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Play in Healthcare: Gift or Strategy?
Examining the Provision of Play in Healthcare Settings Through the Lens of Gift Theory

Julia Whitaker[1]; Chika Matsudaira[2]

[1] The Society of Health Play Specialists, UK

[2] University of Shizuoka Junior College, Japan

E-mail: registration@sohps.org.uk; matudair@u-shizuoka-ken.ac.jp

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Abstract

The evidence for play as a key component of child development is well established and play scholarship has had reverberations in all aspects of children's lives. This paper asks whether increased awareness and acknowledgement of play's multiple benefits for children's learning, health, and overall development have led to its instrumentalization as a strategy for change and in so doing appropriated a unique gift of childhood. It examines whether gift theory can enhance an understanding of the play experience, specifically in relation to play in healthcare settings. Drawing on their experience as Health Play Specialists in the UK and in Japan, the authors propose that when the provision of play in hospitals and other healthcare settings can be framed as a gift exchange, the integrity of the play experience is preserved, but that this is conditional on the giver's consciousness and the quality of the relationship between the player and the provider of the play.

Keywords: *Gift Theory; Hospital Play; Hospital Play Specialist; I-And-Thou, Mauss*

Introduction

The evidence base for *play* as a key component of child development is well established (Whitebread et al., 2012; Whitaker & Tonkin, 2023) and play scholarship has had reverberations in all aspects of children's lives, from education to healthcare, the home to the marketplace (Henricks, 2020). This paper explores whether the increased awareness and acknowledgement of play's multiple benefits for children's learning, health, and overall development have led to its instrumentalization as a strategy for change and in so doing appropriated a unique gift of childhood.

The paper uses Matsudaira's (2025) thesis on Mauss's *Essai Sur le Don* [*The Gift*] (1925/2016) to examine whether gift theory can enhance our understanding of the play experience as it relates to play in the context of healthcare. Citing examples from their clinical practice as Health Play Specialists [HPS] in the UK and in Japan, the authors propose that when the provision of play in hospitals and other healthcare settings can be framed as a gift exchange, the integrity of the play experience is preserved, but that this is conditional on the giver's consciousness and the quality of the relationship between the player and the provider of the play.

Play

Play is a universal feature of childhood (Whitebread et al., 2012), ubiquitous across cultures (Whitebread & Basilio, n.d.) and 'one of the oldest forms of socio-human interaction' (Catalano, 2021). Play has contributed to human survival and evolution since the prehistoric period (Kets de Vries, 2012) and its perception as a fundamental element of human nature and development has been recorded since Ancient times (Ardley, 1967). The indigenous peoples of the Americas and the Pacific Nations regarded children's play as a way of 'knowing and being', crucial for their continued survival and growth (James et al., 2019), and the Abrahamic faith traditions are aligned in the belief that play is a gift of childhood which should be honored as a source of connection with the divine (Miller, 1974; Shama, 2023; Toth, 2023).

Thinkers of the Modern Era revived the status of play as essential for personal growth and self-actualization (Henricks, 2014). In the 17th Century, John Locke (1824) advocated for children's play to be taken seriously as a source of learning and personal development, and Jean-Jacques Rousseau (1892) proposed that play provides children with opportunities for the 'experiences and reflection' necessary for growth (Frost, 2010). These are insights which subsequently found realization in the play pedagogies of Froebel (1782-1852), Steiner (1861-1925) and Montessori (1870-1952), and which are implicit in many current Early Years policies in the UK and elsewhere (e.g., Education Scotland, 2020; Fleer, 2013; Welsh Government, 2024).

