Music Thanatology:

Prescriptive Harp Music as Palliative Care for the Dying Patient

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Prescriptive Harp Music as Palliative Care for the Dying Patient

By

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ABSTRACT

As the concepts of hospice and palliative care for the dying have gained acceptance in both the medical community and general society, increased opportunities have developed for music therapists to work with patients who are terminally ill. Developed by Therese Schroeder-Sheker, music thanatology is a field whose practitioners provide musical comfort, using harp, at the bedside of patients near the end of life. During these prescriptive “music vigils”, the clinician-musician individualizes the music to meet the patient’s needs, carefully observing physiological changes and cues, breathing patterns, and synchronizing the music to match the patient.

Using data collected from 65 patients, this study was designed to assess the effectiveness of prescriptive harp music on selected palliative care outcomes using a sample of de-identified data forms from past music vigils. Sixty-five patients were administered a 25-95 minute intervention of prescriptive harp music. The two certified music thanatologists collected vital signs (respiration rate, pulse rate and rhythm) before the vigil began (T1) and again following the vigil (T2). Observational indicators (wakefulness, agitation and depth of breath) were also assessed at (T1) and (T2).

Results from this study provide evidence that a prescriptive vigil conducted by a trained music thanatologist may have a positive affect on dying patients. Patients were more likely to experience decreased levels of agitation and decreased levels of wakefulness (the patient was in a more restful state), while also being able to breathe more slowly and deeply with less effort. Findings suggest that the health care community as well as family members should consider music thanatology as a form of palliative care for dying patients. Future research in music thanatology is necessary to provide further evidence that supports existing programs or hospices which provide music thanatology as a service and to encourage the establishment of future music thanatology training programs.
Little research has been done concerning the effectiveness of palliative care therapies for the dying. Most potential patients die before thorough research can be completed or before pre/post tests can be implemented. This lack of research on the final days and hours of life is unfortunate because there are opportunities to make these last moments more peaceful and positive by examining them more carefully. Elizabeth Kubler-Ross, a pioneer in the field of death studies, stated that the best way possible to study death and dying is to allow critically ill patients to be the teachers (1969). If research can identify effective palliative care therapies by observing patients and studying their responses, more people can benefit from the comforting effects of palliative care.

**Dying in the Hospital Setting**

Of the 2.3 million Americans who die each year, three fourths are elderly (Field, 1997). It is estimated that about 75% of the deaths in the United States occur in institutions despite the fact that most people say they would rather die at home (Ferrini, 2000). The general hospital is the most common location for death, although some deaths occur in nursing homes and mental facilities. Those that do not take place in institutions are likely to be sudden, ranging from traumatic accidents to peaceful death in sleep. This means that the dying phase of life usually occurs in surroundings unfamiliar to the patient. Dying is now likely to be managed by strangers, institutional personnel, rather than the family, and in some cases the family is not present at all (Caugill, 1976).
The hospital is an institution which is not, by definition, designed to meet the human needs of people whose physiological condition is beyond the hospital's capability for successful life-saving intervention. As a consequence, many people are needlessly isolated and lonely when they become patients in hospitals during their last days.

Communication at the End of Life

Servaty and Hayslip (1997) reported that most dying individuals are relatively unsatisfied with the communication they receive from others. This is because most communication during the last moments of life is one-sided (i.e. the living person pleading with the dying person to "hang on") or awkwardly silent. When loved ones are anticipating the patient's impending death, they may find it difficult to express feelings, thoughts, and last wishes (Krout, 2003).

