury risk. Avoid major dental changes of an aesthetic nature (such as veneers or crowns on anterior and posterior teeth) without first testing while playing the instrument and recording reference points beforehand, as alterations to embouchure seal and sound quality could lead to future problems.

- Identify and minimize parafunctional habits not required for music—teeth clenching/grinding (bruxism), gum chewing, nail/cheek/lip biting—as they can aggravate dental and orofacial problems.
- Maintain strong oral-hygiene routines and regular dental checkups; oral health influences comfort, endurance, sound quality, and infection risk.
- Ensure that instrument teachers remain alert and sensitized to recognizing early signs of muscular deconfiguration (such as loss of endurance or register) that may progress to embouchure dystonia, so they can guide or recommend timely intervention by trained healthcare professionals.
- Emphasize the importance of warm-up, stretching exercises, and cool-down for the facial muscles and lips in wind instrumentalists.

j. Critical thinking and artistic identity
   - Encourage critical engagement with harmful norms across musical traditions—such as rigid score fidelity or composer deference in Western classical music, or 'winner takes all' logics in contemporary popular music—as well as with injurious pedagogical practices and discriminatory ideologies related to disability, gender, race, or neurodivergence.
   - Challenge prevailing assumptions around perfectionism, artistic success, and institutional reward systems by recognizing the potential value of improvization, reinterpretation, cultural hybridity, and broader definitions of excellence that promote artistic sustainability.
   - Examine how broader systems and contexts—such as institutional culture, social norms, or industry pressures—shape health, artistic identity, and well-being.
   - Support students to identify different types of assumptions—such as those grounded in historical precedent, tradition, or empirical observation—and reflect on how they shape musical beliefs and practices. Encourage students to assess whether these assumptions remain valid or helpful within present-day contexts, rather than accepting them uncritically.
   - Equip students to recognize logical fallacies, cognitive biases, and unexamined beliefs that may influence decisions about training, performance, and professional life.

k. Artistic citizenship and music in society
   - Explore the role of music in public health, creative health, social movements, and community-building.
   - Examine ethical considerations in artistic engagement across diverse audiences and contexts.
   - Recognize and advocate for careful training, support, and stability and remuneration for musicians working in creative health and related settings, acknowledging the musical, social, and emotional labor of such work.

l. Professional advocacy, career literacy, and rights
   - Provide practical knowledge in contracts, financial literacy, taxation, and intellectual property.
   - Educate students on professional rights, labor laws, and the role of unions and advocacy bodies.
   - Explore how music-related skills can be applied in roles beyond the music profession, without framing such transitions as failures.
   - Analyze how access, equity, and well-being are shaped by class, race, gender, and precarity.
   - Include health and safety principles for rehearsals, performance spaces, and touring.
   - Identify where policy and research are still evolving, and where students can access reliable, up-to-date guidance.

By embedding these learning outcomes and content areas in the curricula, tertiary music institutions can help shape a new generation of musicians who are not only technically skilled, but also self-aware, critical, adaptable, and equipped to thrive in complex professional environments.

As one contributor put it, the goal should be understood "not as additional content, but actually… cultural change." A course can introduce knowledge, but only an institution committed to transformation can turn that knowledge into lasting practice.

An invitation to lead change

This position paper offers flexible, evidence-informed recommendations to help tertiary music institutions strengthen health across institutional life, supporting students through training and into sustainable careers in an evolving landscape.

Health promotion cannot sit in optional workshops or standalone modules. It must address the structural and cultural conditions that shape everyday learning and work. In Western classical contexts, hierarchies, exclusionary norms, and legacies of abuse continue to affect student and staff experience. In popular music contexts, rapid technological shifts, market oversaturation, intense competition, and high expectations can amplify pressure and uncertainty. Responding to these realities requires leadership, courage, and ongoing accountability.

Transformation does not need to be rapid or uniform. Institutions can begin with targeted, feasible steps that create wider effects across pedagogy, culture, and student experience. Adopting a systemic perspective from the outset, grounded in a broad, multidisciplinary understanding of health, helps avoid fragmented initiatives and supports integration, sustainability, and relevance.

These changes are not an added burden; they advance outcomes institutions already prioritize. Healthier environments support retention, learning, creative risk-taking, staff sustainability, and graduates' long-term employability, while fostering more inclusive and socially engaged music-making. Although this initiative began with health education, our collaboration made clear that education is only effective when matched by institution-wide alignment. The recommendations here reflect international, transdisciplinary consensus: health, artistry, and equity must be developed together.

Conclusion

Tertiary music institutions do more than train musicians; they shape the profession's values and norms. With that influence comes responsibility, and the opportunity to lead toward healthier, more inclusive, and socially just musical futures.

This framework is ambitious but practical: it supports embedding health across curricula, pedagogy, leadership, and student agency, and it reframes excellence to include sustainability, reflection, and the capacity to challenge harmful traditions. The difficulties many musicians face—pain, psychological distress, burnout, and marginalization—are not inevitable or individual failings; they are shaped, reinforced, and perpetuated by systems that institutions can change. This includes preparing not only performers, but also future teachers and leaders who can carry health-supportive practices into schools, health and care settings, and communities.