Despite cultural variations in its manifestation and interpretation across historical, geographical, and social divides (Whitebread & Basilio, n.d.), contemporary play scholars are broadly in accord that, in its purest form, 'Play is activity that is (1) self-chosen and self-directed; (2) intrinsically motivated; (3) guided by mental rules; (4) imaginative; and (5) conducted in an active, alert, but relatively non-stressed frame of mind' (Gray, 2013a). There is a long-established evidence base for play's role in physical, psychological and social development (Whitebread et al., 2012), not just in childhood but throughout the lifespan (Whitaker & Tonkin, 2021) and, while play is often characterized by its purposelessness (Brown & Vaughan, 2010), advances in neuroscientific research reinforce the view that play has clearly identifiable positive outcomes. In the words of Sumrell (cited in FLS, 2019), 'The truth is that play seems to be one of the most advanced methods [that] nature has invented to allow a complex brain to create itself'.

Gray (2009) describes play as 'the germ that grew to make us human'. An innate feature of the human brain (Burghardt, 2005) and observable pre-birth (Trevarthen, 2011), play is not a skill that needs to be learned or acquired through instruction or experience, but an inbuilt source of creativity and joy (Gray, 2009): the birthright of every child.

Play as a Strategy for Change

Perceptions of play in the current climate seem to fall into two camps. On the one hand, play is widely written about, discussed and promoted in relation to education, health and wellbeing, the environment, and the workplace (Tonkin & Whitaker, 2021). On the other hand, play is notably absent from children's everyday lives, victim of a focus on school performance, intensive parenting, and digital distractions (Gray et al., 2023; Haidt, 2024). Poulsen (2019) writes that, 'Play is the primary purpose of

play', yet play is increasingly appropriated for purposeful ends, a strategy with its origins embedded in the history of Psychological Science.

It was the emergence of Behavioral Psychology at the start of the 20th Century which heralded the purposeful application of play as an agent of change. Advocates of a *field-theory approach (*Lewin, 1939*),* which asserts that it is possible to understand, predict and change the behavior of individuals and groups by studying the intersection of physiological, psychological and sociological variables, began to explore how children's play behavior could be employed in the fields of education, healthcare, and public health. Henricks (2020, p.149) defines this 'managed style of play', by which 'social organizations - governments, schools, and businesses - use play to further their own objectives' as a 'perversion of human creativity' (Henricks, cited in Poulsen, 2019).

The pioneers of Early Education (e.g., Froebel (1782-1852); Steiner (1861-1925); Dewey (1859-1952); Montessori (1870-1952)) had formalized the Platonic observation that children learn best through self-directed play (Ardley, 1967), and contemporary studies now robustly support the concept of 'learning through play' as the most effective source of learning throughout childhood (Parker et al., 2022). However, the idea that children learn by following their natural inclinations and interests is being rapidly eclipsed by the promotion of educational programs designed to accelerate learning and raise performance measures (Gray, 2020; Palmer, 2016), leading to a diminution of the self-directed 'play element' (Huizinga, 1938) in so-called 'play-based learning' (Strauss, 2020; Vartiainen et al., 2024). Simply calling an activity 'play' does not make it so (Jensen at al., 2019) and 'even young children can detect when adults offer them a learning activity under the guise of play' (Bodrova et al. 2023).

The arrival of psychoanalytic theory during the first decades of the 20th Century (Tarzian et al., 2023) introduced the conceptualization of play as a 'therapy', which could be used with children to reveal their innermost thoughts and feelings (Koukourikos et al., 2021) and help them to communicate more fluently than by using words alone (Hutton, 2004). The subsequent evolution of 'play therapy' to include directive approaches (Leggett & Boswell, 2016) in which the therapist assumes responsibility for steering the play, redefines the play element as a therapeutic tool, contesting the notion that play is an experience characterized by its purposelessness (Gray at al., 2023).

During the middle of the 20th Century, psychoanalytic thinking fed into research into the plight of children in hospital (Davies, 2010). This led to major healthcare reforms and paved the way for the first hospital play schemes (Harvey & Hales Tooke, 1972). These were modelled on community play provision and designed to normalize the hospital experience for young children (Evans, 2020). The subsequent formalization of 'Hospital Play' as a distinct specialism in pediatrics placed new emphasis on its therapeutic benefits, supporting the contention that such purposeful play fundamentally alters the quality of the play element (Digennaro, 2021) and results in the reclassification of play as a treatment modality. The evolution of play in hospital is witness to a change in the power dynamic when the play of the child becomes determined less by their own attitudes and interests and towards more goal-oriented activities which are selected by adults for their usefulness (Digennaro, 2021).