One of the main reasons why many people avoid talking about death among those who are dying is the hopeless and unbearable feeling that there is nothing they can say or do to comfort the patient. Advanced age and illness are so devastating that although the intention is to communicate hope to the patient, many times the only thing that is communicated is despair. The dying person frequently senses the fear and anxiety that their friends and family feel about dying often as a result of their reluctance to make eye contact, touch, or even have a conversation with the dying person. Thus begins a cycle of awkward, unfulfilling attempts at communication. Also, many people are physically very limited in how they can communicate in their final days and hours of life. There are, however, ways to communicate without verbal conversation.
Music as Communication

The use of music as a tool of communication has long been established (Hodges and Haack, 1996). Indeed, the power of music is that it has the ability to soothe (Aldridge, 1996) or to stir the listener in many varying dimensions (Khan, 1983). The Oxford Textbook of Palliative Medicine (Doyle, 2004) states that music possesses eight elements of nature. They are:

1) The intrusive and reaching qualities of sound, certain melodies and songs;
2) The expression of human thought, experience, hopes and dreams;
3) The elements of music such as frequency, intensity, tone color, intervals, harmony, rhythm, and tempo;
4) The physiological impact on the body;
5) The intricate connection to the life of men and women;
6) The potential to stimulate creativity and to provide aesthetic experience;
7) The representation of diverse cultures and beliefs; and
8) The reflection of spirituality and spiritual issues;

Human beings are able to connect with music at a level appropriate to their personality, intellect, or need at any given moment, regardless of age, race, or religion and they can do so on superficial, emotional, cerebral, or spiritual levels (Doyle, 2004).

Music has a significant role in fostering hope and a sense of purpose in an individual (Aldridge, 1999). Hope involves feelings and thoughts, and requires action. Like music, it is dynamic. Patients knowing that the hope of life has been removed can, however, hope that they will be reconciled to their families or hope that they can tell
their feelings to their friends. Discerning these subtle dimensions of hope and offering
the means for their expression is a central part of palliative care (Aldridge, 1999).

Music Versus Other Therapies

Music may be the most preferred therapy for dying patients for several reasons. First, hearing, often outlasting both sight and speech, is the sensory ability which usually functions until the end (Tomatis, 1996). Therefore a person who can no longer see or speak can still listen. Second, a remarkable attribute of music is its ability to influence the heart and the brain on a physiological and psychological level simultaneously (Doyle, 2004). Rhythmic pulse and musical sound waves affect pulse and brain functions (Clynes, 1982). It is this exact combination of effects that breaks through anxiety, irrationality, and intangible and inexplicable resistance to medication and other medical measures (Boisvert, 1984).

During the dying process, the comfort of the patient should be paramount. In fact, there is no other time in life when comfort could be more important. A qualitative study of music therapy in hospice care showed that patients had a decreased perception of pain after exposure to a music intervention (Starr, 1999). But music can affect far more than just the perception of pain. Music, as auditory stimulation, plays a part in controlling pain (Doyle, 2004). Auditory stimulation has a pronounced physiological effect on the body that may be related to the gate control theory of pain (Zimmerman, 1989). Intense stimuli through the thalamus, midbrain, and brain-stem cause production of modulating substances (endorphins and serotonin) and inhibit the release of neurotransmitters, therefore stimulating the closure of the gate. Furthermore,
the diversional and associative qualities of music may distract attention from the adverse nature of the stimulus (Magill-Levrault, 1993), thus inducing relaxation of muscle guarding at the site of the pain (Zimmerman, 1989).

There is very little in the current traditional medical system that provides human nurturance to the soul when the body is beyond repair. As medical technology becomes ever more skilled, its practitioners recognize that there is suffering which eludes even the most advanced technological measures. Many physicians and caregivers might welcome music as an adjunct form of care that offers an opportunity for relieving such suffering at the end of life.

Music as Palliative Care

Palliative care and music therapy are both relatively young disciplines (Rykov, 1998). As the concepts of hospice and palliative care for the dying have gained acceptance in both the medical community and general society, increased opportunities have developed for music therapists to work with patients who are terminally ill (Aldridge, 1999). Music therapy has evolved as an effective complementary therapy to many traditional medical services and procedures (Dileo, 1999).

Music can gently guide terminally ill patients through their final journey and prepare a path for existential transition and transformation—their rite of passage.

Consider this example of the world famous composer, Mozart:

On the final evening, December 4, family and friends gathered around Mozart in Vienna to sing selections from the unfinished Requiem. Mozart
began to sing the alto part, imitating the trumpets by puffing out his cheeks. "Here is my death song," he said, invigorated by the music....

