INSTITUTE TO ENHANCE PALLIATIVE CARE

PALLIATIVE CARE CASE OF THE MONTH

With News from the Institute

Music Therapy for a Terminally Ill ICU Patient

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Volume 7, No. 3 **April 2007**

Case: Mr. H was a 67 year-old man with congestive heart failure (CHF) who was awaiting a heart transplant and on a Left Ventricular Assist Device (LVAD). The plan was to get Mr. H to a stable medical condition so he would be able to receive his transplant. Over the course of his hospital stay, Mr. H had serious setbacks which caused him to be moved to an intensive care unit, where he developed sepsis. Mr. H's wife was constantly at his bedside, and both Mr. H and his wife were extremely positive, friendly people who were able to get along with everyone they met.

The Palliative Care team referred Mr. H to Music Therapy (MT), and his care was assigned to one intern. At the first session of MT the Music Therapy Intern (MTI) met with Mr. H and his wife to establish rapport and to find out their musical preferences. At the end of the session, Mr. H spoke about his daughter who lives out of town and is unable to visit often, and how he felt the MTI reminded him of his daughter. Mr. H also said that he was not so sure about MT until the end of the initial session, but now he was a believer in MT. Mr. H was very eager to have the MTI return again.

The next time the MTI entered Mr. H's room Mr. H was preparing to take a nap, but asked MTI to come in and play some music. Though Mr. H was very tired, he was engrossed in the music and able to choose each song he wanted to hear. Mr. H again expressed how much he enjoyed the music and asked the MTI to come back soon.

The next week, Mr. H was more awake and alert and he wanted complete silence in his room during MT. He got very agitated when a nurse came in the room and began to speak during the music. It was obvious the patient needed an outlet for the stress he was experiencing. Mr. H also invited the MTI to stay and listen to a CD of songs his wife brought in. This was a wonderful idea because it gave Mr. H a chance to share his music with the MTI and be in control of what music was played.

The following week, Mr. H and his wife were playing a board game in the visitor's lounge. Mr. H insisted that the game be put on hold for music. Mr. H made all but one of the song choices, and then he asked his wife to choose a song. The couple listened to the song together, and it was a great way for them to express their love for each other and allow for intimacy in a very non-intimate environment. As always, Mr. H was very enthusiastic about the MTI returning soon.

Later in his stay, the Mr. H became septic and was transferred to Intensive Care (ICU). The patient was non-responsive when the MTI came to see him, but it was important to continue playing music for him because sometimes when patients are non-responsive, they can still hear what is happening in their environment. As Mr. H's condition improved, he was able to communicate through body movements and affect. During one session in the ICU he even conducted the MTI with arm and hand movements.

The last time MTI saw Mr. H was when he was in the Intensive Care Unit (ICU). Mr. H was unable to speak, so MTI made the song choices for him and Mr. H was able to agree to the choices with a nod of his head. MTI chose a love song, and Mr. H and his wife were able to share a loving moment, holding hands, making eye contact, and smiling. Mr. H was only able to tolerate two songs during this session due to pain. Soon after the last session, the patient and the family decided to withdraw life-sustaining measures and the patient passed away peacefully under the care of the Palliative Care Team.

Discussion: Music therapy can be used to achieve many goals with palliative care patients. Music can help patients cope by empowering them to implement and manage certain aspects of their environment in order to enhance their level of comfort.[1] Also, when patients are dying and feelings can only be expressed with difficulty, music may be a facilitator. The patients have their thoughts directed to the meaning of life as it approaches its end; they think both of the past and the future.[2] Allowing times for reminiscence and enjoyment, supporting spirituality, celebrating holidays, facilitating emotional intimacy between families, stress reduction, coping with illness, and giving the patient some control are some of the goals that were achieved in MT. "Palliative Care and Music Therapy are the two bright stars in the galaxy of the medical firmament. They are having a great impact on acute medicine as a philosophy of care when cure is no longer possible."[2]

References:

1. Clair, A. A. (1996). *Therapeutic uses of music with older adults*. Baltimore: Health Professions Press.
2. Pratt, R.R. & Grocke, D.E. (1999) *MusicMedicine 3: MusicMedicine and Music Therapy: Expanding Horizions*. Parkville, Victoria, Australia: Faculty of Music, The University of Melbourne.