Play is increasingly promoted as a panacea for the travails of a 21st Century childhood (Tonkin & Whitaker, 2021) and public health interventions to address concerns around childhood obesity, physical inactivity, and mental ill-health, for example, are frequently presented in a playful guise (e.g., INEOS 2024; Mindfulness in Schools Project 2024). Evidence that children's emotional wellbeing is enhanced through opportunities for play (e.g., Play Scotland, 2020; Tonkin & Whitaker, 2021) lends credence to the promotion of play in schools, in hospitals, and in community settings while at the same time challenging the perception of play as a spontaneously generated activity (Davis et al., 2024). Digennaro (2021, p. 658) exposes the embedded belief that for play to be assigned value it must now be seen to have a specific function, that 'it must serve for some specific purposes and, thus, it must be oriented by an adult toward

specific goals'. The irony is that adult involvement in children's play interrupts its flow and thus 'potentially diminishes its potential benefits' (Bodrova et al., 2023, p. 5).

The utilization of play and playful activities to facilitate children's learning, their physical and mental wellbeing, and to help and support them in difficult times, is congruent with research evidence for play's involvement in the physical, psychological and neurological processes involved in child development (Whitebread et al., 2012). However, the utilitarian application of this innate component of healthy development risks usurping 'the only field of experience in which children have the possibility to be by themselves and act accordingly' (Farné, 2005, p. 177), with the unintended consequence that it undermines the very benefits of play which it aims to promote (Hillen et al., 2012). Frahsa and Thiel (2020) argue that 'the basic intention of play to "simply make children happy" has given way to the goal of making them healthy and functional'.

Playing to Get Well

In a review of the evidence that children are 'hardwired' to play, Sigman (2015) inserts the caveat that for play to flourish it requires time, space and opportunity. Play may be integral to a child's developmental processes, but its free expression is context dependent. When a child's basic needs are unmet, when they are overcome by grief or anxiety, when they are fearful or in pain, the play drive can be inhibited in the struggle for physical and emotional survival (Lowenfeld, 2008). Winnicott (1968) stated that, when a child is unable to play, 'something needs to be done to enable [them] to play' - and in the healthcare setting this is the role of the HPS.

The profession of Hospital Play Specialism was established in the UK in 1963 on the initiative of Susan Harvey, advisor to Save the Children Fund [SCF]. Harvey recognized parallels between the trauma experienced by children displaced by war and that of children isolated by hospitalization and, with the support of pediatrician Dr David Morris, she introduced the UK's first hospital-based playgroup at the Brook General Hospital in London (Whitaker & Matsudaira, 2022). By 1970, SCF had established 17 hospital play schemes in the UK, with similar initiatives emerging in Australia, New Zealand and North America.

The first hospital play schemes were modelled on community play provision and staffed by playworkers and nursery nurses. The hospital playroom represented a secure emotional base for the child, and featured familiar toys, books, and games which served as a bridge with home and family life (Evans, 2020). Writing in 1965, Harvey identified three points in favor of introducing play in the hospital environment. Firstly, the children were happily engaged in interesting activities and had opportunities for expressing their feelings through their play. Secondly, the presence of a playworker allowed nurses to concentrate on their clinical duties. Thirdly, the playworker was seen as a non-medical, friendly, and sympathetic presence by the children and their parents (Harvey, 1965). By the date of the publication of the seminal text *Play in Hospital* (Harvey & Hales-Tooke, 1972), Hospital Play Specialism was set to become a distinct profession with its own training course and professional association. In 1985, the establishment of the Hospital Play Staff Examination Board [HPSEB] formalized the qualification and registration of Hospital Play Specialists [HPS] as the profession expanded its reach and firmed-up its identity in the multi-disciplinary team (Whitaker & Matsudaira, 2022).