Shortly after midnight, Mozart died. On his deathbed, the child prodigy who had been bathed in music while still in the womb and the composer who could channel heaven-sent concertos and symphonies, asked to be surrounded by music and singing (Campbell, 1997).

When suffering has to be resolved and pain relieved, music is what takes the patient, both body and soul, to a higher level of "being". Ultimately, the music assists terminally ill patients to find a path of acceptance and existential resolution from which to leave their bodies, and for those who believe in an after life, eventually separating themselves from this world to the next (Aldridge, 1999).

The Music Practitioner/ Music Thanatologist

Benzon (1993) reminds us that the evolution of an expressive culture, irrespective of the expressive medium, depends upon our ability to use that medium. Hence the need for the skilled practitioner- someone who can orchestrate, compose and choreograph with the patient. Those trained in music therapy use interventions based on a thorough knowledge of all facets of music, the behavioral sciences, current treatment, educational and medical models and accepted therapeutic approaches (Doyle, 2004). The music therapist working in palliative care will need to be familiar with the care philosophy as well as the principal diagnostic and treatment modalities (Doyle, 2004).
Developed by Therese Schroeder-Sheker (1994), music thanatology is a field whose practitioners provide musical comfort, using harp, voice, and a special repertoire of music, at the bedside of patients near the end of life. The word "thanatology" comes from the Greek word for death, thanatos. The service at the bedside, known as the music vigil, is delivered by one or two highly trained music thanatologists. Its purpose is to serve the needs of the dying and their loved ones with prescriptive music. At the bedside of the dying, the music thanatologist uses the raw materials of music prescriptively to assist the patient in their dying process.

Music thanatologists acknowledge that music is far more than repertoire; music applied prescriptively is understood as a transformative current that bridges and communicates, reorganizes and transforms, unbinds and loosens (Harpsong, 2004). At the bedside, the clinician-musician individualizes the music to meet the patient's needs, carefully observing physiological changes and cues, breathing patterns, and synchronizing the music to match the changes in the patient. The music is prescriptive for the individual, and is guided by the patient's cues in that moment. Warm overtones gather within the room, the vibrations of the harp are felt deeply on the skin. These are things that no recorded tape or CD can provide.

Music Thanatology as a Line of Research

Though music therapists are gaining respect internationally through the establishment of practices and programs in hospitals and hospices and through data-based publications in professional journals, the specific field of music thanatology is in its infancy. For the most part, only case studies on music thanatology have been
available (Schroeder-Sheker., 1994). Hilliard (2001) states that palliative care music
therapy needs to be a research-based clinical intervention in order to best serve
patients and families. It is only through empirically testing interventions on the
terminally ill and dying patients that practitioners can determine the effectiveness of
interventions that are best for actual treatment (2001). This line of research could result
in improved care to terminally ill patients as well as support current music thanatology
programs and stimulate the development of new training programs.

As a first step toward this end, the purpose of this study was to determine to what
extent music thanatology (defined as a prescriptive harp vigil at the time approaching
death) may benefit patients by reducing agitation, increasing relaxation, as well as its
potential effect on physiological measures. Therefore the following research questions
were addressed:

1. How do the patients' levels of agitation and wakefulness change over the
course of a live harp vigil?
2. How do patients' breathing rhythm, effort, depth and rate (breaths per minute)
change during a live harp vigil?
3. How does a patient's pulse change during a live harp vigil in terms of rate
(beats per minute) and strength of pulse?
METHODS

This study was designed to assess the effectiveness of prescriptive harp music on selected palliative care patient outcomes using a sample of de-identified data forms from past vigils. Secondary analyses were performed on data forms collected by two certified Music Thanatologists at the time the vigils were being conducted. A delimiting criterion for this study was that the sample only included patients receiving vigils for the first time (n=67). The age of the patient could not be determined from the obtained data forms, though it is estimated that approximately 90 percent of the vigils were conducted on those over the age of 60. Sixty-five of the 67 eligible forms contained enough data to be usable.