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APRIL 2007

NEWS FROM THE INSTITUTE

The Coalition for Quality at the End of Life Brings in National Expert on Disparities in End-of-Life Care for African American Communities

The Coalition for Quality at the End of Life (CQEL), a regional coalition of leading health systems, providers, insurers, citizen groups, governmental agencies, and philanthropic, faith-based, and professional organizations concerned about the quality of care available to seriously ill and dying people and their families, invited Dr. Richard Payne to Pittsburgh as a consultant on March 19 and 20, 2007. Dr. Payne is Duke University's Director of the Institute on Care at the End of Life and an internationally known expert in pain relief, palliative care, oncology, and neurology, who is a pioneer in overcoming disparities in palliative care. He delivered a public lecture, attended a special CQEL meeting, and participated in a working lunch held by CQEL's Committee on Engagement of Underserved Communities. It was a very informative and productive two days. CQEL members and the health care community are looking forward to working with Dr. Payne and the Institute on Care at the End of Life in the future on issues of disparities in palliative and end-of-life care.

Richard Payne; Brenda Gregg, Children's Hospital of Pittsburgh

"Living and Dying in Black and White: What Do We Really Know, and What Can We Do?"

March 2007, CQEL, University of Pittsburgh's Center for Minority Health, and UPMC Cancer Centers sponsored Dr. Richard Payne's public lecture, "Living and Dying in Black and White: What Do We Really Know, and What Can We Do?" Over 100 attended at the UPMC Shadyside site. It was also attended via teleconference at the following locations:

- Hospice of Lancaster County
- UPMC Passavant Hospital
- UPMC Northwest Hospital
- UPMC McKeesport Hospital
- Arnold Palmer Pavilion, UPMC Cancer Center, Latrobe
- Uniontown Hospital

Dr. Payne's lecture focused on health care disparities for African Americans and how these disparities throughout the life span ultimately impact the care received near the end of life in African American communities. In addition, he discussed several initiatives that have been undertaken to try to better understand as well as address these disparities.

Photos from his visit and a link to Dr. Payne's PowerPoint presentation: "Living and Dying in Black and White: What Do We Really Know, and What Can We Do?" is available on the Institute website http://www.dgim.pitt.edu/iepc/eol_care.html

Allegheny County Nursing Schools Come Together to Discuss Palliative and End-of-Life Curricula

On April 16, faculty and administrators from the five nursing schools in Allegheny County with baccalaureate programs came together to discuss the state of palliative and end-of-life care content in their respective curricula. The five schools included Carlow University, Duquesne University, LaRoche College, Robert Morris University, and the University of Pittsburgh.

Throughout our lives, nurses are the compassionate face of the health system—touching, listening, and healing. The nurse unites technical skill with compassion. While applying the tools and techniques of advanced medical science, the nurse is equally committed to entering empathically into the life of the sick person, addressing not only the physical aspects of disease, but also the sufferings of illness.

Perhaps more than any other area of medicine, palliative care—which serves the needs of the critically ill and the dying—requires the practitioner to combine technical skill with empathy. Palliative care is supportive care that works to alleviate pain and symptoms in order to maintain the best possible quality of life for people, whose lives technology has extended, and for their families.

It is therefore no accident that nursing has been the profession at the forefront since the beginning of the palliative care movement. At a time when our rapidly aging population is increasing its need for palliative care, it is urgent that we have a reliable workforce of appropriately trained nurses to deliver it.

Ultimately, participants from the meeting are investigating possibilities for conducting a coordinated needs assessment to inform curricular reform. A follow-up meeting to think about ways to further examine this aspect of the undergraduate curriculum at their institutions is being planned for later in the summer.