In 1993, The European Association for Children in Hospital [EACH] published a Charter for children's healthcare which includes the assertion that children in hospital should have 'full opportunity for play, recreation and education suited to their age and condition and shall be in an environment designed, furnished, staffed and equipped to meet their needs' (EACH n.d., Article 7). The EACH Charter identifies the therapeutic aspects of play in hospital which are now supported by the research evidence: as a means of information sharing and preparation for clinical procedures; as an aid to coping with pain and emotional distress; and as a means of expressing and communicating strong feelings (Gjærde et al., 2021; Perasso & Ozturk, 2022; Tonkin et al., 2023)).

At the time of writing, there are almost 700 registered HPS in the UK, whose role as integral members of pediatric healthcare teams is to advocate for, and facilitate, the play of babies, children and young people supported by playworkers and nursery nurses (Society of Health Play Specialists, 2024). In 2007, the first HPS training course was established in Japan, where there are now 270 qualified practitioners delivering play in hospitals across the island nation . Similar schemes operate to varying degrees throughout America, Australia, Canada, Europe, Hong Kong, and New Zealand. With increased recognition of the importance of play when children are sick, charities such as Starlight Children's Foundation in the UK (2024) have joined with other child health organisations to call for play services to be available to all children accessing pediatric care in the fulfilment of their rights under the UNCRC (Whitaker & Tonkin, 2023).

Zosh et al. (2021) propose that play encompasses 'a spectrum' of activities and experiences, ranging from child-directed 'free play' (Gray, 2013b) to purposeful play with an extrinsic goal, directed by adults (Hassinger-Das et al., 2017). The concept of a 'play spectrum' resonates with Whitaker's (2022) adaptation of Moyles' (2010) model of a tripartite 'pedagogy of play' as applied to the different facets of play in the healthcare setting to distinguish between *pure play*, *playful learning*, and *playful teaching*. Zosh et al. (2021, p.2) argue that by framing play in this way, it is possible to 'retain a play essence where children experience joy and have agency in their play contexts while also recognizing that play may take many different forms and serve many different functions'.

- *Pure Play*, or 'free play', is defined as 'play which is intrinsically motivated, self-initiated and developed by the child with an unspecified outcome' (Whitaker, 2023, p. 5). It both soothes and empowers the pediatric patient because it supports the developmental processes and offers freedom and choice in an environment where the autonomy of the child is otherwise restricted (Bricher, 2020).
- *Playful Learning* can be understood as an extension of pure play and describes learning opportunities which arise spontaneously and which engage the child, but which the child may or may not perceive as play (Whitaker, 2023). The role of the HPS in playful learning involves the judicious arrangement of the play space with resources which invite exploration or investigation of the healthcare environment, such as a medical play box or hospital dress-up (Whitaker, 2023).
- *Playful Teaching* involves a more active role for the adult. It describes the purposeful play designed to equip the pediatric patient with some knowledge or skill which will facilitate their successful negotiation of the healthcare experience (Whitaker, 2023). Playful teaching includes *Play Preparation* for surgery and medical procedures, using real medical equipment or facsimiles of the same; and *Therapeutic Distraction*, or coaching in strategies to reduce pain or anxiety.

There are undeniable benefits to integrating play in children's healthcare (Perasso et al., 2021) and the development of Hospital Play Specialism (now known as Healthcare Play Specialism or Health Play in the UK) over the last 60 years has improved the healthcare experience for children beyond measure (Whitaker & Matsudaira, 2022). For the child in hospital, play represents a map with which to navigate a safe route between the 'inner world' created by their play and the 'real world' of the healthcare encounter (Matsudaira, 2025). It empowers the child in their search for meaning and joy when they are sick and allows them to master the threat to their physical and psychological integrity, 'with a renewed sense of self and … personal resourcefulness' (Whitaker, 2021, p.70).

