Music another weapon in palliative care arsenal

For music therapist Deborah Salmon, work on the palliative care ward at Montreal’s Royal Victoria Hospital comes down to just one thing: finding the person within the patient. “The hospital setting is usually so busy because of budget cuts, and with everyone rushing around the human, spiritual and emotional aspects of the person are often neglected,” she says. “Music has such breadth and depth and can touch people on so many levels simultaneously that it is an ideal tool to help people connect with what is important in their lives.”

As patients and their families spend their last hours together, Salmon uses live and recorded music, environmental sounds, guided imagery and relaxation techniques to help patients cope with pain, nausea and anxiety. Patients can express their feelings by choosing favourite hymns or songs associated with special memories. Musicians from the community often come to play on the ward, and there are CD and tape players at every bedside.

Music therapy has been part of the Royal Vic’s innovative palliative care program almost since its inception in 1975, and Salmon has been part of it for 12 years; her salary is supported by donations. Over those years the music-therapy field has grown, with more than 150 papers now published on music therapy within palliative care alone. Master’s-level degrees in music therapy are now offered in Canada and doctoral degrees are available in the US, and new patient populations, including abused women and women in childbirth, are benefiting from treatment.

Music therapists use a variety of techniques. They may employ relaxation techniques to help cardiac patients feel calmer, says Salmon, or AIDS patients might compose a song with the therapist or play a drum to express what is happening in their lives. When a patient has Alzheimer’s disease, the therapist might try to achieve a momentary connection by singing songs that were significant in the person’s life. And as a pain management tool, music may distract patients, helping them to relax.

Sometimes, adds Salmon, music helps patients let go and die more peacefully. “When a patient is close to death, music can help create a sense of calm in the room. Sometimes I’ll sing or play in rhythm with a patient’s laboured breathing, gradually modifying the music to a more regular or slower rhythm. In many cases, the patient’s respirations seem to follow the music, becoming slower and more relaxed.” — © Janice Hamilton

Seal-oil capsules enter market

Two Newfoundland companies are trying to convince Canadians to pop a few seal-oil capsules every day — along with their multivitamins or calcium supplements. Canomega Industries of Brigus and Seafreeze Foods Inc. of St. John’s both make their own brand of capsule. The oil is rich in omega-3 fatty acids, which are believed to be useful for treating several medical conditions.

Seafreeze has been selling its seal-oil products in the Asian market for several years, and introduced its Omega 3 Plus capsules in Canada last November. “People in Asia have a long history of using seal oil so they were very receptive to our product,” says Karl Sullivan, vice-president of Seafreeze. “The next logical step was to target Canadian cities like Toronto and Vancouver, which have large Asian communities.”

Canomega also had plans to break into the Southeast Asia market, but the company had to shift gears quickly when Newfoundland’s fisheries minister started extolling the benefits of seal oil in his speeches.

Seal oil (continued on next page)
Escalating waiting times have Canadians in an uproar about their access to health care, and almost everyone has a story to tell about the aftermath of years of health care cuts. However, no one seems to know exactly how governments should re-invest in health care.

The CMA has responded by proposing a long-term solution. Its Access to Quality Health Care Project proposal urges the federal, provincial and territorial governments to collaborate on developing national guidelines for funding and providing appropriate access to health care.

The project would be led by the CMA in collaboration with the public, other health professions and governments, and would set guidelines for reasonable waiting times and develop a methodology to assess access to care. It would then test these principles in pilot studies.

Although there is substantial anecdotal evidence concerning acceptable waiting times, the CMA is proposing additional levels of evidence: expert opinion, polling, reports from other health care provider organizations and governments, and research studies. The CMA acknowledges the need to develop higher grades of evidence such as observational studies and randomized controlled trials.

Dr. Sam Shortt, the director of health policy at Queen’s University, said it is extremely difficult to obtain information on waiting times because data are not gathered in a central repository. “Setting benchmarks for waiting times is all very well,” said Shortt, “but first you need a system in place to gather data.”

Shortt, along with Stephen Lewis in Saskatchewan and Morris Barer in British Columbia, are just completing a study for Health Canada on the status of waiting times across the country. They gathered data from a literature synthesis and surveys of 73 providers, consumers and administrators, provincial governments and up to 1000 hospital and district health associations. It’s not known when the results will be made public.

Shortt said objective research on waiting times is available for some diseases. He suggests that research should concentrate on the access “hot spots”: cataracts, hip/knee surgery, MRI scans, cardiac and cancer care, and outpatient mental health services. “The existing literature is a good place to start,” he said.

The CMA hopes to help develop reliable databases on access to quality care. “These would give us a better understanding of the impact the federal funding cuts have had across the country,” CMA President Victor Dirnfeld said at a recent meeting in the NWT. “These cuts have created a chain reaction. Reductions in every province and territory have led to a widespread destabilization of the system.”

Dirnfeld said governments now “lurch from crisis to crisis” as they try to re-invest in health care. In December 1997 federal Health Minister Allan Rock told the CMA’s Board of Directors he would welcome a pan-Canadian database of health care information. — Barbara Sibbald

Seal oil (from previous page)

“John Efford was telling people how seal oil had helped his diabetes and, suddenly, the local market went crazy,” says Kevin Donahue, Canomega’s marketing director. “Everyone was looking for seal oil. We had to move quickly and get approval from Health Canada for our labels and packaging and get Omegavite on the shelves in Canada.”

The federal government allows companies to market seal oil as a nutritional supplement or food product. In fact, international health organizations recommend that people consume 1 to 3 grams of omega-3 fatty acids a day. However, manufacturers can’t make any health claims about these fatty acids, seal oil or their specific product.

Dr. Fereidoon Shahidi, a biochemist at Memorial University of Newfoundland, has done extensive research on seal oil’s properties and has published a book on the development of seal-related products. Shahidi said there is only anecdotal evidence that seal oil has a positive impact on humans, since no formal studies have been done. — © Beth Ryan, St. John’s