This study is a SECONDARY analysis of a data set collected by Music Thanatologists, Harpist 1 (AD) and Harpist 2 (AP). The vigils recorded on the forms were conducted at several locations in the northern intermountain region of the U.S. from hospices and hospitals in 1998 to 2001.

Each vigil consisted of 25-95 minutes of prescriptive harp music. The music thanatologist collected vital signs (respiration rate, pulse rate) before the vigil began (T1) and again following the vigil (T2). Observational indicators (wakefulness and agitation) were also assessed at (T1) and (T2) using a 5-point scale. Anchors for the wakefulness scale are: 1 (not awake) and 5 (awake); agitation scale: 1 (calm) and 5 (agitated). Finally, pulse rhythm was measured as regular or irregular and pulse strength was measured as weak, palpable or bounding.

Data were entered and analyzed using SPSS version 12.0. After running descriptive statistics for measures of central tendency (means, medians), dispersion
(SD) and after checking for normality, changes between T1 and T2 on all outcomes addressed in the research questions were examined using paired T and Wilcoxon signed ranks tests.

**RESULTS**

Selected descriptive data of the sample appears in Table 1. Almost two-thirds of the patients were women (64.6% N=42). The most common time vigils took place was in the early afternoon (noon to 3:59 pm) (47.6% N=31), while they were least likely to occur during the late night hours (8pm-11:59pm) (4.6% N=3). Vigil length ranged from 25 to 95 minutes and had a mean length of 54.5 minutes (SD=14.2 min). Fifteen (23.1%) of vigils exceeded one hour in length.

**Table 1. Sample Characteristics**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Category</th>
<th>N</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Male</td>
<td>23</td>
<td>35.4</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>42</td>
<td>64.6</td>
</tr>
<tr>
<td>Harpist</td>
<td>Harpist 1 (AD)</td>
<td>19</td>
<td>29.2</td>
</tr>
<tr>
<td></td>
<td>Harpist 2 (AP)</td>
<td>46</td>
<td>70.8</td>
</tr>
<tr>
<td>Start Time</td>
<td>8am-11:59am</td>
<td>17</td>
<td>26.2</td>
</tr>
<tr>
<td></td>
<td>12pm-3:59pm</td>
<td>31</td>
<td>47.6</td>
</tr>
<tr>
<td></td>
<td>4pm-7:59pm</td>
<td>14</td>
<td>21.6</td>
</tr>
<tr>
<td></td>
<td>8-11:59pm</td>
<td>3</td>
<td>4.6</td>
</tr>
<tr>
<td>Length</td>
<td>30 min or less</td>
<td>6</td>
<td>9.2</td>
</tr>
<tr>
<td></td>
<td>31-60</td>
<td>44</td>
<td>67.7</td>
</tr>
<tr>
<td></td>
<td>61-90</td>
<td>14</td>
<td>21.6</td>
</tr>
<tr>
<td></td>
<td>More than 90 min</td>
<td>1</td>
<td>1.5</td>
</tr>
</tbody>
</table>

*Mean = 54.5 min; SD = 14.2 min; Range = 25 to 95 min*
T-tests revealed no statistically significant differences in outcome variables between the vigils conducted by Harpist 1 (AD) and Harpist 2 (AP) except in three instances (Depth Time 1, Agitation Time 1 and Agitation Time 2). However, in these cases the mean differences were not substantial and given the number of statistical tests generated (13), they were more likely random occurrences. Also, after running a Chi squared test on categorical measures of Breathing Rhythm, Pulse Rhythm and Pulse Strength, no significance was found between the two harpists. Therefore, both groups of vigils were combined for the subsequent analysis of the research questions.

Outcome measures that were continuous in nature were compared using a paired t-test at the start (T1) and completion (T2) of the vigil. As illustrated in Table 2, all indicators except pulse rate demonstrated statistically significant changes from T1 to T2. The average respiration rate decreased by 1.1 breaths per minute during the music vigil. The findings also indicate that the patients took deeper breaths with less effort needed to complete those breaths. Wakefulness and agitation levels of the patients decreased from T1 to T2 (both p< .05), indicating that the patient was somewhat more restful and calm at the conclusion of the music vigil.