The challenge for healthcare play providers is to find a way of preserving the play element of healthcare play services such that 'it retains its specific attributes of intrinsic motivation and free engagement' (Whitaker 2023, p.11) notwithstanding its usefulness as a therapeutic modality. Frohlich et al. (2013) identify a paradox which applies to play in healthcare as much as to play in other contexts: while free play is advocated as a fundamental right of childhood, it is simultaneously instrumentalized as an intervention or strategy for change. Contemporary research which supports the critical importance of

play for child development seems to now 'implicitly require that it [must also] be productive and progress-oriented' (Frohlich et al., 2013, p. 17).

Gift Theory

Gift theory offers a new way of thinking about the meanings underlying the provision of play in healthcare settings. Framing play as a gift exchange is a way of trying to ensure that it remains under the ownership of the child, and to restore the role of the HPS as facilitator rather than strategist.

The concept of *gift* is used by social scientists to refer to the transfer of objects or services as a means of creating or maintaining social connection. Throughout history and across cultures, gift-giving has taken many forms and served many different purposes, but it is generally understood to be a symbolic communication of appreciation or worth (Sahlins, 2003). However, even when the gift represents an expression of positive feeling, it can also burden the recipient by reinforcing social hierarchies or power relationships (PLOS, 2024). Mortelmans and Sinardet (2005) make the case that, while gift-giving suggests an inherently altruistic motivation, gifts also require some form of reciprocation if they are to serve a relational function. They argue that gift-giving creates a 'balance of debt' which is essential for the continuation of the relationship between giver and recipient.

The origin of gift theory can be traced back to Marcel Mauss's *Essai Sur Le Don* [*The Gift*] (1925/2016). Mauss studied patterns of gift-giving across different societies and identified three common elements to the social practice of gift exchange: the obligations to give, to receive, and to reciprocate. Mauss perceived the gift as a structural force which serves to bind people together in a cycle of reciprocal commitment generated by clearly defined social norms and expectations (Nakajima, 2022). Mauss's circular model of reciprocal exchange is reinforced by recent studies which suggest that the act of giving seems to be socially contagious, in that those who receive acts of kindness or generosity are inspired to perpetuate the cycle of giving (Kumar, 2022).

While Mauss perceived gift exchange as a circular process of social connection, other researchers have interpreted gift-giving as an individual strategy for self-promotion (e.g., Blau, 1964). Yet others argue that it is possible for a gift to be devoid of any meaning at all, such that the parties involved in an exchange of gifts 'feel uncertain as to why they have given or received from that person at that time' (Sagawa, 2019). The practice of gift-giving is paradoxically more complex and more ambiguous than might at first be first assumed (Sagawa, 2019).

Evidence from brain imaging suggests that the acts of giving and receiving activate parts of the brain associated with reward and pleasure (Rajalakshmi, 2023). These are brain regions which stimulate the release of dopamine and oxytocin, which may explain why the exchange of gifts is self-reinforcing (Rajalakshmi, 2023). Recent evidence further demonstrates that the act of giving reduces symptoms of depression and anxiety, boosts confidence, and raises self-esteem (Cregg & Cheavens, 2023) which may be consequent to the arousal of a vicarious sense of pleasure when witnessing the pleasure of others (Rajalakshmi, 2023).

There are marked distinctions between Mauss's cyclical concept of gift exchange and the contrasting theories of the *pure gift* (Washida, 2001) and the *mutual gift* (Fukada, 2015).

The 'pure gift' is an unconditional act, free from any expectation of return or reciprocation (Washida, 2001). It transcends the social relationships, obligations, and expectations which are central to Mauss's thesis. The archetypal pure gift is the way in which new parents play with their newborn child in the act of welcoming them to the world (Jennings, 2010), with no other motivation than to create a connection (Trevarthen, 2011). The parental instinct to play with a child at the very start of life arises from the joy surrounding the child's birth. When parents play with their newborn, they convey the

message, 'you (the child) and I (the adult welcoming the birth) are connected', and the child receives the joy of their parents as a gift and experiences a sense of belonging to human society (Matsudaira, 2025).