Adopting these recommendations is therefore an act of transformative leadership, not compliance. They are intentionally adaptable: meaningful change begins with honest reflection and succeeds through sustained, visible commitment. Institutions that embrace this shift will cultivate graduates who are not only artistically skilled, but also reflective, collaborative, and equipped to thrive, and, in doing so, will help build a more ethical, resilient, and socially engaged music sector.

Notes

1. Understood here as the music education provided to tertiary music students around the world, rather than teaching music in pre-tertiary schools as in the US.
2. Subject areas can include composition, music theory/musicology, music education, music technology, music therapy, music and health, music business/management, jazz studies, ethnomusicology, performance science, conducting, popular music, music performance, film scoring, arts administration, etc. The diversity of institutions and subject areas also informs the diversity of degrees/career paths. All music students need health promoting curricula, but some of the degrees/careers—like education and therapy—may have additional health needs because those individuals will be responsible for the health and well-being of others.
3. Christopher Small (1998)'s concept of musicking frames music as a participatory and relational activity rather than a static product. Accordingly, "to music is to take part, in any capacity, in a musical performance, whether by performing, by listening, by rehearsing or practicing, by providing material for performance (what is called composing), or by dancing." (p. 9).
4. This is a co-author-compiled selection to capture the variety of current provisions, not an exhaustive or fully representative list of each institution's initiatives. The list includes initiatives housed within music units (departments/schools/colleges), or within stand-alone specialist music/performing arts colleges, schools, academies, and conservatoires, rather than campus-wide resources.
5. In the Music Department of King's College London, performance assessments encourage radical reinterpretations, allowing students to negate traditional score fidelity or performance conventions. This promotes persuasive communication and imaginative musicianship, challenging existing norms to celebrate individual artistic intent (King's College London (2015). Music performance examinations at King's College London: Guidelines for Performance I, II, III, APS, Music Department [PDF]. Retrieved from King's College London internal course materials.).
6. CoLab. https://www.trinitylaban.ac.uk/story/colab/.
7. An example of this point is the Master's in Piano Improvisation at Hochschule für Musik und Darstellende Kunst in Stuttgart (Germany), which combines classical improvisation techniques with innovative cross-arts collaborations. It equips students to blend music with other artistic mediums, fostering

creativity and cultural dialogue in unconventional way: https://www.hmdk-stuttgart.de/studiengang/master-kuenstlerische-klavier-improvisation; Centre for Creative Performance & Classical Improvisation, at Guildhall School of Music and Drama, UK: https://www.gsmd.ac.uk/study-with-guildhall/music/performance-and-collaboration/centre-for-creative-performance-classical

8. Institutions may find it helpful to consult existing international frameworks and networks, such as the Healthy Universities Network, or the Okanagan Charter (soon to be renamed the Limerick Charter), which provide models, principles, and case studies for embedding health across tertiary/higher education settings.
9. Challenging Performance by Daniel Leech-Wilkinson: This project provides an excellent starting point for courses aimed at questioning conventions in Western Classical Music. Through examples of creative interpretations that deviate from traditional practices, students are inspired to rethink performance norms and explore new artistic possibilities: https://challengingperformance.com/the-book/; Chiu and Lockhart (forthcoming)'s chapter in the Oxford Handbook of Musician Health Advocacy which offers an example of a course aimed at examining how our ideas about health and illness are influenced not only by biological factors but also by cultural values, social hierarchies, and historical beliefs.
10. Understood here in a broad sense, referring not only to students enrolled in music education programs, but also to other music students, such as performers, who may have an interest in teaching music.
11. For instance, in contexts where a large share of undergraduates pursue music education (e.g., the United States), institutions have a particular responsibility to equip these teachers, extending health promotion beyond higher education into schools and communities.
12. Institute for Work & Health. Primary, secondary, and tertiary prevention. https://www.iwh.on.ca/what-researchers-mean-by/primary-secondary-and-tertiary-prevention.
13. For a comprehensive overview of risk and protective factors associated with mental health, please see Ripani and Matei (forthcoming).

Acknowledgments

We thank Natalie Roe, Chair of Conservatoires UK Student Network, for her invaluable input into this Position Paper.

Disclosure statement

Adam Spira has served as a consultant to Sequoia Neurovitality, BellSant, Inc., Amissa, Inc., and Synaptic Health, LLC. The other authors report there are no competing interests to declare.

Generative AI statement

The authors declare that Generative AI tools (ChatGPT and Claude) were used solely for linguistic and stylistic refinement of text originally written by the authors, including improvements to clarity, flow, and organisation. They were not used to generate new ideas, analyze data, interpret findings, or formulate conclusions. All AI-assisted edits were carefully reviewed before being integrated into the manuscript.

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