Table 2. Means in Selected Outcomes at Start and End of Vigil

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Time 1</th>
<th>Time 2</th>
<th>t-test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
</tr>
<tr>
<td>Respiration Rate</td>
<td>21.2</td>
<td>8.1</td>
<td>20.1</td>
</tr>
<tr>
<td>Depth*</td>
<td>2.1</td>
<td>.72</td>
<td>2.3</td>
</tr>
<tr>
<td>Effort*</td>
<td>2.5</td>
<td>1.0</td>
<td>2.3</td>
</tr>
<tr>
<td>Pulse</td>
<td>85.1</td>
<td>13.5</td>
<td>83.6</td>
</tr>
<tr>
<td>Wakefulness*</td>
<td>2.8</td>
<td>1.4</td>
<td>2.5</td>
</tr>
<tr>
<td>Agitation*</td>
<td>2.2</td>
<td>1.0</td>
<td>1.9</td>
</tr>
</tbody>
</table>

*Scale of 1-5  
**p < .05  
*** p < .01
Changes in categorical variables from T1 to T2 were assessed using the Wilcoxon signed ranks test (see Table 3). The majority of patients were demonstrating regular respiratory and pulse rhythms at the start of the vigil (75.8% and 72.7% respectively) and this pattern essentially continued at the T2 measurement. Similarly, approximately two-thirds of patients had a palpable pulse throughout the vigil. Consequently, no changes in respiration, pulse rhythm or pulse strength were detected.

Table 3. Means in Selected Outcomes at Start and End of Vigil

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Category</th>
<th>Time 1</th>
<th>Time 2</th>
<th>Wilcoxon Signed Ranks Test Sig. (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resp. Rhythm</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Regular</td>
<td>47</td>
<td>42</td>
<td>.206</td>
</tr>
<tr>
<td></td>
<td>Irregular</td>
<td>4</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Apneiac</td>
<td>11</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Pulse Rhythm*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Regular</td>
<td>32</td>
<td>21</td>
<td>.564</td>
</tr>
<tr>
<td></td>
<td>Irregular</td>
<td>12</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Pulse Strength*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Weak</td>
<td>17</td>
<td>13</td>
<td>.157</td>
</tr>
<tr>
<td></td>
<td>Palpable</td>
<td>30</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bounding</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

No significant differences

*The number of patients in Time 1 compared to Time 2 decrease due to the inability of the music thanatologist to take measures at post-test. This is most likely attributed to the patient entering a state of rest in which the music thanatologist did not want to disturb the patient by making physical contact to measure a pulse.
Sixty-nine percent of patients were under sedation and almost 34% of patients were observed to be in pain during the music vigil. Repeated measures analyses of variance were conducted on those variables where paired t-tests detected changes over time in which sedation and pain were added as between-group factors. A group effect for pain was detected for the variables of depth of breathing, wakefulness, agitation, and a group effect for sedation was observed for respiratory effort from T1 to T2. In each of these instances, those who were in pain were breathing less deeply (M=1.85 vs. 1.97), were less awake (M= 2.95 vs. 2.43) and more agitated (M= 2.57 vs. 2.29) than those who were not in pain during the time of the vigil. Also, those who were under sedation were breathing with less effort (M= 2.73 vs. 2.41). However, the group by time interactions were not significant. Therefore, any changes that occurred were independent of whether the patients were experiencing pain or were sedated during the vigil. Finally, Pearson product-moment correlations indicated no relationship between T1 and T2 outcomes and the length of the vigil.