The 'mutual gift' is a social process with meaning and value beyond the mere exchange of objects, services, or favors. The concept of the mutual gift is used by Fukada (2015) to define the exchange of gifts that establish and maintain human relationships, creating mutual trust and respect (Fukada, 2013, pp. 620-627). In his examination of the relationship between the providers and recipients of public services, Fukada maintains that health and social care practices which lack the character of gift, result in services which also lack the emotions created by the experiences when people meet, and that the act of 'giving service' in the absence of emotion commodifies the gift exchange as a purely practical or economic arrangement (Fukada, 2015, p.26).

While the concept of the mutual gift implies an expectation of some form of return or reciprocation, it does not infer equivalence of type, value, or timing: the reciprocation may occur in a completely different form and on a different timescale (Sarthou-Lajus, 2012). Mortelmans (cited in Goldhill, 2016) explains: 'You don't need to repay the things given to you in a material way. You can also be nice or perform some other kind of behavior'. In the following scenario, for example, the caregiver acts with positive intent to connect with the recipient despite their action involving a breach of protocol; and their gift of connection is returned by the recipient in the preservation of the secrecy surrounding the act.

> *'One day, my sister suddenly disappeared. Just like that, she was gone. A strange atmosphere filled the house. On weekends, we were often taken to a large building and waited by the elevator. Only my parents went beyond the door, returning after a while, but there was an unspoken rule not to ask anything. One day, while waiting by the elevator, a nurse gestured for me to hurry up and come inside. She opened a door, and there was my sister on the bed. I don't remember what I did, but she was there. After a while, the nurse hurried me out again. I never told my parents about that. The next time I saw my sister was at her funeral. Without that moment of seeing her alive, I would have become a terrible person. That moment allowed me to live in human society.'* (personal communication).

A commonly encountered barrier to gift exchange in public service is the need to prove the worth of any interaction (Yano, 2008). Yano states that gifts can be found in texts related to education, nursing, and welfare with the caveat, if you look closely (2008, p. 170). The reason for their opacity is that, once identified, any gift must be reinterpreted as a means to an end (Matsudaira, 2025). Yano (2008) warns that, if the gift element of giving service is overlooked, all acts involving others will be subsumed into the narrative of commerce with the consequence that we will only be able to talk about acts involving others in terms of their rational and functional usefulness (p.170).

Ich-Du: The Gift of Connection

In 1925, the philosopher Martin Buber wrote that, 'The key to creating society that is nourishing, empowering and healing for everyone lies in how we relate to one another' (Buber, cited in Ricketts 2023). Buber uses the concept of *Ich-Du* (I-Thou) to describe relationships in which people connect with integrity and genuine feeling, accepting of their own uniqueness as well as the uniqueness of the other, free from 'judgment, qualification, or objectification' (Berry, 2012). The 'I-Thou' relationship is characterized by mutuality, reciprocity, and open dialogue (Abun & Magallanes, 2018) and Buber contrasts this with 'I-It' connections, in which the other party is objectified for personal advantage. The I-It relationship is asymmetrical because it is based on an opaque agenda rather than open dialogue and creates distance rather than closeness between the parties (Abun & Magallanes, 2018).

Current research into the science of social connection now provides empirical evidence to support Buber's (1923/2008) treatise on the importance of relationships. Social relationships have been shown to

be critical to physical and mental health and to longevity (Seppälä et al., 2013), an impact evident from early childhood (National Scientific Council on the Developing Child, 2020). There is evidence that the human need for social connection overrides even the most basic needs, such as for food and shelter (Lieberman, 2014). Buber's (1923/2008) philosophy has had a lasting impact on modern thinking, most obviously in person-centered approaches to health and social care practices, and it offers a way of interpreting the contrast in the play experience when play is offered as a gift and when it is deployed as a strategy for change.

Buber's (1923/2008) differentiation between I-Thou and I-It relationships lends support to the idea that the potential for a gift exchange between the provider and the recipient of services is deeply related to the giver's consciousness (Matsudaira, 2025). In the healthcare setting, there is an obvious asymmetry in the relationship between healthcare personnel and patients, due to the disparity in knowledge, skills and influence, and to the consequent dependency this fosters. Given this power differential, the actions and decisions of healthcare professionals must prioritize a patient's needs and interests over clinical or economic considerations (Matsudaira, 2025) if they are to possess the quality of an I-Thou interaction and allow for mutual gift exchange to take place. Consider the following contrasting scenarios in which a child requires a blood test for diagnostic purposes and relies on the intervention of a doctor to draw the blood.

Scenario 1 (I and Thou):

The doctor is motivated to gift their skill at venipuncture by a desire to restore the child's health. Acknowledging the uniqueness of the child, they explain the testing procedure using language the child comprehends and relate an amusing story to engage the child's attention while the test is performed. The child reciprocates by accepting the need for the test and cooperating with the procedure. This represents a mutual gift exchange because each party engages with integrity and with respect for the other's unique role in the interaction: the doctor gifts their expertise and positive intention: the child returns the gift by engaging cooperatively in the interaction.

Scenario 2 (I and It):

The doctor is motivated to carry out the venipuncture by the desire to attend a meeting which is due to start imminently. They want to complete the procedure as swiftly as possible and make no attempt to explain or engage with the child, who responds by resisting the blood draw. In an attempt to break the deadlock, the doctor then threatens the child with negative consequences if they do not cooperate, resulting in a dominance-subordination relationship. A gift exchange is untenable in this scenario.

The Gift of Play in Healthcare

When the healthcare environment, and the people working in it, demonstrate that they not only permit, but encourage and value play for its own sake, it fosters a positive perception and relationship between the child and the healthcare experience (Whitaker, 2023). When time, space and the opportunity for play are given without conditions, free from expectation or evaluation, the play can be seen as an example of Fukada's (2015) pure gift.

A child is born with a complex heart condition and, despite the best efforts of the medical team, is not expected to live beyond the first few months of life, during which they remain in the hospital. The child's mother is conflicted: she wants to spend precious time with her baby but also has a toddler at home who is unsettled by her absence, and she struggles to balance her commitment to each of the children. Every morning, before the mother arrives at the hospital after taking her other child to daycare, the HPS allocates time to play with the baby; rocking, soothing and singing cradlesongs. She charts the play interaction in the medical records in line with protocol so that

the mother knows her baby has not been ignored in her absence. When the child reaches the end of life and the family gather at the bedside to say their Goodbyes, mother asks for the HPS to join them, to 'sing one more song' to send the baby on their way: a pure gift of pure play, given freely and without expectation.

In contrast to the above example of play as a pure gift, play which satisfies the tenets of Mauss's circular concept of the gift relationship must meet the triple obligations to give, to receive, and to reciprocate. Presented with an opportunity to play, the child must first be free to choose whether or not to receive the gift of the play. Freedom to choose recognizes and respects the child's particularity and is vital for the creation of I-Thou relationships. Reciprocation occurs when the child engages in the play and extends it according to their own self-identified needs and interests. When the child is free 'to act as active agent[s], exploring and transforming the diverse aspects they encounter' (Vartiainen et al, 2024), play allows them to craft their own responses to circumstances free from interference which is essential 'for comprehending what we can be and what we can do' (Henricks 2014, p. 211).

In the hospital playroom, a child is playing in the 'home corner' vigorously stirring a cooking pot. Another child looks on:

Child A: Mix, mix, mix! Mix, mix, mix! Mix it up.

Child B: What are you making?

Child A: I'm making a very strong medicine.

Child B: Who for?

Child A: That one over there (pointing to a doll).

Child B: Is it yucky medicine?

Child A: Yes, very yucky medicine. It's very strong.

Child B: Does the baby spit it out?

Child A: No, they're not allowed.

Child B: Does it make them better.

Child A: Yes. But they have to swallow it.

Whether or not an episode of playful teaching can be framed as a gift exchange is dependent on the underlying intention of the person doing the teaching (Matsudaira, 2025). When there exists open dialogue between teacher and learner, and a genuine respect for the uniqueness of the other, playful teaching is nested within an I-Thou relationship and takes on the character of a gift.

A child scheduled for surgery rejects the offer of procedural preparation. Another patient passing by asks the HPS, 'Is it for port surgery?' (The insertion of a 'portacath', a central line located in the chest which allows for repeated venous access). The HPS replies affirmatively and explains that the first child is reluctant to prepare. This prompts the girl to lower the neckline of her T-shirt to reveal her own port, saying: 'Look, this is a port. You can touch it.' She takes the first child's hand and lets them touch the port, smiling and saying, 'It doesn't hurt, it's not scary', before returning to her play. The first child successfully undergoes surgery.

The girl has experienced playful teaching in preparation for medical procedures, she has a trusting relationship with the HPS and fully understands the HPS's intentions. Seeing that her experience could help a fellow patient, as well as the struggling HPS, she intervenes and quickly alleviates

the other child's anxiety. When the HPS thanks her, she replies, 'It's no big deal, I just know it's not that scary. I wanted to tell him.'

The above scenario exemplifies the circulation of Mauss's three obligations and is recognizable as a gift exchange deriving from I-Thou relationships. The girl receives the gift of playful teaching from the HPS and returns it by helping the HPS to overcome an impasse with another patient. The other child receives the gift of reassurance from the girl and reciprocates by successfully undergoing surgery.

Thinking about play as a gift, whether in healthcare, public health, or education, invites curiosity about the various reasons adults allow, invite, or encourage children to play, and the ways in which adult involvement in the play critically alters the play element (Whitaker & Matsudaira, 2022). Any discussion of play as a gift relationship must acknowledge and address the potential for the act of giving to create a dominance/subordination relationship between the giver and recipient (Matsudaira, 2025). When the agenda for play is oblique or the playful learning opportunity is forced, or when playful teaching is delivered with the pre-determined goal of patient compliance or clinical efficiency, the possibility of an I-Thou relationship is annulled. While the play 'intervention' may achieve the intended outcome, it will lack the quality of gift (Fukada, 2015) to become instead a strategy for change. In the purposeful deployment of play, any usefulness evaluation denies the possibility of unconditional acceptance (Matsudaira, 2025).

Since the inception of Hospital Play in the 1960s, the HPS has been in a uniquely privileged position within the pediatric team, free to engage with the child within the patient. When Harvey (1965, p.123) defined one of the points in favor of hospital play schemes as the 'presence of a friendly, sympathetic person, unconnected with illness', she anticipated the value of the HPS offering a different sort of relationship from that of their medical colleagues with their clearly defined, goal-oriented, clinical tasks and objectives. The HPS is someone free to give the gift of play, who sees the child in all their humanity and who recognizes that play needs no external validation. The gift of play in healthcare both empowers the child in the present and endows them for the future, allowing for the continuous circulation of gifts through the generations (Sarthou-Lajus, 2012)

Conclusion

This paper addresses the question of whether the growing recognition of play's many benefits for children's health and development has led to the risk of appropriating a unique gift of childhood as a treatment modality or strategy for change. Focusing on the provision of play in healthcare, the authors argue that viewing play through the lens of gift theory restores ownership and agency to the child whilst maintaining play's inherent health-giving properties, but that the potential of play as a gift revolves on the nature and quality of the relationship between the player and the provider of the play.

A healthcare encounter exposes our human vulnerability and dependency on others. Providing time, space and opportunity for play in healthcare settings preserves and restores the integrity of the child in the face of this fragile dependency. Play is at the heart of what it means to be a child, essential for all aspects of development and growth and an inbuilt source of joy. When play is gifted with unconditional respect for the uniqueness of the child and for their right to self-determination, it can be transformational - nurturing and strengthening relationships, deepening mutual trust, and increasing their understanding of the world. The HPS is in a unique position to foster the I-Thou relationships which nurture gift exchange and allow the play element to flourish. In the face of increasing demands to rationalize the role and function of play, the challenge for the HPS is to resist the commodification of play as a strategy for change while simultaneously championing its value as a health-inducing experience.

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