Table 4. Pain vs. Sedation

<table>
<thead>
<tr>
<th>Variable</th>
<th>Category</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sedation</td>
<td>Yes</td>
<td>45</td>
<td>69.2</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>12</td>
<td>18.5</td>
</tr>
<tr>
<td></td>
<td>Missing</td>
<td>8</td>
<td>12.3</td>
</tr>
<tr>
<td>Pain</td>
<td>Yes</td>
<td>22</td>
<td>33.8</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>36</td>
<td>55.4</td>
</tr>
<tr>
<td></td>
<td>Missing</td>
<td>7</td>
<td>10.8</td>
</tr>
</tbody>
</table>
DISCUSSION

Research question 1 addressed how the patients' levels of agitation and wakefulness changed from the beginning to the end of a live harp vigil. Results suggest music thanatology vigils do have a significant influence on both the agitation and wakefulness of the patients. The patients' wakefulness levels decreased by the end of the vigil potentially indicating a more calm and restful state. The agitation levels also decreased even if they were initially experiencing pain. The results of this study suggest that a properly conducted harp vigil may provide a general sense of calmness for the dying patient.

Research question 2 examined how patients' breathing rhythm, effort, depth and rate (breaths per minute) changed during a live harp vigil. Most patients in this study maintained a regular respiration rate, both at the start and completion of the vigil. On the other hand, patients took deeper breaths with a decrease in effort to complete those breaths at T2 compared to a more shallow breathing pattern when the vigils began. This suggests that the shallow breaths experienced by some at the end of life stage can become deeper and more effective with less effort on behalf of the patient with a music vigil intervention. Also of importance is the finding that the respiration rate of the patient slowed by at least 1 breath per minute during the music vigil. Most likely these changes are based on the physiological effects that music had on the body, corresponding with ability of the music vigil to calm and comfort the patient during the vigil.

Finally, research question 3 addressed any changes in pulse during a live harp vigil in terms of rate (beats per minute), rhythm and strength. It was very interesting to find that there were no statistically significant changes in these factors observed in this
study. This is somewhat unexpected given the prescriptive nature of music thanatology which distinguishes it from traditional music therapy. Based on an initial assessment of the patient's pulse rate, strength and rhythm, as well as an assessment of the breathing rate, depth and effort, the music thanatology practitioner gages the music according to these levels. It could be expected that pulse is an indicator with the most potential for change. Several reasons might be offered to explain why there was no significant change in the mean pulse outcomes. First, it is not known to what extent the music thanatologist changed the tempo of the music during the vigil. It may not have been prescriptively indicated for all patients so cases where this might have occurred possibly were camouflaged by the mean scores and therefore went undetected by the statistical tests that were conducted. Second, many pulses were not measured at T2 due to the restful state of the patient, therefore skewing the results that might have otherwise been significant. Finally, although music thanatology appears to influence the agitation, wakefulness levels and breathing patterns of the patient, pulse may be affected by other factors not accounted for in this study. While pain and sedation were assessed, further research that identifies and controls for other influences on pulse might yield a greater understanding of the potential effect the vigil would have on pulse rate, rhythm and strength.

There were several limitations to this study. First, measurements were only taken at the endpoints of T1 and T2 and did not take into account changes that could have taken place during the vigil. Other limitations of this study's design include the absence of inter-rater reliability between harpists and the lack of opportunity for using multiple raters. Because of the subjective nature of measuring some variables, it would
be important to incorporate some measure of inter-rater reliability or multiple rater system to achieve standardized rating results in the future, which might increase the power of the study. Also, it is not known to which points the patients are in the dying process. A sample group of patients who were at the same point of the dying process could show alternate mean scores at Time 1 and Time 2. And finally, the study only included those patients who were receiving a vigil for the first time. It is not known what multiple vigils on the same patient might detect.

The findings of this pilot study, however, do suggest a promising line of research in palliative care. It is suggested that future empirical studies should be conducted on patients receiving music vigils, using multiple raters and more sensitive measures as indicators such as continuous instead of categorical rating scales for respiration rhythm, pulse rhythm and pulse strength. In addition, future experimental studies would benefit from conducting this study with those who do receive a harp vigil vs. those who do not. While likely preliminary, the findings from this study provide some evidence that the health care community as well as family members should consider music thanatology as a form of palliative care for dying patients. Therefore, physicians and caregivers should welcome music thanatology as a form of palliative care. Future research in music thanatology is necessary to provide evidence that supports existing programs or hospices which provide music thanatology as a service and to encourage the establishment of future music thanatology training programs.
REFERENCES:


